IELTS

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Investigating the language needs of international nurses: insiders' perspectives

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Abstract

Nurses are required to engage in a wide array of communicative activities, involving all four language skills, for a range of functions that are central to successful healthcare. Many of these are not addressed in the IELTS test papers.

Smith et al (2005) report a large number of complaints of clinical malpractice that are related to weak communication skills of international nurses. If these complaints were justified, they would call into question the current English language requirements for these nurses. To register for practice in the UK, international nurses must first acquire a minimum of 7.0 IELTS in all skill areas. This paper reports on a project that investigated the extent to which existing IELTS English language requirements for internationally qualified nurses are appropriate and adequate for the contexts in which these nurses hope to work.

The approach was qualitative, with data gathered from interviews and focus groups. A rich picture of nurses' daily communication emerged from the study. Nurses have to engage in a wide array of communicative activities, involving all four language skills, for a range of functions that are central to successful healthcare.

The overall findings of the research are that the IELTS test assesses certain aspects, predominantly in relation to listening, of English language use that are criterial for successful communication in nursing. However, in all four skills, there are many competencies required to achieve IELTS Band 7 that are, at most, marginally relevant to assessing whether overseas-trained nurses have the requisite English competence to practise in the UK. Conversely, some language skills and strategies essential for nursing are not tested at all by the IELTS test.

Acknowledgements

Publishing details

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Rev. Dr Mark Garner is Director of the Centre for Language Assessment Research and Head of Whitelands College at the University of Roehampton. He has many years of experience in communication research, particularly in relation to communication by the emergency services and in healthcare. He has established postgraduate programs in Applied Linguistics at six universities in four countries, and has supervised 13 successful PhD students in various topics in Applied Linguistics. He is currently Convener of the Master of Arts in Applied Linguistics and Teaching English to Speakers of Other Languages at Roehampton. He also has a particular interest in the teaching of research methods, and was co-editor of the first book on research pedagogy (Garner, Wagner and Kawulich, 2009). He has presented at national and international conferences, and published extensively, in all of these fields. His latest book (with Dayong Huang) is *Testing a Nation: The Social and Educational Impact of the College English Test in China* (Oxford: Peter Lang, 2013).

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IELTS Research Program

The IELTS partners – British Council, Cambridge English Language Assessment and IDP: IELTS Australia – have a longstanding commitment to remain at the forefront of developments in English language testing. The steady evolution of IELTS is in parallel with advances in applied linguistics, language pedagogy, language assessment and technology. This ensures the ongoing validity, reliability, positive impact and practicality of the test. Adherence to these four qualities is supported by two streams of research: internal and external.

Internal research activities are managed by Cambridge English Language Assessment's Research and Validation unit. The Research and Validation unit brings together specialists in testing and assessment, statistical analysis and item-banking, applied linguistics, corpus linguistics, and language learning/pedagogy, and provides rigorous quality assurance for the IELTS test at every stage of development.

External research is conducted by independent researchers via the joint research program, funded by IDP: IELTS Australia and British Council, and supported by Cambridge English Language Assessment.

Call for research proposals: The annual call for research proposals is widely publicised in March, with applications due by 30 June each year. A Joint Research Committee, comprising representatives of the IELTS partners, agrees on research priorities and oversees the allocations of research grants for external research.

Reports are peer reviewed: IELTS Research Reports submitted by external researchers are peer reviewed prior to publication.

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INTRODUCTION FROM IELTS

This study by Carole Sedgwick, Mark Garner and Isabel Vicente-Macia was conducted with support from the IELTS partners (British Council, IDP: IELTS Australia, and Cambridge English Language Assessment) as part of the IELTS joint-funded research program. Research funded by the British Council and IDP: IELTS Australia under this program complement those conducted or commissioned by Cambridge English Language Assessment, and together inform the ongoing validation and improvement of IELTS.

A significant body of research has been produced since the research program started in 1995, with over 100 empirical studies receiving grant funding. After a process of peer review and revision, many of the studies have been published in academic journals, in several IELTS-focused volumes in the *Studies in Language Testing* series (www.cambridgeenglish.org/silt), and in the *IELTS Research Reports*. Since 2012, individual reports have been published on the IELTS website after completing the peer review and revision process.

In this study, the researchers engaged with nurses in the United Kingdom to learn the ways they use language in their workplace, looking at all four language skills. Obtaining the stakeholder perspective is a common approach for a number of recent IELTS-funded research projects, i.e.: school principals (Murray, Cross & Cruickshank, 2014); teachers (Gribble, Blackmore, Morrissey & Capic, forthcoming); engineers and accountants (Knoch, May, Macqueen, Pill & Storch, 2015); employees in a range of other professions (Moore, Morton, Hall & Wallis, 2015); and doctors, nurses and healthcare regulators (Gribble et al., forthcoming).

Stakeholders' views are very useful. They can inform us about how they use language, and therefore, the extent to which the IELTS test is appropriate for use. They can also inform us about how they use the test, and therefore, the extent to which the test is being used appropriately.

The day-to-day language requirements of nurses are particularly interesting, as this report shows. On one hand, a very high level of skill is required in the oral modalities because communication can involve complicated socio-pragmatics. Patients may obfuscate on sensitive topics, so nurses need to listen between the lines, or patients make requests that nurses must refuse with tact. On the other hand, a lower level of skill appears to be required in the written modalities, because there is seldom the need to read or write complicated extended texts. Mostly nurses deal with notes, forms, charts and checklists.

In applying stakeholders' insights to the assessment of international nurses' and health professionals' language abilities, a few points are worth considering. One is that the assessment has to be designed according to the type of test desired. Where pragmatics are concerned, it can be difficult to determine when one is testing language ability and when one is testing something else. Research shows that there are English first language medics who are poor communicators but excellent clinicians nonetheless – which would indicate that this is not (just) a question of language. In some contexts, there are limitations on what these tests are legally allowed to measure, and in different contexts, they are used in combination with additional checks and requirements. Thus, it is important to determine what is desired, what is allowable, what is feasible, and also what is fair.

Two is to determine how that ability can be tested in a way that is valid and reliable. In writing, for instance, a test can indeed ask nurses to produce notes and fill out forms. However, the amount of language elicited may not be sufficient to reliably differentiate between more able and less able candidates. Thus, in designing these tests, the competing requirements of validity and reliability need to be weighed and balanced against each other.

Three is that an appropriate standard needs to be set. Given what the study found, one would expect that a higher standard would be required in listening and speaking, and a lower standard in reading and writing. A look at the current requirements of regulators shows that this is not the case by and large, so this is an area that regulators may wish to explore further.

In determining an appropriate standard, it is also worth considering the context in which these decisions are being made. The reality is of skills shortages in receiving countries and a not unlimited supply of international nurses. Under the circumstances, one would need to weigh whether the demands of patient safety may be better served by having a larger number of linguistically-qualified nurses or by having a small number of highly-qualified ones.

To sum up, this study raises important and difficult questions, the answers to which are not necessarily straightforward. They are ones that all stakeholders need to continue to engage with, and IELTS will certainly take part in that conversation.

Dr Gad S Lim, Principal Research Manager
Cambridge English Language Assessment

References to the IELTS Introduction

Gribble, C., Blackmore, J., Morrissey, A. and Capic, T. (forthcoming). Investigating the use of IELTS in determining employment, migration and professional registration outcomes in healthcare and early childhood education in Australia. *IELTS Research Reports Online Series*.

Knoch, U., May, L., Macqueen, S., Pill, J. and Storch, N. (2016). Transitioning from university to the workplace: Stakeholder perceptions of academic and professional writing demands. *IELTS Research Reports Online Series 2016-1*.

Moore, T., Morton, J., Hall, D. and Wallis, C. (2015). Literacy practices in the professional workplace: Implications for the IELTS reading and writing tests. *IELTS Research Reports Online Series 2015-1*.

Murray, J., Cross, J. L. and Cruickshank, K. (2014). Stakeholder perceptions of IELTS as a gateway to the professional workplace: The case of employers of overseas trained teachers. *IELTS Research Reports Online Series 2014-1*.

CONTENTS

1   INTRODUCTION

Non-native speakers of English who hold nursing qualifications obtained in countries other than those of the European Economic Area and Switzerland must fulfil two conditions before they can be registered with the Nursing and Midwifery Council (NMC) to practise their profession in the UK. First of all, in addition to professional requirements, they must provide evidence of English language competence by achieving a minimum overall score of Band 7 on the IELTS (International English Language Testing System) test, with no separate skill score lower than Band 7. When this requirement is satisfied, there are currently two systems in operation that specify assessment requirements for full registration:

For applications before 1 October 2014

- successful completion of an Overseas Nurses Program (ONP), which is a compulsory 20-day period of protected learning
- a period of supervised practice, where appropriate, during which they must complete a record of achievement in practice, validated by their mentors.

For applications after 1 October 2014

- a computer-based test of nursing competence, consisting of multiple-choice questions that assess theoretical practice-based knowledge; the test is to be taken at a Pearson Vue test centre in the home country
- successful completion of this test is a pre-condition for an assessment of clinical knowledge in an Objective-Structured Clinical Examination (OSCE), administered by the University of Northampton in the UK.

1.1   Aims of this project

The project aims to determine whether the existing IELTS English language requirements for internationally qualified nurses are appropriate and adequate for the contexts in which these nurses hope to work. The project will address the following research questions:

1.   What are the actual language requirements in terms of each skills area for overseas nursing practitioners seeking to practise their profession in the UK?
2.   To what extent does the IELTS reflect the language needs of practising nurses?

1.2   Context

The context for the research will be different specialist areas in hospitals within the UK NHS.

1.3   Rationale

A disproportionate number of complaints are lodged each year relating to international nurses who obtained their qualifications from outside the European Economic Area (EEA). The reasons given for these complaints are diverse, but errors of judgment, which would usually be perceived as simple mistakes in British-trained nurses, are regularly reclassified as clinical malpractice in internationally-trained nurses, arising from perceived 'poor interpersonal and communication skills' (Smith et al., 2005, p. 75).

2   LITERATURE REVIEW

There is a vast range of literature dealing with the crucial roles that nurses perform in healthcare communication: as advocate, carer, mentor, coordinator, collaborator, assessor and confidante. As mediators, nurses have to express medical concepts in everyday English, and vice versa, adapting their linguistic register to the needs of different professional colleagues and patients (O'Hagan, Manias et al. 2013; San Miguel & Rogan 2012; Apker, Propp et al. 2006; Fleischer, Berg et al. 2009; Bourhis, Roth et al. 1989; Morse & Piland 1981).

Research has investigated how nurses demonstrate professional identities and manage conflict (Apker, Propp et al. 2006; Morse & Piland 1981; Sheldon, Barrett et al. 2006); how they draw on different knowledge sources in patient care (Inger, Andershed et al. 2010); how they facilitate and deal with disclosure of private information (Candlin 1997; Ford 2009; Petronio & Sargent 2011); use strategies to elicit specific information from patients and colleagues (Apker, Propp et al. 2006; San Miguel & Rogan 2012; O'Hagan, Manias et al. 2013; Epp & Stawychny 2002; Rayo, Mount-Campbell et al. 2014); and reassure anxious patients (Apker, Propp et al. 2006; O'Hagan, Manias et al. 2013). All of these studies illustrate aspects of the range and complexity of spoken communications in nursing.

Additional communicative demands are reported by (O'Hagan, Manias et al. 2013; San Miguel & Rogan 2012; Candlin 1997; Fleischer, Berg et al. 2009; McCabe 2004), which are attributed by Candlin (1997, 2002) to recent changes in nursing practices from task-based, focusing on physical needs, to a therapeutic, more holistic approach to patients' psycho-social needs, implicating sophisticated communicative resources. These challenges to nurse communication are likely to be compounded when nurses who have developed professional identities and knowledge of practices in different cultural and linguistic contexts come to work in the UK.

Buchan and Seccombe report a recent rise in the registration of nurses from EU and non-EU countries, with a relatively higher increase (numbers have doubled in the past two years) in the former. The largest groups in the former category are from Romania, Portugal, Spain and Ireland, and in the latter category, from India and the Philippines. The rise is attributed to a shortfall in the supply of nurses in the UK following reduced funding to recruit and train British nurses and to stricter work permit and registration requirements for non-EU nurses. Previous nursing shortages resulted from similar cuts to the funding of UK training in the late 1990s, when internationally trained nurses provided a short-term solution. Recruitment of international nurses peaked in 2002, when they constituted almost half the nursing workforce. Buchan and Seccombe argue that it is too soon to predict a rise, but there is definitely a reversal of the 2002–2010 downfall (2012). NHS Employers (2014) report a shortage of nurses leading to a policy of active recruitment of overseas nurses with a trend towards the recruitment of EEA nurses.

Two million candidates took the IELTS test in the 12 months prior to May 2013. The test is currently recognised by more than 8,000 organisations worldwide, including many professional organisations. It was developed as an English language test for university entry in the UK. Originally launched as the ELTS (the English Language Testing System), it was revalidated in 1989 as the IELTS (International English Language Testing System), in partnership with the International Development Program of Australian Universities and Colleges (IELTS, No Date).

Merrifield (2007), who conducted an impact study into the use of IELTS by professional associations in the UK, Canada and Ireland, observes that the test began to be increasingly adopted outside the universities as an English language entry qualification between 2000 and 2009. She was unable to account either for the decisions that led to its adoption, or for the stipulation of specific levels required for health professionals wanting to practise in these countries because records were no longer available. However, she points to the fact that the test is attractive to organisations because there is broad accessibility; frequent test dates (it is offered four times a month in over 135 countries with a broad network of test centres); and a short waiting time for the results. The test is also valued because it tests performance directly (using authentic writing tasks and a real-life person-to-person interview), rather than indirectly through grammatical and lexical competence (Merrifield 2007). Furthermore, the security and integrity of the IELTS and the research underpinning the quality assurance processes inspire confidence in the test.

Nonetheless, despite the assurances of quality, researchers have questioned the content validity of an English language test, which was designed for university entry, but has come to be used as a language entry test for other professional contexts.

Davies (2001), in his review of the early versions of IELTS, argues that the later general version of the test is no worse an indicator of linguistic performance than the earlier versions, which included specific purposes modules that students could select. He concludes, however, that there are sound pragmatic reasons for designing tests that assess language use for a specific purpose (LSP) because candidates' motivations for taking the test are largely instrumental (i.e., to register to practise in a specific professional area). Merrifield (2007) agrees, and argues for an LSP test designed specifically for nurses and based on the results of research into communication requirements in this field, on the grounds that testing nurses was a relatively new and unexamined application of IELTS. In her study, three health organisations in the UK, one in Canada and one in Ireland advocated specific health content in the IELTS test (2007) for use in this field.

Arakelian (2003) and Hearnden (2008) are highly critical of IELTS as an English language entry qualification for nurses because, they argue, the academic test tasks are not relevant to communication in nursing. For example, the writing focuses on argument and paragraph structure, rather than note-taking and record-keeping, which are more important kinds of writing for nurses. Moreover, the claim that IELTS is culture-free does not seem relevant or appropriate to nurses, who need to be able to deal with communication requirements in a specific cultural context (Arakelian 2003; Hearnden 2008).

The only IELTS benchmarking study that has been conducted specifically in relation to communication in nursing was undertaken by O'Neill et al (2007) for the National Council of State Boards of Nursing (NCSBN) in the US, who wanted to recommend to nurse licensing boards a minimum English language requirement on the IELTS exam for safe and effective practice. A panel of 28 experts was convened for the study. Most of the panel members were practising nurses, including international nurses who had taken the IELTS as an entry requirement. A minimum level of 6.0 in each skill and 6.5 overall were recommended as a result of the study, and this was accepted by the NCSBN. The O'Neill study did not, however, critically examine the content validity of the IELTS test.

There have been specific purposes English language tests for nurses in Canada since 2002 and Australia since the early 1990s. The Canadian English Language Benchmark Assessment for Nurses (CELBAN) involved nationwide research using mixed methods: a survey with 1,000 nurses, who were asked to rank language tasks; focus groups in five Canadian provinces; interviews and observations (Epp & Stawychny 2002).

The Occupational English Test (OET), designed for health professionals who want to register to practise in 'an English speaking environment' (OET, 2007) is recognised in Australia, New Zealand and Singapore. The specifications were developed by McNamara (1990)

using questionnaire data from previous test candidates who had progressed into practice, and direct observation of health professionals in the workplace. As local nurses were on strike at the time, the questionnaire data for nurses was supplemented by data from discussions with nurse educators and those responsible for retraining nurses. McNamara describes the test as a 'weak' performance test because it focuses on only the linguistic aspects of performance. The speaking module is currently being reviewed to strengthen the OET to reflect more closely health practitioners' communication. The first phases of the project have involved what Pill and O'Hagan (2012) term 'indigenous' criteria. They collected and analysed nurse trainer feedback on trainee interactions with patients.

The CELBAN and the OET claim to assess the English language proficiency of nurses for safe practice in Canada and Australia respectively. The question arises, however, of how specific a specific purposes test can be (Alderson 1988). Alderson (1981), Davies (2001) and Fulcher and Davidson (2007) have argued that language tests cannot be too specific because it is impossible to adequately predict language in a domain of use. On the other hand, Weir (2005), Douglas (2000), Brown (2008), and McNamara and Roever (2006) argue that research on language in the target language use situation is necessary, despite the difficulties involved, to ensure the context or content validity of a test. This is reflected in the research questions of the present study, which uses qualitative methods to assess whether the academically-oriented IELTS test is appropriate for all nurses wishing to practise in the UK, and, if it is, whether the levels specified for each skill, and overall, are adequate (or even too high).

3   METHODOLOGY

3.1   Theoretical framework

The epistemological framework that underpins this project is essentially constructionist. The decision to focus primarily on a non-positivist paradigm reflects the nature of the questions to be answered in the study: the data must be situated within the work experiences of nurses. It was therefore necessary to 'construct' our understanding of these needs through carefully managed interactions with nurses and through a systematic monitoring of the demands on their language in a typical working day.

In terms of test validation, this practice-based study links an understanding of a language domain, (Mislevy et al., 2003) with that of the cognitive resources brought to that domain by practising professionals (Weir 2005). In other words, it connects the test-taker to the language of the domain (Weir 2005; O'Sullivan & Weir 2011; O'Sullivan 2011), thus helping define the cognitive linguistic resources needed for an individual to communicate successfully in the domain.

It also, crucially, provides information about linguistic performance requirements in the nursing domain and how these requirements are reflected in the test.

3.2   Research design

Qualitative data were gathered from focus groups and in-depth interviews, to provide an emic (insider's) perspective on communication in nursing. The research investigated communication as a social behaviour in the hospital, to discover what communications nurses regularly engage in, and, through working closely with individual nurses, what unexpected communications they may have to deal with. Given the relatively small size of the project, a rigorous investigation of IELTS levels required was not possible. The primary focus of the current project was on identifying nurses' communication practices in order to address the research questions, in particular question 2, which has not been directly addressed in previous IELTS research.

The table below shows that the project design consisted of two main phases focusing on qualitative data from interviews and focus groups, supplemented and supported by documentation: codes of practice and standards for competence, registration requirements for international nurses from the NMC website; hospital literature (protocols, forms); email exchanges with participants; and information for test-takers, researchers, organisations and teachers from the IELTS website.

Phase	Instrument	Analysis
Phase 1	Tracking Study	Qualitative analysis of the transcribed audio data from weekly interviews with four nurses over a period of 1 month.
Phase 2	Focus Groups	Qualitative analysis of responses from two focus groups: UK-trained nurses, and overseas and EEA-trained nurses

The tracking study constituted the first phase of the data collection process. Initial findings from the tracking study helped to inform questions and prompts for the focus groups.

3.2.1   Ethical considerations

As the project was undertaken by CLARe, ethical approval was sought and obtained from the University of Roehampton's Research Ethics Committee. Ethical considerations included the following aspects.

- *Method of recruitment of participants*
  Participants were recruited through personal contacts. No participants were recruited though the NHS.
- *Preservation of participants' anonymity*
  From the transcription phase onwards, individuals were referred to by a coded identifier (e.g. N1, N2 – nurse 1, nurse 2, etc.). At no time were names associated with the participants (either on the recordings or in the transcriptions).

▪ *Participants' informed consent*
All participants were given two consent forms, containing information about the project including: the scope of the study; the number of participants; the duration of the study; and the risks and benefits of the project. They were asked to sign one consent form and retain the second for information. They were informed that they had the right to withdraw from the project at any time.

▪ *Risks and benefits to participants*
There were no perceived medical, physical or psychological risks associated with this project. The project was carried out within the UK and no participants were aged less than 18 years; overseas regulations did not therefore apply and CRB checks were not required. Members of the focus group and nurses involved in the tracking study were paid a research participants' daily sum of £20 per person to cover out-of-pocket expenses (keeping records, stationery, etc.) plus travel expenses and refreshments during interviews. Nurse advisors were paid an honorarium of £300 per day.

▪ *Storage of data*
Raw data: recordings have been stored in a password-protected folder held on a secure drive at the University of Roehampton.
Numerical data: as above (all files are password protected and no names or other information to be used for identification purposes are contained in these files). All data will be retained for a minimum of 10 years from the date of any publication that is based on it.

▪ *How ethical considerations arising from the project will be handled*
The research considered the English language requirements of all non-English-native speaker potential nurse applicants to the NMC register and did not seek to differentiate on the basis of either nationality at birth or current citizenship.

NHS Research Ethics Committee approval
This project is a Service Evaluation rather than Research as defined in the NRES publication *Defining Research*. No patients were recruited through the auspices of the NHS. Consequently, ethics approval was not required from the NHS Research Ethics Committee. Furthermore, as nurses were interviewed in their own time outside their hospital setting, approval was not required from hospital management.

3.3 Data collection

3.3.1 The tracking study

It was decided to track non-native (including EEA) rather than native English-speaking nurses because they are (or could be) required to achieve the specified IELTS scores; hence their views are more germane to the aims of the research.

Four non-native English-speaking nurses (two trained within, and two outside, the EEA), all of whom were working in London hospitals, were each tracked for one month.

Each nurse was interviewed, as close to the end of a shift as possible about the communications he/she had dealt with during that shift. All interviews were conducted in the nurses' own time, away from their place of work, and, as far as was practicable, the interviews followed shifts at different times and on different days of the week, so as to provide as comprehensive a view as possible of the totality of day-to-day communication. Before the final interview, the four participants completed a practice IELTS test, and in the interview their accounts of the communicative events they had engaged in were reviewed in relation to that practice test.

The participants' details are as follows.

1. N1 is a male nurse from the Philippines working in the post-anaesthesia unit of a public hospital.
2. N2 is a female nurse from India working in a surgical unit in a private hospital.
3. N3 is a female nurse from Portugal working in the high dependency unit of a public hospital.
4. N4 is a female nurse from Hungary working in the admissions department of a private hospital that specialises in plastic surgery.

Of the two nurses from outside the EEA (N1 and N2), only the latter had had to achieve the required IELTS levels; the former came to the UK 13 years ago, before this requirement was introduced.

3.3.1.1 Preliminary meetings

The consent form was circulated to the nurses that had agreed to participate, before signing. The researcher arranged a preliminary meeting with each nurse, either via Skype or in person. This meeting aimed to build trust and rapport – a conversational partnership (Rubin & Rubin 2005) – by sharing contextual information and encouraging the participants to ask questions.

The researcher began by explaining the aims of the project and the requirements of participants, confidentiality, and the right to withdraw. Secondly, the researcher explained her role in the university and interest in the project, and encouraged participants to ask questions and talk about, *inter alia*:

▪ their roles as nurses in their country of origin

▪ their roles as nurses in the UK

▪ their reasons for coming to the UK

▪ the length of time they had worked in the UK

▪ the number of years they had studied English and the nature of their language training, including opportunities for practising English before they came

▪ differences they had noticed between nursing practices and culture in their former country and the UK.

The researcher took notes on each nurse's bio-data during this part of the meeting. At the end of the meeting, the rules of engagement were established, the times, places, and duration of future meetings were negotiated, and how and when meetings might be cancelled or rearranged. Permission was sought from, and granted by, all the participants for the forthcoming interviews to be recorded.

3.3.1.2 The interviews

The interviews were open-ended. Nurses were asked to take the researcher through the previous shift from the beginning to the end, focusing on their communications. The interviewer participated as an active listener, back-channelling, asking for clarification and/or expansion of points, and prompting where relevant, to maintain the focus on communication. Notes were taken during the interviews, for backup in case of recording failure, and to highlight points that were regarded as salient by the interviewee.

The interviews usually lasted about an hour. They were held in cafés in locations convenient for the nurses, where they could relax and unwind with food and a non-alcoholic drink, if they wished. The locations gave rise to occasional interference from background noise in the recordings, but the natural redundancy built into the conversation resulted in no serious loss of information.

As noted above, before the final interview, all four participants were given a copy of practice IELTS papers for reading, listening and writing. They were asked to complete, in advance of the interview, the reading test and also to consider the relevance of all three tests to their work as nurses. In the final interview, nurses listened to extracts from each listening task, and assessed extracts from recordings of spoken performance and responses to writing tasks, using the IELTS 'public' criteria for each skill area. They were then prompted to compare practice material for each skill area with communications they experienced in nursing.

3.3.2 The focus groups

Two focus groups of practising nurses were convened to provide further insight into types of activities and interactive events in specific nursing contexts and to identify actual language requirements of nursing in those contexts.

Details of the focus groups are as follows.

Focus group 1

Venue: A London training centre for nurses on the Overseas Nursing Program.

Participants: Four nurses who trained overseas and who are non-native speakers of English. Specifically, the participants were:

- a female nurse from India working in admissions in a private hospital
- a male nurse from the Philippines working in recovery in a London public hospital

- a female nurse from the Philippines working on a ward in a London public hospital
- a female nurse from the Philippines working in a public nursing home.

Focus group 2

Venue: A training suite in a busy NHS hospital.

Participants: Seven female nurses who trained in the UK and are native speakers of English. Specifically, the participants were:

- a ward sister
- two surgical ward nurses
- a high dependency unit nurse
- two ward nurses
- a cardiology ward nurse.

The focus groups were attended by the three members of the research team: Dr Carole Sedgwick, Dr Mark Garner, and Ms Isabel Vicente-Macia. All three participated in asking questions and providing prompts to facilitate the talk. Before the focus groups formally commenced, all those taking part shared refreshments and engaged in social interaction, with the aim of establishing a warm, relaxed, and trusting environment for the ensuing discussion.

As in the tracking study, a copy of the consent form was sent to all participants. The form gave participants a brief outline of the project and their ethical rights. All this was further explained verbally at the beginning of each of the focus group meetings; participants were given the opportunity to ask questions, and the chance to withdraw. They were also asked for permission to audio-record the group discussion; they were assured that recordings and transcriptions would be seen only by the researchers, that any published extracts would be anonymised, and that specific items would be removed from the transcript at the request of any participant, either at the time or subsequently.

The following prompts were then used to generate discussion between participants relating to their communications.

1. Think of a recent example of a communication in your workplace that was challenging. Describe the communication to the group and say why it was challenging.
2. Brainstorm: with whom do nurses communicate in their work, and for what purposes?
3. Describe a recent exchange involving you, a doctor and a patient.
4. What do you think is typical of the various kinds of communication that nurses have to engage in? What is typical about them?
5. Anything more about communications that has not been mentioned.

3.4   Analysis

3.4.1   Recording and transcription

The interviews and focus groups were recorded using a DS5000 digital recorder and uploaded onto a Mac PC using DSS player software. The interviews were transcribed in standard written form using an AS5000 Digital Transcription kit. It is well established that the data are transformed at each stage in this process, but the significance of the transformations is reduced by focusing the subsequent analysis on the salient themes and topics rather than on the detailed linguistic realisations of them. However, false starts and hesitations were included, as much as possible. This was to give a flavour of the discussion, and to indicate where participants were choosing their words more carefully, or had difficulty expressing what they wanted to say, which could inform the analysis. In doing this, the researchers were cognisant of 'managing the tension between accuracy, readability, and political issues of representation' (Duff & Roberts 1997, p.170).

3.4.2   Analysis

The members of the research team shared access to the collected data, transcriptions, and the developing analysis via Dropbox. The transcriptions were analysed with the aid of NVivo 10 for Mac software. The recordings were used to complement the transcription, to provide a check for accuracy and to inform the interpretation of the data (Flick 2009). The analysis focused on the participants in daily hospital communications (spoken and written) involving nurses, and the nature, frequency, purposes, and challenges of those communications.

Material provided for teachers on the Cambridge ESOL IELTS website (descriptions of the examination, practice tests, resources for practice and assessment criteria), as well as research investigating the IELTS test were examined to identify what was assessed in each skill area: speaking, listening, reading and writing. This was compared with nurse accounts of their communication practices in the tracking study and focus groups, and nurse estimates of the relevance of practice materials and the 'public' criteria at the pass level of 7.0 for registration in the UK.

3.4.3   Feedback

A draft version of the final report was submitted to four expert readers (a nurse, nurse trainer and two long-term patients) for their evaluations and comments. All four stated that the project reflected their experience of nurse communications. Some suggestions were made for minor modifications of detail, which were incorporated into the final report.

4   NURSE COMMUNICATIONS

4.1   The tracking study

It is evident from nurses' accounts of their communication practices that the 'language of nursing' is highly complex and multi-faceted. Nurses described communication practices during the day in different hospital environments: general nursing on the wards in two private hospitals, a post-anaesthesia care unit, and a high dependency unit. Some practices are common to all; others are more prominent in one or another environment. Each nurse's account, to a greater or lesser degree, focused on patient care through the hospital process. Accounts moved through admission, pre-operative care, theatre, post-anaesthesia, post-operative care, to discharge, post-discharge complications, and a possible return to the ward.

Communications are described under each skill heading in terms of the social functions they perform. The illustrative excerpts from the data explain these functions, which cannot be understood independently of the communicative context.

4.1.1   Speaking

4.1.1.1   Communicating with patients

Nurses are in charge of patient care. They are expected to induct the patient into hospital life, elicit and check information for patient records, keep the patient informed, request cooperation from the patient, and respond to the patient's needs.

An important general point to note is that social conversation plays an important role in establishing a good relationship that will help to make the patient's time in hospital as positive as possible and facilitate more specifically healthcare-related communication. This essential communicative skill is discussed in more detail below.

4.1.1.2   Eliciting information

Participants recounted eliciting and checking personal information and medical history at different stages in the process of patient care. This function is particularly salient for the ward nurses in the private hospitals, because they are responsible for admitting the patient.

> ...have to check the patient's main basic details, like the name, date of birth and the spelling. If something is wrong, then you have to start the process. (N2, Interview 2)

Nurses have to find ways to elicit information about negative reactions to medication:

> I ask the patient about the – about the pre-op check list completed that uh we have to – and encourage the patient actually during the admission process to give us explanation if they have any worse reaction of any medications. (N2, Interview 2)

Strategies to facilitate this include replacing vague general terms with more concrete examples that patients are likely to understand:

> *We can ask the patient: 'Do you have any allergy, drug allergy?' The patient said: 'No' and then… [you find] they are allergic to seafoods. [They say] 'you didn't ask, you said medication', but sometimes it's the same because when you're allergic to seafood that means you are allergic to iodine because seafoods contain iodine.* (N1, Interview 1)

Such examples require nurses not to make cultural assumptions:

> *We have to check about their jewellery or body piercing, they have any contact lenses hearing aids …one day, like, I had a patient, she was elderly, and I didn't ask her about the belly piercing, and then we went to theatre…and when the anaesthetic nurse, she had to check with the patient same questions which we have asked…so she asked her: 'Have you got any body piercings?' She said: 'Oh, yeah, my belly'.* (N2, Interview 2)

Another essential strategy is to check against the hospital records information that is given to the nurse:

> *They have to be able to confirm their full name and date of birth for you to be able to match that and to be sure that the identification is correct.* (N3, Interview 2)

> *[When] they are ready for this patient we have to go through the paperwork again saying like the consent form is signed or if they've got like knee surgery or hip surgery it's marked with the band so we have to do the check again [at the] beginning [we] will tell them, 'These are the questions we're gonna ask you again and again'.* (N2, Interview 2)

Eliciting information about the patient's condition is an essential part of monitoring a patient's recovery:

> *I always ask: 'How're you feeling?' 'Do you have any pain?' 'Do you feel sick?'* (N4, Interview 2)

> *We do full assessments of the patients…So things like …we ask the patient: 'How are you feeling?'… if the patient is in pain and how much pain does he communicate to me, I have to write it, and we use a certain pains force. So…how much pain would he be feeling from 0 to 10…being 0 low pain, 10 the worst pain that you ever imagined and they give that information.* (N3, Interview 1)

Nurses may need to check a patient's willingness to allow others to be present during a potentially embarrassing examination:

> *There was one situation where I had to do a twelve ECG, electrocardiogram, and it involves exposing her chest, I've asked her whether she wanted me to ask the family to leave, and she said no. She wanted them to stay.* (N3, Interview 3)

One important function of the capacity to engage in social conversation, mentioned above, is that it can assist the nurse to elicit essential information:

> *When they're chatting and they're doing a lot of stuff and then when you started asking: 'Are you in pain?' and they started concentrating, 'Uh, yes, there is some – a little bit in my –' after all this conversation.* (N1, Interview 3)

> *He will close his eyes, and he will hold his chair very tightly, so I'll ask: 'Are you in pain?' and he'll say: 'There's cramping pain'. So, because when they are talking, we can…understand the emotion, like if anybody is in pain, they won't be able to talk normally.* (N2, Interview 3)

4.1.1.3 Providing information

Nurses need to orient the patient to the hospital environment, as well as explain facilities, processes procedures, and recovery.

> *First of all are we gonna wish them like good morning or good afternoon. Then you have to introduce ourselves, like my name is X and I'm going to admit you – prepare you for the procedure. We have to explain the process what I'm going to do, and then…* (N2, Interview 2)

> *So we receive them at reception and we take them straight to the room and then we show them the ward where they can find nurses' station, if they need anything. Then show them around the room, just show them that they have a bathroom in the room, they don't have to go out to the corridor for that. Just let them know they can turn on the TV. They can make themselves comfortable. Show them there is a big wardrobe they can put their stuff in and just tell them some general information like fire alarms and these things.* (N4, Interview 2)

> *We have to explain to the patient like what procedure they had and how long it will take for them to recover.* (N2, Interview 2)

They may have to explain such matters to the patient's family over the phone:

> *He asked me to speak to his wife over the phone because he wanted to know what he could have with him and the wife is gonna come and visit him that afternoon…she wanted to know…exactly what she could bring him into the hospital…things like toiletries, slippers, and something to entertain, if they like to read or in this situation he had an i-Pad, so, it was the i-Pad.* (N3, Interview 3)

4.1.1.4 Requesting action

Nurses need cooperation from the patient in pre- and post-operative care. A particular example is the need to give instructions to the patients about behaviours that will aid the recovery process. After discharge, this is in the form of a written discharge letter, which must also be explained verbally:

> *We have to write the discharge letter, and with date information about the procedure…we have to elaborate that, and we have to give them instructions about the wound care pain management and if they got stitches, like when the stiches gonna come out, plus any appointment with the consultant, usually we send them by post. So we have to inform them everything, and we have to let them know that if they need anything, they can call us directly in our ward.* (N2, Interview 2)

There is a need to offer alternative solutions if a patient is unwilling to comply with a request:

> *Ah, first step, what I ask is about the jewellery… usually people don't like to take off their wedding ring so we have to offer them…to cover the wedding ring with a tape.* (N2, Interview 2)

The need for an alternative solution may arise from pressures on space in the hospital:

> *I've explained to my patient that we have to leave that room…I've explained to him that luckily he didn't have any isolation risks, so, he didn't need to be in that room although it was quite comfortable to be in a separate room. If he would mind we would move into a bay. And I explained to him what was going on. He was quite OK with it.* (N3, Interview 3)

At times, a patient's unwillingness to comply with a request may be so strong that the assistance of a superior has to be sought in order to avoid conflict. Uncooperative behaviour can put the nurse in a vulnerable position – for example, if the patient's condition were to deteriorate – so detailed record-keeping is also essential.

> *[The patient] was elderly, so doctor asked us to allow him to stay for few hours…before discharge I told him that he need to mobilise, and when…he can walk normally and there's no problem, he can go home. I took him for a round, but he was running…In the corridor. So 'You don't need to run', only he said he can't walk slowly. OK. But later on I checked his dressing. There was a little ooze. When he came back after surgery it was nice and clean…I gave him all the instructions, saying like he's…not allowed to do any heavy lifting but his bag was very heavy. So, I told him: 'Do you need a hand, so I can drop you downstairs?' He said: 'No, it's fine'. He didn't allow me to say anything. My manager, luckily, she was there, so she saw that I'm explaining him everything, but was no bother at all…And when he left, she came to me and she…asked me to write everything that I've explained…to the patient, and saying like patient was not paying any attention.* (N2, Interview 3)

> *Because he had anaesthesia today, 'I can't allow you to go for a fag, but, if you want to go, it's your choice', but he said he have to go it was his wish…I documented on the notes, and I informed the consultant, and I rang him, and I told him that he went for a fag. Since then he was going every half hourly…I told him: 'Whenever you will go, please let me know', in case he's gone for a fag and he fainted there, it's my responsibility, and…he he had a lot of family members there. I said: 'Don't allow him to go alone because if he faint, he's gonna be in trouble'.* (N2, Interview 3)

4.1.1.5 Refusing a patient's request

The pragmatics of refusal, in any context, require communicative tact (Leech 1983), the more so if the interlocutor is a patient who is anxious or in pain:

> *He was complaining that it was really painful for him to sit up, because he's had the operation on his abdomen so it…wasn't very comfortable for him and uh yes, so he was a little bit crying, which I can understand because you know some people just, if they don't feel well they don't feel well.*

> *C: How did you deal with that? What did you do?*

> *I just had to reassure him that he just need to rest a little bit and…during the transfer to the ward from recovery that makes them feel a little bit uncomfortable and I…explained that I can't give him any medicines for the pain and the sickness… he's had already something in recovery, and I said to him maybe…the transferring makes you feel a bit uncomfortable. So just I advised him to have a little rest for about half an hour and then, if he still feels uncomfortable, we can give him something.* (N4, Interview 2)

> *This morning, she was uh – she was very chatty, and she asked me, 'Could you give me extra pillow?'… And I said to her: 'Can I just get the pillow when somebody is around because I cannot leave you on your own to get the pillow?…I'm still not allowed to leave you on your own', and she said: 'OK, that's fine'.* (N1, Interview 3)

As a representative of the medical staff, a nurse often has to respond with patience and firmness to a patient's request, and explain the reason for a delay.

> *She said…she's going home at 4 o'clock which is not good, it's actually her consultant's fault because we are ringing him…he must be in theatre, so the phone was going on voice mail. He rang back around 3 o'clock…She wanted to go at 2 because her father was there like around one-ish…she was pressing the buzzer half hourly. What is happening? What is happening?…[I] told her we left the message and he must be in theatre that's why he's not responding. Every half hour we have to literally go there tell her the same story. (laughs)* (N2, Interview 3)

They only ask us sometimes is what time they going down to theatre, and we always say, 'Well, don't know really. The consultant will come. He's got a list. He will tell you if you are the first or second or third.' Or, if you know that theatre is running late, you just say, 'Sorry but theatre is running late so might be a bit delay'. (N4, Interview 3)

4.1.1.6 Reassuring the patients

Catering for a patient's needs, wants and concerns demands much more than the straightforward communication of information. It involves taking account of the patient's self-esteem, feelings and concerns. Nurses have to have a range of strategies for calming and reassuring patients. As experienced professionals, they may appeal to normality, and give assurances of positive outcomes:

N: She was very anxious when she was talking to me …she was like, literally, shaky. I asked: 'Are you OK?' and she said, yes, she's fine, but she wasn't. Then I told her that after surgery she will be fine, and it's normal…even though it's a tiny operation, we are anxious. So there's nothing to worry. I just gave her a little bit of psychological support, make sure she's OK.

C: Did that seem to calm her a bit?

N: Not really, because she recently – she had her breast surgery for cancer. She was saying like, it's not been a very good year for her. I said, don't worry, the year is ending soon, so she'll feel fine. (N2, Interview 3)

She was a bit anxious. She was a bit scared of the anaesthetic…I knew that she's had this before and I just tried to tell her: 'You know, you had this done before it wasn't a bad experience. You know what to expect, roughly, so it can't be worse really'. (N4, Interview 3)

I said, 'Everything is OK. It's gonna be OK, don't worry'…because she looked quite scared and quite concerned. I said that…to reassure her…And she turned to me and said: 'That's what they said last time'. And you can understand how she would be. (N3, Interview 3)

N3 reported spending two hours trying to calm the patient, who was extremely anxious because she was returning for a second cardiac operation as a result of complications arising after the first. In her effort to ensure she did not subvert her efforts, N3 completed her records while continuing to talk and reassure the patient:

What I did in that situation was, I had my notes in the computer. [I] explained to her that I needed some time to get the paperwork ready, but I was there listening to her talking to me and I would answer. (N3, Interview 3)

Time pressure, which is often a complicating factor in nurse-patient communication, is evident here because the records needed to be complete before the patient could progress onto the ward. In this incident, Nurse 3 was under pressure from the sister-in-charge to vacate the bed.

And she…was very grateful 'cos we…understood her requests and all…I had my nurse-in-charge saying that I had to clear the room until 11 'clock in the morning…We are very pressured in terms of getting patients in and out. So this is something that we need to, we kind of get used to work with it, but it's not that easy. (N3, Interview 3)

It can be helpful to assure the patient of the support of others in the hospital community.

I explained that his temperature was high, and obviously he asked what could be the cause, and he was a bit concerned about it, and I did explain to him that it's a common situation…it would likely be that we have to take some blood samples to try to find out, and I said I would communicate it with the medical team. (N3, Interview 2)

Providing assurance may involve more than one medium of communication as well as other participants:

They're already stressed 'cause they didn't have anything to eat and drink…I always tell my patients after finishing the admission that I'll tell the catering staff that you are here so you can order something to eat and drink later on and they say, 'Oh, that's fine, thank you'. (N2, Interview 2)

[After discharge] they sometimes phone up 'Oh my nose is bleeding' after a rhinoplasty, for example, but we always say it is normal, and we even say it before they go home…We can give them advice uh, but if you can't help them we…just say: 'OK give me your phone number. I will ring your consultant, and…he would give you a call back'. (N4, Interview 3)

4.1.1.7 Engaging the patient in social conversation

As noted at the beginning of this section, social conversation plays a variety of roles in patient care. It aids recovery:

Some nursing care is not really urgent. I just let them talk because sometimes it's also therapeutic to say what you want to say. It makes you feel better, and helps your recovery as well, and…at the same time you can assess them…You don't let them sleep all the time…sometimes it's a good diversion as well if they're in pain or things like that.
(N1, Interview 3)

N: I was able to have a sort of social, while we were walking around, which was one of the things I wanted to do with him, because he was a week in intensive care in bed, so he needed a lot of physiotherapy. That was like his second walk, so, it was really important for him. He was a bit scared. And, again, I managed to do a few checks and my nursing bits in that period of time.

C: So, you're assessing him while you're actually walking around as well.

N: Yes. So, I did one assessment before he got up and walked with me, and then, as we were walking we were talking about different things.
(N3, Interview 3)

Social conversation can provide a distraction from unpleasant procedures.

C: Do you do you have much opportunity to talk to the patient, chat to the patient? Do you just, asking about their lives or…?

N: Yes I always do because uh it's easier for them to tell me like uh if I – I always – I encourage them to talk because if…I need to give you injection she would just – it's not nice, so I always try to talk.
(N2, Interview 2)

Furthermore, it helps to maintain the dignity of the patient.

C: Did you carry on talking to her when you were going upstairs?

N: With the patients, yes uh. Sometimes I talk to the porter, but uh but at the same day I cannot [talk about] the patients, so it doesn't make the patient feel isolated. You just doing your own conversation… I always make sure that if the patient sometimes is quiet like this morning. When we transferred her… she was probably tired, so I said: 'Are you OK?' because she was bit chatty.
(N1, Interview 3)

There is an important role for humour, which can promote a patient's sense of well-being:

And later on he had bone scan, and when he came back, he will come at the nursing station, and even though we're doing something, start talking with us because he must be bored doing nothing…He was chatting. I was completing the notes. 'You're really active now go back to your room because anyone who's pregnant can't go near him because…he's radioactive for 6 hours. Maybe I'm pregnant. Go inside your room'…I was kidding…He said OK, finish your work, then I'll come back.
(N2, Interview 3)

One of our patients…the health-care assistant went to help him to put the gown. I was busy with the other patient. After that I went to put some eye-drops in his eyes…and he told me, 'You know that girl she was very rough when she put the dressing-gown and he had one big line here…Look, my arm is shorter'. 'Oh my god, how come it's possible? Did you told her?' He said: 'No, if I'll tell her she's going to feel bad. She's a nice girl'… I said: 'OK, I'll check with her', and later on I told her. She said, 'Oh my god'. They both made me feel a fool. (laughs) He said: 'We're trying to make you fool'. I said: 'I can't smack you because you got pain everywhere…' and they were laughing.
(N2, Interview 3)

…because nobody wants sympathy from anyone, isn't it, even though if I'll be at that stage I don't want anyone to…sympathise towards me…not a lot of humour around. (N2, Interview 3)

Humour may be particularly helpful if a patient's self-esteem is threatened.

I helped her to eat as well because they have so many contraptions…I know she can manage I want to try to promote independence, but at that particular moment she needed some help, so I said to her, 'Just tell me want you want and I'll do it for you'…'Do you want some butter and marmalade?' and she said: 'Just give me as a piece...you can feed me like a baby'. I said: 'Yeah, yeah, you're a big baby'. So I fed her, actually. (N1, Interview 3)

4.1.1.8 Interpreting and translating

If the patient speaks little or no English, there are additional challenges in all of these communications. This can demand a great deal of patience and ingenuity from the nurse.

I've had experiences with having to call family with a patient that does not understand English…patients get really agitated and you can't understand what they're saying. They can't understand you and it's a big drama…You don't know whether they asking for tea or they're asking for painkiller…There was one time that we had to call a patient's son into the hospital around 2am, because this patient was shouting…When you do have Arabic patients that don't speak any English, we ask their family to put in a piece of paper things like this: 'pain' and then they write how you say the word 'Salaam' and then they write their thing, whatever it is…So, you can do that and the patient can point or if they say 'Alam' you know it's pain and then things like that. Water, tea… I know a few...ICU [Intensive Care Unit] has these charts because obviously some patients can't communicate…because they have tubes down their throats, for example…They have these charts with pictures, so you just point at the pictures. So, you have means of non-verbal communication to try. So this is quite useful. (N3, Interview 2)

In addition to using strategies to interpret and translate in communications with non-native speakers of English, nurses must be able to translate medical language into terms comprehensible to every patient:

So she was…really concerned of everything that was going on around, really tearful. And I had most part of my morning was sitting, literally, sitting down with her, and her husband, to go through the whole of her journey in hospital, so to speak…She sort of…wanted everything to be explained in detail, every little thing that was gonna be done to her…It is a challenge to put some of our technical things into words that people can understand because if I was to talk to her in a very technical way, she wouldn't understand it. And I think she would be more alarmed, because it all sounds very – very serious, very complicated. (N3, Interview 3)

When we are talking to the patient, we are not going to talk to them like in medical languages like we are…going to use the layman language with them, we are not going to use the scientific word, we have to make it easier to make sure they understood, we want to explain them and what we want them to do. (N2, Interview 3)

When the teams come…in, next to the bedside of the patient, things are discussed in terms of the clinical situation of the patient. They address the patient in terms of wanting to know how they are, what they need. Then we [nurses] sometimes…speak a little bit more technical. So most of the times, we apologise to the patient and we say we're now gonna speak a bit about numbers and technical things, but, obviously, then we will explain to you…what it is what we're saying. Between me and the medical team, we have that communication in terms of numbers and [inaudible] and infusions and things like that… And a plan is make for the day and it's written on the notes and we explain to the patient what it is, that we are talking about, and what it is that's gonna happen at that moment. (N3, Interview 1)

Explanations may have to be provided for the family as well.

So [the doctor] left because they have to see all the patients and then, when the family came in, before and when the family came in, then it was the whole process of explaining in detail what was going on. (N3, Interview 3)

Translating from one register to another is particularly challenging if the communication involves a patient or family members with limited English.

We have to…work as a patient advocate [and] sometimes we are having any patient with the language barrier so we have to understand their relatives or them and then we have to go back to the doctor explain [to] them what patient wants or what they need and we have to carry forward the consultant or doctor's conversation we have to explain to the patient. (N2, Interview 3)

The nurse is an important communicative go-between for various healthcare professionals, as well as for the professionals and the patient.

We have to communicate with the multi – whole multiple disciplinary things saying like physio or what doctor want physio to do or what physio they want patient to do and what they want us to do with the patient.
(N2, Interview 3)

4.1.1.9 Communicating with doctors and line managers

Nurses have a major responsibility to act as mediators between doctors and patients, including requesting action from doctors on the patient's behalf.

We have to ask the doctor…we can't give any medication basically so we have to explain [to] the doctor that patient is having high grade fever so we'll ask them to write some antibiotic or any medications which will help the patient to reduce the temperature. (N2, Interview 4)

One of the things that I know I need to get ready is a paper, because you know we work in a computer system…One of the papers we need to get ready is the patient's list of drugs that they are on, like their drug chart – it has to be chart that's on paper and not on the system. This is not my responsibility because I don't prescribe drugs. But as always it looks like we are at the centre of everything, so, it's sort of our responsibility too – we need to have that to be able to do a safe transfer to the wards. It's the doctor's responsibility, but in the middle of it, we need to call them, let them know that this is happening and that they need to come back and do it. (N3, Interview 3)

We have to check the prescription whether is correct or not because we are going to give the medication so it's we are responsible…so if we are happy with that, we will give the medication to the patient… we have to evaluate that and then we have to implicate something else like if it's reduced we'll continue with the same medications…and if it's gone more higher we have to go back to the doctor and tell him that the medication [didn't do] anything and they need to write something else. (N2, Interview 4)

Nurses have to be able to placate the patient if the doctor does not immediately respond.

> *One patient had some breast surgery, and consultant told her that he will come to review the patient 5 o'clock in the evening, but there was nothing mentioned on the notes, and, when we received the patient from recovery they didn't told us anything about that, so we prepare everything for her to go home…I went to see her just to ask her what arrangement [have been] done to go home. Her husband was already there, so they were a bit angry, not on me, on the consultant. That consultant…didn't turn up, and so I reassure him that I'm going to ring him on the mobile. So I rang the consultant. I told him that the patient is waiting for him to review, but he…said he's in the clinic. As soon as he'll finish the clinic, he'll come and review the patient. So he turned up at 7 o'clock, and he said patient have to stay overnight.*
> (N2, Interview 2)

The nurse may feel compelled to request a senior member of staff to check if they suspect an error.

> *It has to be double check, and uh and we found out yesterday, when we give the blood transfusion, the patient was positive, and the blood we were about to give was negative, so I had to make sure that it was the correct blood, so I had to approach the nurse in charge.*
> (N1, Interview 3)

> *[The handover nurse] told me that we are not following protocol and she didn't know why, I didn't want to do it without asking the team so I called the HD [High Dependency] consult – my HD doctor, and I asked him to come in and review that with me because I was concerned about that I knew from the verbal handover, that we were not following the protocol and I didn't really understand why, but I just didn't want to do anything that would harm the patient.*
> (N3, Interview 1)

Such communication may appear to challenge the authority of someone with higher status in the hospital hierarchy.

> *I've managed to get a hold of one of the doctors of the team. He came and did the chart and then he left. And, unfortunately, I didn't see the chart until he actually left. And then I noticed that there were a couple of things wrong, so I needed to call him again and explain to him…this is not right, so you need to come back.*
> (N3, Interview 3)

> *Normally, some doctors say: 'Oh, I'll come and check the patient', but uh this doctor he just said: 'Low urine output, OK. You can give Possumide', and I said: 'Have you prescribed? Can you look?' because normally some doctors they look and they check the balance. There's a lot of things to consider before you give a drug, but he was very cool. He said give the Possumide. I said: 'Have you prescribed? Can you check?' 'You can check.' 'OK, I will look' but I said: 'I will come back for you if I –'*
> (N1, Interview 3)

These communications require the ability to avoid conflict to achieve desired outcomes. It should be noted, however, that participants reported communication with the junior doctors does not necessarily require nurses to demonstrate acknowledgement of rank. In fact, the reverse can be true.

> *There is that concept of the junior doctors, sort of, are quite open to our advice and ideas because they're in that phase of learning…if you are junior doctor and coming to hospital, you don't want to get nurses cross with you. They'll make your life miserable.*
> (N3, Interview 3)

While acting as intermediaries between patient and doctor, nurses are also members of the medical team and can be involved in discussions over patient treatment.

> *We have a multidisciplinary team office where sometimes they are, if they are not seeing another patient, and that's where I met them and that's where I spoke to them...One of the doctors comes with me, assesses the patient and we discuss the interventions that we think are appropriate to take…*
> *In this situation yesterday, I immediately asked if they wanted blood cultures. That's what we usually do, which they agreed.*
> (N3, Interview 1)

Communication is not always successfully collaborative and may require the nurse to remind the team of the nurse's role as a team member.

> *While I was gone, the cardiology team was seeing one of my patients in the morning, so they came in, saw the patient and left. They didn't say anything and they didn't leave anything written. And this is one of the main problems I have sometimes in there. When I came back, I had to call them again, to try and get them to come back again, because I had questions for them…obviously, the whole idea is to come up with a specific plan and to write something on the notes, because otherwise if they are there and they don't communicate with anyone, you have no idea they want and there's nothing written.*
> (N3, Interview 1)

4.1.1.10 Communicating with other nurses

Nurses are expected to work collaboratively with other nurses to assure the safety and security of the patient during their care. At the end of the shift, through the handover process, continuity of care is maintained by passing on information about the patient's medical history, focusing on the period that the patient has been under their care in the hospital, the current condition of the patient, and treatment plans.

> *Take the handover from the recovery nurse, like what procedure they had, what sort of stitches or incision or dressing they have, and when the consultant is going to see the patient, and if there's any particular precaution for that patient or instructions to give.*
> (N2, Interview 2)

> *She gave us the detailed history of the patient, like, what operation they had and what is the present status, how was the night, like one of them was in a lot of pain during the night. So whatever she had done for that patient, she explained it to us, and some of the – two of them supposed to go for the CT scan so she let us know the time is arranged and they are going for CT scan.*
> (N2, Interview 3)

> *That includes what time they came back from recovery and includes all the medications they need to be given, or they have been given already, any particular reports or instructions from the surgeon, if they are eating, drinking, mobilising and – and basically everything, you know, any medications need to be down for the discharge.*
> (N4, Interview 3)

> *[to explain] which unit to ask the doctor to prescribe because it's not prescribed, things like that.*
> (N1, Interview1)

Handover requires nurses to read from their notes that they make as the record of patient care that they keep during their shift.

> *And so we, basically, write everything down for every single patient, and then we talk about it when the night staff is coming on but they have the written version as well, so if they can't remember something it's actually there, especially very helpful with the drains…maybe two or three patients got drains, and it's really good just to look how much it was in that time. For example, if the consultant comes…if you don't remember any more about one of the patients you can just have a look at it and see.*
> (N4, Interview 3)

> *We always read…but sometimes it's not that easy because every now and then you get a different patient. If you memorise everything you might be saying something that belongs to another patient. So it's safer to just open the notes and this is the procedure. This is the medical history.*
> (N1, Interview 1)

Handover may be performed at the bedside of the patient.

> *Yes, we handover in front of the computer and our system is like closed sheets and as you are handing over you are showing things on the computer at the same time you are explaining what's going on you are basing that on the numbers and the figures you see on the computer.* (N3, Interview 1)

Nurses need to be sensitive to the patient who can overhear at handover. To be a successful communicator, a nurse needs to recognise circumstances in which it is necessary to exercise discretion.

> *If there are any sensitive issues, we don't talk to about in front [of the patient]…as an example, the previous night…I was handing over one young boy that, unfortunately, his twin brother died when he was admitted into the hospital…So, the mum and dad, obviously, at that stage didn't want to tell our patient that his brother had died…So, because this is a very important piece of information, this was handed over outside of the room. This is the kind of sensitive information that we don't talk about in front of the patients. For example, what sometimes happens is, because we are handing over a patient in front of five others, and five other patients are listening…if a patient has a background of some particular disease …obviously, we're not gonna shout that in front of everybody…And sometimes, you put your notes up and you just point, so my other colleague can read it, rather than me saying it out loud…The most common situation is when people have excessive alcoholic, a patient piece of information…that I need to hand over. But I'm not gonna say that out loud in front of the patient. You know it looks like I'm calling him drunk… So the nurse reads and she nods her head.*
> (N3, Interview 2)

Nurses may also require collaboration from a colleague to validate the handover information.

> *During her presence, the other nurse who was going to look after the patient, I asked her to feel the pulse because they can easily say the patient had no pulse, so I had to make sure that she knows that when I handed over to her, there was a pulse. I asked her. I said, 'Feel it. There's a pulse.' Because it's a blame culture. They say: 'Oh, I didn't check. I'm sure there was no pulse when I received the patient', things like that.* (N1, Interview 2)

It is essential that the information nurses give at handover is accurate. Inaccuracies can have serious consequences.

> *After the handover we do certain safety checks around the bedside of the patient and check the drugs that the patient is receiving and things like that. So at that moment in time you are, basically, making sure that what's handed over and what is prescribed and what it is, what is written on the computer matches with what you've got in terms of – And if it doesn't, we file an incident report.* (N3, Interview 1)

While caring for a patient, nurses frequently work in pairs, for example, to negotiate workloads.

> *My buddy was there like we have to work like one nurse and one health care assistant. So we are working together…I'll just check with her like a – we are going we're gonna have this much of admissions – who do you want to admit? And like if they are four patients she'll say she'll admit two and I say OK I'll admit two. We have to do routine of the patient for the patient. So 10 o'clock, 2 o'clock, 6 o'clock so we decide. She's happy and she done the observe 10 o'clock, 2 o'clock and 6 o'clock.*
> (N2, Interview 2)

Collaboration from a colleague can be important in pressured situations.

> *So I asked my colleagues because I couldn't leave the patients, so I asked my colleagues to keep an eye on – to get the medicines for me.* (N1, Interview 3)

> *I had one of my colleagues that was a runner, which means he has no patients and he's just helping out… I told him briefly like, this is what's happening and I think I'm gonna be in here for quite a long time so, could you facilitate some of the things that I need to do with my other patient. And then, whenever I have this all sorted I'll be 100% focused on that. And he was really good, he helped me a lot so. It was one of the ways that we could actually do it, because otherwise it wouldn't be possible.* (N3. Interview 3)

For any critical treatment, nurses collaboratively check patient records.

> *I have to double check with another nurse, and we have to make sure, even though the patient was unconscious yesterday because she was sedated when we did the blood transfusion. So I have to check from the wristband, and we have to check it by the bedside. It's the protocol by the bedside with two nurses, and check if its order is correct and if there's any allergy.*
> (N1, Interview 3)

Nurses also may have to issue instructions collaboratively to a patient, if there is a need to assist mobility.

> *Basically I went in with her in the room and we basically between us and the patient talk about the best way of how to literally step by step how are we gonna stand up and how are we gonna sit on the chair. Are you going to hold on to the bed? Are you going to stand up and now you have to turn right or turn left, step, step, things like that.*
> (N3, Interview 1)

They also engage in social chat with colleagues.

> *N: We've done all the cleaning, the tidying up from the ward from the weekend, re-stocked everything dressings, syringes, whatever we needed all the dressing trolleys were re-stocked.*

> *C: Do you speak to each other when you're doing that?*

> *N: Yeah, we just talk about the weekend and what we've done and you know, the usual stuff. If there was anything interesting happened on our day off. For example, I was off Friday and apparently they were really busy so they were saying about how it was, and not enough staff.*
> (N4, Interview 3)

4.1.2 Listening

Listening is a crucial element of every verbal interaction. As with speaking, successful communication in the various interactions in which nurses participate in the course of their work requires the ability to listen appropriately in a range of contexts: interlocutors have different relationships with the nurse; communicate for different functions; and speak in different registers and with a variety of accents.

4.1.2.1 Handover

The importance of handover in patient care was noted in the preceding section. Handover involves both written and spoken language: the outgoing nurse needs to elaborate verbally on the written notes, expanding, clarifying, and explaining them.

There are frequently two stages of handover. The first stage is in front of all the nurses because nurses may need to help with a patient who has not been allocated to them. In the second stage, the nurse(s) individually responsible for a particular patient during the shift that is ending hand over to the nurse(s) who will take that responsibility during the new shift.

The first stage is necessarily brief, communicating essential information about each of the patients.

> *There's certain things like, regarding breathing or regarding circulation, certain things we look at: is anyone more distressed, is any patient requiring high doses of oxygen, is any patient requiring high doses of certain medications to maintain their blood pressure, or things like that. And very importantly, we get communicated which patients are for resuscitation or not…You only want to pick up the particular things. You might actually not say anything about certain patients is progressing well and there's nothing to say…you might actually not speak of that patient at all to the whole meeting, because it's something that will last maximum 5–10 minutes.*
> (N3, Interview 1)

The meeting is done in front of a whiteboard. The board, which is in a public space, typically provides only brief written information about the patient, for reasons of security, and to protect the patient's privacy. The nurses must therefore listen attentively to the spoken elaboration of that information.

If there are any information at all on the board, it's always something that if anyone else looks at it doesn't really make sense. Nothing that you can disclose, and even – and we are handed…our handover sheet…for example, if the patient has an order to not resuscitate it is not written on that piece of paper. Because that piece of paper can be left on top of the table by someone and you never know who's gonna see it. (N3, Interview 1)

Because of the high premium on listening, nurses have to check understanding if they are uncertain about information that has been communicated orally.

I try to verify. That's the best thing: to verify, because in nursing environment you're not allowed to make mistakes, actually. (N1, Interview 2)

Despite any irritation it may cause other medical staff.

You probably feel anxious sometimes…because some doctors can be stroppy because you didn't get straightaway what they meant. (N1, Interview 1)

In the second stage, involving two (or occasionally more) nurses, the incoming nurse(s) must listen carefully in order to ensure the continuity and appropriateness of the care for each patient, including what the patient has been told by the outgoing nurse(s).

When we are handing over, we need to listen very carefully what the other nurse says what happened and I know we have the written handover, but we also have to listen to each other because sometimes we say more than was written down.
(N4, Interview 1)

What I tried to explain was, [the patient] was very anxious and scared because it was her second operation. So, she [the outgoing nurse] wrote something like: 'patient was reassured and we had a conversation about every aspect of the procedure as she wants to be informed of every detail…of our nursing care'…And then I verbally handed over to the nurse in the ward, exactly that, that she needed a lot of support. (N3, Interview 3)

There may be additional challenges to listening at handover, as Nurse 1 explained in several places in Interview 1.

There are moments when you have to adjust your hearing because they [non-native English speaking nurses] have different intonations – compared to British. (N1, Interview 1)

She works over nights and she's probably tired… I have to sometimes to ask her: 'Would you say that again' because I wasn't sure. She was rushing to go home of course…and the intonation is not as clear as, you know, when you come in the morning, and if I have to adjust my ear to the tune because she is not the same.
(N1, Interview 1)

She sat down and talked to me, but she had the face in the computer because she was handing what she wrote on the computer, and sometimes it's easy, we communicate face to face, but it's difficult at the same time because she had to look at the computer. …At least it helps, the movement of the mouth and expression on her face. I couldn't sometimes figure out if there's something that I really have to pay attention to.
(N1, Interview 1)

Further difficulties may arise from the use of ambiguous or unfamiliar expressions.

Here was a situation where the senior nurse…gave me a piece of paper and I asked her: 'What do you want me to do with this piece of paper?' She said: 'Give it to the porter twenty to' and like I was thinking about the number 22, so I was a bit embarrassed to ask because there were doctors, nurse-in-charge, so I tried to be closer to her, and I said: 'What do you mean by 22?' and then she said she meant by 20 to 3 o'clock (laughs), so different from 22.
(N1, Interview 3)

Additionally, terms can have specific technical meanings in a hospital context.

N: She asked me to get ready for the surgeon's patient, so when she said 'get ready' means you have to put all the things that you need to minimise any delayed nursing care, so you have to get ready… all the things that you might think were possible in an emergency, and make sure all the beds are vacant and you have to prepare the (inaudible) meter, 6, you already have to set up to the standard setting

C: So all they say to you is, 'Get ready'. They don't give you any other instructions?

N: They don't give instructions. When the manager said: 'Get ready', you should know what you need to do. (N1, Interview 2)

4.1.2.2 Professional development seminars

Staff may be offered or expected to attend local seminars, where they listen to presentations and discussions. One hospital in this study ran a weekly forum to discuss medical and ethical issues of concern to the hospital. However, it seems that the presentations delivered by doctors can be difficult for native, as well as non-native English-speaking nurses, to comprehend.

> *Different doctors they do the presentation. We were there to listen…Sit and listen, and sometimes they [his colleague] ask me: 'Do you understand that?' (laughs) So, I don't really understand, even some of the English, because maybe it's me, because I'm not English. So I asked some of the English colleagues. I said: 'Do you what they're talking?'*
> *'I don't really know what they're talking about'.*
> *So I feel better because it's not me.*
> (N1, Interview 3*)*

4.1.3 Reading

There is very limited reading material involved in day-to-day nursing. As Nurse 2, in Interview 4, said: *We don't need to read that much information*

Most of the reading that nurses have to do is in the form of notes, form headings, checklists, or checking information about dosage, saturation and expiry dates on medicines. The reading is not challenging as long as the nurse understands the medical terminology (including abbreviations) that is used. Terminology can be problematic for nurses newly arrived in the UK, because a number of medical terms and abbreviations vary across cultures.

The patient's medical notes form the core documentation that nurses have to deal with.

> *You should really read the notes because that's where you that's where you get the idea – that's where you get the information that will help you to look after the patient because if you don't have that information then – because every patients, they are different. Some patients can be different than other patients, so the only way to be able to do with your own patient, or the patient you're looking after, is by reading their notes.*
> (N1, Interview 1)

The notes contain a doctor's report, which can be a source of difficulty.

> *They use some terminology that sometimes only the doctor can understand, unless you do some research: what do they mean by…? But they do a full report which…is typewritten by the secretary, because what they do, the doctors, is they dictate and then pass it over to the medical secretary [who] will write it and put it in the medical notes and then next to the patient. The rule is the notes should go where the patient is in the hospital. You cannot take it out…*

> *If they are going for x-ray usually they should bring the notes because if something happened downstairs during the x-ray, the emergency people have a quick look what sort of allergy, what sort of contra-indication, medication to resuscitate the patient.*
> (N1, Interview 1)

Any terms in the notes that the nurse does not understand can be clarified via a computer, or with the help of the medical team.

> *We don't need to read that much information. We have to go through like, whatever doctors are writing in the notes. We have to go through with those, and, like, we're having everything in the computer now, if you are not familiar with anything, we are allowed to go on Internet, and we can get the information through that, plus we've got like local policies and procedures if we are not sure with anything we can open it and go through the thing… if anyone [is] not competent to do anything we just need to dial the sister- in-charge and they will guide us for whatever it is.*
> (N2, Interview 4)

> *N: We have difficulty to read the doctors' notes (laughs) sometimes.*
>
> *C: Do you have to ask the doctor to explain sometimes, then?*
>
> *N: We can't really, because by the time they [are] in theatre again with another patient or they've left, because they hand over to the recovery nurse, so they know the post-op plan and everything, so they just hand over to me…the recovery nurse will write it down, and then she will tell me.*
> (N4, Interview 2)

Nurses also read the prompts and headings required to complete the computerised charts and forms that are in the patients' notes.

> *These numbers and these details are filled in every hour by me, by a nurse. So, this is part of the computer system, so this is already there and we fill in for each hour. There's lots more...This is like the very beginning of the system and it all always looks like this…I do pre-operative checklists which…just says, for example, 'patient had a shower the night before' and you just tick it. 'Patient has been nil by mouth from midnight', and you just tick that. Just basic sentences saying exactly what the patient needs to be checked against.*
> (N3, Interview 2)

More extensive and challenging reading materials occur in the protocols that nurses have to learn and follow. Protocols are nursing procedures expected by some of the specialists. These are expressed in terms of familiar medical routines.

It's quite tricky to remember everyone's protocol. We have them written down as well, so we don't know something, we can always look up…sometimes they don't have any protocol, so they just tell you that 'Oh just keep an eye on her just watch out for haematoma' for example and that's it…

If there's someone coming new, they always, give us the protocols at the first time and then, slowly slowly we learn it, so we don't have to actually look up all the time…it's usually sent by email, so we just print out the email, and we have one surgeon who is really particular…This is what he does. And those patients are – well, he's really really, really strict with his protocol, so he's got his written protocols. I think it's about one, two, three, four pages. And every single patient has to have it in the notes and then we have to follow the protocol…For example: 'patients nil by mouth', so that mean they cannot eat and drink before the operation. And after the operation, the first day, IV [intravenous] fluids, what IV fluids he wants and how many mm per hour and IV medications, what IV medications he wants and how many times a day, and when the patient can start drinking and sipping water, when can they mobilise and…well, basically, everything.
(N4, Interview 3)

In addition to medical notes, charts, protocols and policy statements, which they are required to complete as part of their duties, nurses can conduct their own research into the medicines they are using, and medical procedures. This involves extracting information from material, which is often presented in note form.

First of all on every ward we've got BNF [British National Formulary]. It's British for all medications… It's a book available, and every six months they are adding or deleting…We have to look for the book if we are giving any medications to patients and we are not sure how to use that, so we have to look on BNF to know the right route and right strength. Like, if it's an injection, how much water for injection we need to use to dilute it and which is the best way and what are the contraindications for that medicine because we have to be familiar with all those things before giving any medicine. (N2, Interview 1)

Nurses may also gain quick and easy access to up-to-date medical information online.

If I enter any medicine in Medusa, and I click on 'Search' it will give me all the detail about medication, like what it is the main content of the medication and the contraindication, plus why we have to use this medication, what is the best route we can give to the patient, and the side effects which we need to look for, all those things…It will be in bullet points, not like paragraphs.
(N2, Interview 1)

So we usually just google something or if we are not familiar with or something new…Sometimes patients are telling us medications' names and everything, and we just really don't know what it is, so we just look it up in the Internet.
(N4, Interview 2)

We had a doctor who did a very special prostate operation in our hospital, and we never ever heard about it before, so we had to look up, and we had to be very prepared and very familiar with the condition and the with the operation: what they do, how they do it, what are the symptoms for these patients before they come in from theatre.
(N4, Interview 3)

More challenging reading is available to nurses if they want to update their knowledge of nursing care, or other medical issues. Articles were regularly posted for nurses to read in one of the hospitals in the study. Nurses may also subscribe to a nursing journal for their own professional development.

We are not recommended to read, but I'm register with the Royal College of Nursing so they are providing monthly edition…by post, plus I've got online access as well. So whenever we have time, we can go on the Internet and we can read or we can get the knowledge what is happening in nursing.
(N2, Interview 4)

4.1.4   Writing

Compiling records, of various kinds, of patient care is the only writing typically required of nurses, but it is extremely important.

Depend on the patient's condition really, if there is a lot to do or if there are some complications, yes, we do, we do write. We actually have to document everything we do 'cos if we don't document, that means we didn't do anything, so even if we given any medications we just document in the drug chart that we've given. We sign it and we have to write it down how much we gave. We don't have to write down that's painkillers given or anything, because it's there already, but if we change dressings, if we take the patient to the toilet, give the patient eating and drink…We have to write everything down, otherwise the staff who's coming on my shift, they won't know if we don't tell them. So it's best to write everything down. (N4, Interview 2)

Records are written (and need to be read) under pressure of time, and have to be as succinct as possible. Much of the record consists of checklists and forms, tables and charts, with many numerical entries, abbreviations, and formulaic expressions. It also includes a brief narrative of what has taken place during the shift, for handover, the patient records, or critical incident reports.

For each hour you fill in numbers and scores and things, and then, for each one of them, there is a space where you can remark it. So, for example, yesterday, I had a patient who had a high temperature, and in the specific hour, I like – I put 3.30, let's say. And I do a remark saying what happened at that specific time. So at that specific time, I've spoken to my MDT [Multi-Disciplinary Team]. Doctors communicated that the patient had a temperature, and then I got their adviser, what they think it would be best to do and we decided to take blood cultures for that patient, for example…So, what happens is all of that communication is documented on that hour, by me, as a remark on that specific moment. If everything is normal, I don't remark anything. (N3, Interview 3)

As noted above, abbreviations do not necessarily translate across cultures.

When I started they gave us this like booklet of introduction, and there's a whole list of abbreviations that they use, I have never seen so many abbreviations. There's loads.
(N3, Interview 1)

Writing involved in these records tends to consist of formulaic expressions used within the medical community.

We just tick boxes and then we have a part where we have to do some writing so it's just basically at the end we have to put some notes that we admitted the patient so I say: 'Patient admitted. No known drug allergies'. (N4, Interview 3)

Nurses maintain their own detailed handwritten notes of what they do during their shift and use their notes to add to observation sheets, and to complete nurse notes for the patient's record. At handover they read from and elaborate on their notes or computer records. Because of its crucial role, note-taking requires particular skill – a fact that is often overlooked in training.

N: I always take notes because sometimes when there's an emergency, you tend to focus on what's going on. You tend to kind of forget what happened in the conversation, so I always take notes…sometimes, if you're used to the handover, you kind of making your own abbreviation. It's…your own style of abbreviation because if, for example, they said what procedure was done, instead of using the word 'procedure', you just write 'pro' and then said 'cardio-pulmonary'. You just abbreviate, like

C: Did they teach you to do notes?

N: No.

C: No, you just picked it up yourself?

N: Yes, and make that sure you understand what you're writing because people have different ways of abbreviating. (N1, Interview 2)

As described in a previous section, handover notes are important for the nurse taking over at the end of a shift. The handover notes are completed in a form, which may be transferred to or completed on the computer, and then printed off for the incoming nurse at the handover. The incoming nurse may add to these notes as she listens to the handover information from the outgoing nurse, and further during the day, but the handover notes are destroyed when the nurse has finished with them.

Notes written by nurses in the patient record are vitally important for other medical staff to consult, to ensure accountability, and to maintain continuity of care.

We have to write, like, whatever we'll do, we have to write in the nursing plan, and, like, if some consultant, they said that patient needs investigations, so we have to write the same, like, we don't need to write in paragraphs, or we don't need to describe too much. It should be like bullet points, yes, it should be proper sentences, not abbreviation and all those things. It should be, but not all, some statement in the full paragraphs. We have to state them briefly and clearly, so that if we are not there, and in our absence, someone want to know what happened, like yesterday or last week with the patient, they can go back to the nursing notes, and they can check easily, and understand what happened to the patient, and what action we took, and what was the result. (N2, Interview 4)

Some patients, they will refuse for anything, we have to mention that. Like, this patient refused, and with the time and date and time of course, and we have to go back to the patient to check again, and if they say no, then again you have to come back and write it down because, according to NMC [Nursing and Midwifery Council], we've got legal responsibilities for the documentations. So everything will be on our head if something will go wrong. (N2, Interview 2)

Nurse 1 provided an example of nursing notes:

13:15- complained of sudden shortness of breath at 1230.
5LPM [litre per minute] 02 [oxygen] given via face mask as temporary measure while waiting for the doctor.
Duty doctor informed, salbutamol given as prescribed.
Blood test done and sent to the lab).
Chest X-Ray done. Awaiting doctor's review.
(Name of nurse)
Staff Nurse
1345- Patient slightly feel better
*   OR*
1345- Patient condition remains the same.
*   OR*
1345- Patient oxygen level has dropped from 95% to 88%. Patient is conscious but agitated. Duty doctor informed immediately. Oxygen increased from 5LPM to 15LPM.

In private hospitals, detailing of treatment and reasons for the treatment may also be needed for insurance purposes.

In clinical one, like, is a private sector, so most of the time we have got to insure patients. So, if they are insured as a day case and if they are gonna stay over one night, so we have to write in the clinical incident book, so we can prove the insurance that there was a clinical reason and that's why the patient stay over one night. Otherwise they are not going to pay for it. Sometimes that doctor will come, they will say: 'Oh, patient wants to stay, let them stay', though there's no clinical evidence, but we have to write down on that, that patient was in pain, and, obviously they will be in pain, or sometimes there's delay in theatre. So we have to mention that in the incident book, the reason why the stayed over one night.
(N2, Interview 3)

In addition to the routine nursing records, nurses may need to complete additional documentation, for example, to record discussions they have had with patient and family.

If you have a specific family patient discussion, we have a specific conversation about a certain aspect that's bothering the patient or their families, there is a separate form that we fill in with what's happened and what's wrong, what you've done, and what has been discussed at that point.
(N3, Interview 1)

In addition to the nurse notes, and handover documentation, nurses may be required to complete an incident report. According to the account of Nurse 1, the incident report can be completed in note form.

Sometimes there are some incidents that you have to make a full report about the patient's care. We have to stay behind after the work to complete the whole document, especially…if there's a major incident that has to be documented in details that, for example, you increase the amount of medicine because the blood pressure dropped…and you put a note there, 'Increase due to hypertension'.
(N1, Interview 2)

There is an imperative to record detailed information in the case of an incident.

As much detail as you can because then that's investigated by a handler, certain senior people are identified as handlers of incidents. Usually direct that to the ward sister. And she directs it to whoever she thinks is more appropriate to investigate the accident, and then as much detail you can give, it's better for whoever is gonna investigated because, it's obviously, it's easier for them to get to the cause of the incident.
(N3, Interview 1)

Nevertheless, it needs to be a brief and succinct.

When we are writing any incident report, we are not going to write, like, very big. We are going to write briefly, like, what happened, and how many people, like, who are all involved in that incident, and what was the result or what happened at the last.
(N2, Interview 4)

N2 gives an example of the brevity required:

It's a brief but concise statement. The main things are the name of the person involve, date, time, and what happened. We just filled out the form online and sometimes the answers are already provided. We just need to select, e.g. department, e.g. intensive care unit, theatre, high dependency, or catheter laboratory, etc., if the person involved is patient, staff, or visitor then we describe what happened e.g. 'Patient felt dizzy in the toilet and unable to open the door or call for help immediately.' Or 'Patient was verbally abusive towards the staff without apparent reasons.' Or 'Patient found smoking in the ward few centimetres away from the oxygen cylinder.' (Nurse 1, email)

The Datix electronic incident report form used in one of the hospitals partly constrains what is written. In addition to a space to record what happened, there are a number of drop-down menus for nurses to select from to supply required detail, for example, time, location, enabling statistical computation of incident information by hospital management.

4.2 Focus group 1 (overseas trained nurses)

Many of the communication practices identified in the tracking study were also evident in the focus groups. Additional practices highlighted by nurses in these sessions are given below. The skills are not always discussed separately because there was insufficient data on any one skill area, due to the limited time available for the focus group.

4.2.1 Listening and reading

Nurses in this focus group describe many of the same communication practices as those in the tracking study, such as handover and maintaining patient records, which are predominantly handwritten on the ward. They also commented, however, that if the spoken communication has not been clearly understood, relying on a nurse's notes can be problematic:

When someone is giving you handover, and sometimes you don't clearly understand, the only thing that you will look onto is the notes that has been written down. So if the way it was written is not clearly quite good to understand, you will be just left in vague. (F1N1)

Sometimes you can't read the writing, but sometimes you can't really understand what's they're talking about. It's purely nonsense. It does happen. (F1N3)

Nurse 4 illustrates the range of written material a nurse has to scan for information at the beginning of a shift:

> I'll go back to the patients' notes just to make sure if something is missed by the night staff things like if they forgot to tell me that patient need x-ray or the bloods in the morning. So I'll go back to the previous notes, doctor's notes to check the people, shift nurse's notes, and then I'll go back to the drug-chart, to say like if they are due for any medications. (F1N4)

It is important to hear a doctor explain procedures before they are written down:

> I come in to see the patient, they want nurses to be with them, and, [hear] whatever they are discussing with the patients, and before they leave the ward, they have to write their notes as well, if they haven't told us anything. (F1N4)

However, the information is not always delivered orally first:

> Some of them, they're kind enough to tell you verbally, 'Oh, I've written it there, but I have it on the computer'. Some of them – they expect that you read, and then the next day they will be upset, 'Oh, this nurse didn't do this'. What do you expect? I don't have time to read it. It's just a communication problem. It's easier if they talk to you, but if they just write it down, don't tell anything. (F1N3)

As emerged from the tracking study, there is pressure of time, and a need to seek clarification if the written communication is not clearly understood, or to challenge a doctor if an error is suspected.

4.2.2 Speaking and listening

The participants described communications with a range of individuals: medical and non-medical staff in the hospital at different levels in the hierarchy, and patients and their relatives. Their observations confirmed many of those made by participants in the tracking study, and they particularly emphasised the importance to the care and well-being of patients of engaging in social conversation, particularly in relation to the world outside the hospital. .

A lot of the discussion among members of the group (all of whom were originally from outside the UK) concerned the difficulties that newly-arrived nurses encounter in adapting to British accents, usage, and speech styles.

> I think the way it's delivered, the volume of how you talk because they were saying us Filipinos, we always seem to be fighting because our voices are loud, whereas you speak to English nurses, they very calm…We use words like, 'Are you mad, or are you angry?' They were saying, 'Why do you think I'm crazy?' something like that 'cos we use 'mad' as like we are angry, but here being mad is different. It's fun when you think of the language barrier. Sometimes you will think about it. (F1N3)

> It's very different when you experience it, and looking at the people who just recent came here, and then they're nursing straight [away]. If it was me… it will be harder for me to understand the doctors and nurses because, looking back, in 2010, I had the hard time understanding people, so it just took time for me to get on with the people, to understand. Now that I'm working as well as a nurse, it's easier for me because I've been here for quite a while, but I think that's safer for me to speak to the doctor, to really express myself. (F1N3)

> When I was new in this country, at that time, yes, the telephone conversation was a problem because of this noise, and sometimes we can't understand accent. (F1N4)

These difficulties had in some cases been exacerbated by negative attitudes towards nurses from abroad on the part of patients and their relatives.

> Some people are nice, some people are not, depends on the circumstances, but you're just really have to get on. It's quite stressful, specially the language barrier, and the stigma that they put on you, that you're not English. You're not from this country. (F1N1)

> Some of them they look down on you, specially even if they know that you're a nurse for their family or for their relative, they would think you have to do everything for the patient for them, get their drinks from the fridge. It's sort of things like that and even if you continuously communicate with them explain things them, some people just don't choose to understand what you're saying. Even if what you're saying clear, they choose not to listen to you. (F1N1)

4.3 Focus group 2 (UK trained nurses)

4.3.1 Speaking and listening

4.3.1.1 Communicating with patients

As reported in the tracking study, nurses introduce themselves to patients and orient the patients to the environment. They also need to request action from patients. Nurse 1 explained how she negotiates action with patients, a useful strategy to avoid the non-cooperation reported in the tracking study.

> [I] discuss with the patient the plan of action for the day, so let's say somebody needs assistance with their hygiene needs, so they might want a shower. They might want help, so you say, 'Yes, that's fine'. They have a shower, 'I'll help you with your shower', and, 'Shall we aim for this time?' So you'll say, 'Let's aim for half nine.' So you have breakfast. You've sat down after breakfast, and let them go down half nine for a shower, so you're negotiating things with patients as well as delivering care.

In accord with findings in the tracking study and Focus Group 1, nurses use social conversation to relax with a patient and gain information that will aid treatment. It is also used to avoid embarrassment, when they have to perform duties in a room when in front of the patient and/or relatives.

> *We have single rooms, so it's literally just you and the patient, and then with a relative as well. So if you're not talking to them, it can be kind of awkward. So, you know, they're just watching you do something. So, I always try and chat to them when I'm making the bed, when I'm doing my obs.* (F2N2)

As discussed in Focus Group 1, social talk performs a bridge between the world of the hospital and the world outside.

> *I mean, often when you do talk to a patient, often that's what they find so difficult in hospital is being away from all their family, their friends, so they're relying on you to come and bring some conversation, to have time to chat to them, and update them with what's been on the news if they don't feel up to reading the newspaper, and, you know, all of those key things…* (F1N7)

> *Often patients will ask, 'What's it like outside?' That's one of the questions you get asked a lot.* (F1N3)

These nurses also describe communications with patients and relatives who speak little English, using similar strategies reported in the tracking study: pictures, gesture, and learning useful lexis in a patient's language. In addition, the UK nurses report working with interpreters, and using hospital literature that has been translated into languages most frequently spoken by patients. They observe the difficulties experienced by nurses in Focus Group 1, that nurses from outside the UK, whose primary language is not English, have difficulty speaking on the telephone, especially in communication with relatives of a patient, who may use indirectness in talking about the serious condition of a loved one:

> *Often families ask questions in a roundabout way, don't they? Not always direct. And people, if it's not your first language, you don't get what they're saying, where it's coming from.* (F2N3)

It is essential for nurses to reassure patients who are in distress. This is not always successful, and some patients become abusive. In such cases, nurses have to contain their frustration and a desire to remonstrate with the patient.

> *She was verbally abusive to the registrar, calling him all the names under the sun…and he said, 'Stop right there. I've had enough', she carried on, whereas I felt I should have stepped in and said, 'OK, that's enough', but I just couldn't. I froze in the situation, and I didn't know what to say. I was just so shocked, I think. I was just absolutely shocked by the way she lost her temper, and was throwing things around the room.* (F2N3)

> *I think probably everyone could say that they've had a point where you just can't believe that you are being spoken to [in this way], but you don't know how to respond…what do you say? 'Please don't speak to me like that…Please think of the other patients'. 'Let me get somebody else to come and help you', but it just falls on deaf ears quite often, and so then, you know, there is an element of shock 'cos you just don't expect to be treated or spoken to in such a way.* (F2N7)

Nurses have to keep a detailed record of incidents of abuse, which may be needed if the patient raises a complaint:

> *They wrote a letter of complaint…and we were all asked to write our responses, which everyone who was involved did.* (F2N7)

4.3.1.2 Communicating with doctors

Participants also reported the need to question doctors, when they are unable to interpret instructions in the medical notes. Some had also felt it necessary to challenge a doctor's approach. In one case, a participant had taken to task a doctor whose flippant approach, in front of the medical team and other patients, she felt was insensitive to a patient.

> *So I asked him to step outside, and I had a chat with him, and said that wasn't appropriate, and that then he needs to think about his communication.* (F2N5)

After she had consoled the patient, the nurse reported the incident to the doctor's line manager.

> *I then spoke to his boss to suggest that he goes onto the communication training program, and subsequently, before I got a chance to speak to this person's boss, I spoke to the patient, to make sure that she was OK.* (F2N5)

Some doctors have inadequate proficiency in English, which can cause potentially serious problems in communication.

F2N2: He didn't understand really anything I was saying at all, so I had to just talk to one of the nurses in charge, and I think she got some other cardiology person, coming from a different team, to come and prescribe the things for us...I just had to speak really very slowly and he was doing a lot of 'Yes, yes, yes', and nodding his head...I'd phrase it in a different way, and he wouldn't have understood what I said.

CS: So is he not a native speaker of English

F2N2: No, he's not a native speaker.

One participant reported overhearing a misunderstanding between a patient and a doctor, which seems to cause the patient anxiety. She intervened, established what the doctor intended to communicate, and then translated for the patient.

I don't think she [the doctor] quite understood the questions, so the answers she was giving were just not the right answers, basically, and I was kind of behind the curtain...'cos she was contradicting herself in what she was saying. So then she left and the patient then said to me, like 'What have they done?'...and I was like, 'OK, I'll go and make sure I've got the right story' sort of thing, and then, when I went to go and talk to [the doctor], even the conversation between me and her was kind of, quite hard 'cos she didn't think she's understanding me. She wasn't putting across what she wanted to say very well and think I wasn't understanding it very well either, so the whole thing just kind of a bit difficult really. (F2N6)

4.3.1.3 Communicating with other nurses

Participants' descriptions of handover mirrored those in the tracking study; they, too, reported working in pairs to check patients' data and to perform certain actions, such as the removal of drains. Participants also discussed the need to give instructions and explanations to agency staff who are not familiar with the systems on the ward.

[An agency nurse] can just be from anywhere, never worked here before. So then you have to orientate that nurse to the unit that they're gonna be working on that night, you know, things like educating them where the crash trolley is in case of an emergency, how to make phone calls, how to bleep doctors. (F2N7)

A number commented on communications that nurses trained outside the UK, whose primary language is not English, find challenging.

The main problem that they had was the colloquialisms, the slang that we can use, where there were some accents. (F2N3)

She was the only Portuguese nurse on and, I'm northern, I'm sure you can tell, and my friend is northern. We were talking and you don't even pay attention to the fact that she was sat there, and then a bit later on I said, 'Are you all right? You're quite quiet', and she said, 'I just can't pick up because you're so fast, and like I can't pick up your accent, I'm just kind of sat here, and you need to speak a bit slow'. So you have to sometimes just think, slow down a bit and I've got slang from where I'm from so, you know, you have to kind of think sometimes, speak properly. (F2N6)

4.3.2 Reading

The discussion in the focus group confirmed many of the difficulties reported in the tracking study. One example was the use of abbreviations, which are unfamiliar to nurses from outside the UK; another was the problem they may find interpreting doctors', and other nurses' notes, and the consequent need to seek clarification.

And prescriptions you tend to call back and say 'I know what it is 'cos I know what I asked you to prescribe' but that is pointless. Nobody can read that and I think that's quite difficult 'cos I think for newly qualified nurses, or potentially nurses who have just started working in a new place, actually challenging someone over their prescription is quite difficult, but then if you give the medicine and the prescription is illegible, then actually you're compromising your position as well and you know the safety of the patient and all these things. I think we communicate constantly and I think it's one of the more difficult sensitive areas sometimes because you have to be able to say, 'I'm not happy, or this isn't right'. (F2N7)

Sometimes you can only tell because of the dose 'cos it's like (inaudible) 75 and you just see begins with a C and you see a 75 oh that's the (inaudible) but sometimes I've seen the pharmacist writing the name of the drug in green very clearly and then the pharmacist knows what it is and...maybe I can use that for prescription now 'cos the pharmacist – otherwise I wouldn't. (F2N2)

4.3.3 Writing

Discussion in Focus Group 2 raised the importance of clear and accurate writing in compiling the patient's medical notes; the contrast between the nurse's own handover notes and those they write up for the patient's medical record; and also the detail required in an incident report.

If we all looked at each other's handovers now. We're on the same ward today. I wouldn't know what she's on about and she wouldn't know. Our official notes are written properly...it wouldn't be all scribbly. It'd be written properly and you can read from that. The next shift could read and say, this is what happened. (F2N6)

5   RELATIONSHIP BETWEEN THE IELTS REQUIREMENTS AND NURSE COMMUNICATIONS

5.1   Speaking

The general requirements for IELTS speaking outlined by Taylor (2001) are:

Candidates are expected to demonstrate:

1. A wide repertoire of lexis and grammar to enable flexible, appropriate and precise construction of utterances in 'real time'

2. A set of established procedures for pronunciation and lexico-grammar, and a set of established chunks of language, all of which will enable fluent performance with on-line planning reduced to acceptable amounts and timing. (The processing factor) (p. 2).

The IELTS speaking test is a face-to-face interview with an examiner, which lasts for 11 to 14 minutes. The examiner has to use an 'examiner frame', which determines the wording and order of questions and prompts. Examiners are required not to diverge from the frame, so as to ensure that every candidate is given an equal opportunity. The test consists of three parts, which will be discussed below in relation to the nurse communications identified in the research. (The descriptions are from the summary on the Cambridge English website.)

Part 1 – Introduction and interview (4–5 minutes)

In this part, the examiner introduces him- or herself and checks the candidate's identity. Then the examiner asks general questions on some familiar topics, such as home, family, work, studies or interests. This part tests the candidate's ability to give opinions and information on everyday topics and common experiences or situations by answering a range of questions.

The topics in Part 1 are in line with what nurses would be expected to engage with in social chat with patients or colleagues. In the test, however, participation is asymmetrical, with the examiner directing the exchange. This is quite different from the case in the conversations of day-to-day nursing, such as those with colleagues and patients, in which the nurse must be able to take the role of an equal or, with regard to the latter, as the dominant partner. They elicit information, induct the patient into hospital life and processes, reassure nervous, anxious patients, request action from patients, and deal with non-compliance by calling on the support of more senior members of staff. They also use the language of authority in the hospital, medical language, which they explain in lay terms for the patient. That is to say, nurses need to be capable, with a range of interlocutors, of appropriately initiating and closing a conversation, as well as introducing and expanding upon relevant topics.

Part 2 – Long turn (3–4 minutes)

Part 2 is the individual long turn. The examiner gives the candidate a card, on which a particular topic is indicated, along with the points that should be included and an instruction to explain one point in detail. Candidates have one minute to prepare, making written notes if they wish, sufficiently to enable them to talk for two minutes in accordance with the instructions on the card. The examiner tells them when to start and stop talking and may ask one or two questions on the topic. This exercise thus tests candidates' ability to speak, with minimal preparation, at length on a given topic, using appropriate language, organising ideas logically, and relating the topic to their own experiences.

Part 2 is relevant to nurses' communicative requirements. For example, nurses have to be able to engage in extended talk to give information about facilities, processes and procedures to patients; they have to explain a patient's condition to the medical team. The points given by the examiner to frame the talk in the IELTS speaking test are relevant, in the sense that there is information that nurses are expected to include at handover. They need to 'organise their ideas logically', and 'think about their experiences', but the test frame does not allow for responding to requests for clarification, which was found in the research to be an essential aspect of the handover process.

Part 3 – Discussion (4–5 minutes)

In Part 3, candidate and examiner discuss issues related to the topic in Part 2 in a more general and abstract way and, where appropriate, in greater depth. This part tests candidates' ability to explain their opinions and to analyse, discuss and speculate about issues.

Part 3 is relevant to communications between nurse and doctor, where the doctor may ask a series of questions to assess a patient's condition and give instructions for treatment. Nurses may be asked to give and explain their opinions, discuss and propose possible courses of action. As in Part 2, however, the examiner may not depart from the frame, so in the test the communication is one-way, rather than two-way. 'Candidates have little or no opportunity to display their ability to introduce and manage topic development, ask questions or manage turn-taking' (Seedhouse & Harris 2011, p. 20). In the hospital, by contrast, nurses are expected to have some input in decision-making with the medical team, and to participate in an interactive discussion with team members.

Despite the claim that Part 3 assesses interaction, the published criteria for assessment are: fluency and coherence, lexical resource, grammatical range and accuracy, and pronunciation. The descriptors thus indicate a focus on constructing a monologue, for example, through the use of connectives and discourse markers, language-related hesitation, repetition, and topic development.

5.2   Listening

The listening paper has four sections, with ten questions in each section. The questions are in the same order as the information in the recording. Time allowed for listening and recording answers is approximately 30 minutes. Candidates hear the recordings once only. Different accents, including British, Australian, New Zealand and North American, are used. Candidates are penalised for grammar and spelling mistakes.

The test of a candidate's ability to comprehend extended speech that they hear only once is appropriate to, but more demanding than, the sort of listening required in nursing, as nurses have the opportunity to ask for something to be repeated or explained, or seek clarification in a patient's records, or on the Internet:

We can always ask them to explain or to repeat whatever they are saying or whatever we are telling them. We can check with them, like whether they are clear with the instructions or anything. If they are not clear, we can explain them. So to some extent it is relevant, yes. (N2, Interview 4)

Nevertheless, participants agreed that there is always a need to listen carefully, because sometimes what is said is not recorded elsewhere. Time pressure often means that what is said by a member of the medical staff or another nurse at handover must be comprehended immediately, as any delay could have serious consequences. Nurse 2 in Focus Group 1 found the practice required for the listening and reading papers good preparation for nursing in the UK.

You can really practise it sometimes when you're dealing with the patients and the relatives, the listening part, when you focus to it, because most of the materials they're giving is British accent, so to have spent days and months for listening to the listening part, taking the exam on my own. So if compare my listening is a bit more sharper, and then applying to the actual situation.

The audio recordings (rather than a live speaker) used in the IELTS listening test replicate the difficulty nurses may face if the speaker's face is turned away, for example, when reporting information from a computer screen. However, as was frequently noted in the research, nurses have to understand a wider range of English accents in UK hospitals than is represented by the standard Anglophone accents used in IELTS. For example, a participant in the tracking study commented on the practice test: *The English [in the test] is quite clear. Sometimes you have patients with strong accents.* (N3, Interview 4)

The everyday topics in Sections 1 and 2 of the listening paper reflect those that can typically arise during conversations with patients and colleagues. By contrast, the ability to communicate in other topics on the paper, which are relevant to academic education, is not, for the most part, required in nursing. Partial exceptions may occur in professional development seminars offered at some hospitals – which, nonetheless, are optional – and in discussions between members of a medical team, whose main points may need to be summarised for the patient by the nurse.

The listening test uses a range of response formats:

1. multiple-choice questions
2. matching information from the recording to an option on the list
3. plan/map/diagram labelling
4. form/note/table/flow chart/summary completion
5. sentence completion
6. short answer questions.

Response formats 3-6 require no more than two words and/or a number, which is precisely what is required when nurses are listening in order to complete forms, charts and checklists with essential items information. The formats reflect a range of listening activities that nurses might be involved in: listening for detailed understanding of specific points or general understanding of main points, the ability to listen for detailed information, listening for specific information. The last two formats are relevant to eliciting information from patients at admissions and from colleagues at handover.

When we are preparing a patient for any operation we have to ask about the history – medical or surgical history – and we have to pay the full attention for that. I think, yeah, it is relevant… We have to prepare the patient for the surgery and on that checklist we've got blanks. The question will be there, but the blank, in that case, we have to fill. Then we have to ask the patient, and we have to fill them correctly and if anything is wrong there, when patient will go to the operating room again, they will ask the same question, make sure, like, in the wards, we didn't left anything, or we didn't miss anything we have written, like wrong information about the patient. So it is relevant, yes. (N2, Interview 4)

So, we are trying not to miss anything. I think [it] probably helps, the idea that candidates need to enhance their listening abilities to try to figure exactly everything that she said, to, obviously, try and answer the question correctly. So, it's that idea of you trying not to guess anything from what people are saying to you, to get, obviously, the whole picture, because that's what's, pretty much, asked of us. (N3, Interview 4)

5.3 Reading

There are three sections with a reading text in each section. The texts are taken from books, journals, magazines, newspapers and online resources, all written for a non-specialist audience. The description on the Cambridge English website states that: 'All the topics are of general interest to students at undergraduate or postgraduate level', and demonstrate different rhetorical functions, for example, narrative, descriptive, discursive, and argumentative. At least one text contains a detailed logical argument. Texts may also contain diagrams, graphs or illustrations. For any technical vocabulary that is used, a simple dictionary definition is provided.

The test does not assess the same reading abilities as those required in nursing. Nurses have to identify words and phrases, and parse simple syntax in extended narrative. The reading material they deal with – medical notes, handover sheets, forms, charts, checklists, medicine labels and online definitions – is typically in a restricted code, and includes headings, bullet-pointed lists and brief notes, abbreviations and quantities. In contrast, the IELTS texts require an understanding of features of coherence and cohesion in lengthier texts, interpretation of implicit as well as explicit meaning, syntactic parsing of both simple and complex sentences, and the like. The only extensive nursing-related texts, identified by the current study, are protocols, which are predominantly formulaic and predictable, and policy statements, which arguably nurses should read, but which are not encountered in their daily duties.

> *Obviously, on a daily basis, sometimes you don't have time to read a lot of things, for example, even certain specific things like a lot of trust policies they ...need to work according to – you need to read them. ...And they're available on the Internet...You have to read things like this...obviously [the trust policies] are more technical content-wise.* (Interview 4)

Two of the participants did report reading journal articles, for which the ability to read academic texts is necessary, but described this as a personal choice, not essential to their day-to-day work.

The duration of the test is one hour, including time allowed to transfer responses to an answer sheet. As with the listening paper, the reading paper in IELTS uses a range of response formats:

1. multiple-choice questions
2. identifying information (true/false/not given)
3. identifying writer's views/claims (yes/no/not given)
4. matching information
5. matching headings to paragraphs or sections in a text
6. matching a set of statements or pieces of information to a list of options
7. complete sentences based on information in the text by selecting from a range of possible endings
8. sentence completion choosing one or two words and/or a number from the text
9. summary/note/table/flow chart completion using words from the text, or from a list of options
10. diagram label completion
11. short-answer questions.

There are 40 questions in total. The questions are in the same order as the answers that can be found in the text. Candidates are penalised for incorrect spelling and grammar.

The questions assess a range of capacities on the part of candidates, such as to:

- understand the main points
- understand specific points in detail
- identify the overarching topic of a paragraph (or section)
- recognise the difference between the main idea and a supporting idea
- recognise the function of various elements (example, reason, description, comparison, summary, explanation, etc.)
- differentiate factual information from opinions, theories or ideas
- recognise relationships and connections between elements in the text
- skim and scan the text to find the information quickly so that part can be read more carefully for detail
- interpret a detailed description and relate it to information given in a diagram.

The majority of these abilities are essential to the comprehension of extended texts, which, as noted above, are not directly relevant to nurses' reading. A few, however, are relevant: nurses do have to skim and scan text to find information quickly and relate information in medical notes to diagrams and charts in the patient records they have to identify accurately quantities, as well as expiry dates on medicine labels.

Response formats 8-11 above, which specify no more than two words and/or a number in the answer, correspond to requirements of nurses when completing documentation. The requirement to transfer accurate information is important for nurses, and the time constraints are relevant. Overall, however, the IELTS reading test does not assess nurses' ability to comprehend the kind of written language that they encounter in their work.

[It is appropriate] for academic purpose, definitely yes, but for like nursing I don't think so because we don't need to read that much information. We have to go through whatever doctors, consultant they are writing in the notes…We're having everything in the computer now…we can get the information through that, plus we've got local policies and procedures. If we are not sure with anything we can open it and go through the thing. If anyone they are not competent to do anything we just need to dial the sister- in-charge and they will guide us…whatever we are reading in nursing, it's like related to nursing. So we can understand, yes. (N2, Interview 4)

5.4   Writing

There are two writing tasks in the IELTS test. In Task 1, candidates are asked to describe (in 20 minutes, in at least 150 words) visual information (for example, a graph, table, chart or diagram of an object, device, process or event) in their own words, highlighting the most important points**.** In Task 2, candidates discuss (40 minutes, at least 250 words) a point of view, argument or problem, giving evidence and examples, which may be from their own experience**.** Candidates are penalised if they do not write the minimum number of words specified. Time limits are relevant to nurses' writing, but word limits are not.

If you write just like two three sentences, or ten sentences, it has to contain the most important things. So it's not just, like, fill up all the lines, but it has to be something useful, or something important. Something which we could actually use.
(N4, Interview 4)

In nursing, there's no such thing like, you have to write 250 words, 150 words…but when you go to the university, to do some courses, like, for example, critical care course, you are required to do such certain number of words, or [if] you could do a mentorship at university you are required to do some certain number of words so I think this mostly related to continuing education rather than day-to-day nursing basis of writing. (N1, Interview 4)

There was a reasonably high level of agreement among the participants that the writing Task 1 resembles, much more closely than Task 2, the writing that nurses do.

I would say that for me, in my area, we will focus on tasks like Task 1, more relevant and the length is much more relevant, yes…What they ask here for a candidate to do is similar to what we do. We compare the trends of the numbers and we have to say what this happens and…it just relates more to this – I think mainly because of numbers, because [Task 2] is a lot of personal opinion about values of what a person considers reporting. And this [Task 1] is more technical, numbers, patients, and things like that. So, I think in that term it does relate more to writing Task 1 than to writing Task 2. (N3, Interview 4)

However, Nurse 1 and 2 were more skeptical about the similarity of the writing demands:

It's [Task 1] not exactly relevant but, somehow, you can still use it by trying to relate on how the patients improve on a day-to-day basis, comparing. That's the way I look at it, by comparing, but now the NMC say you document for particular. For example, at 10 o'clock you observe that the patient is bleeding you put then '10 am patient's bleeding' and then '11 am patient's treated by the doctor' so that's how you do it but when it comes to writing like this… we could do the same but it's probably not exactly the same as what we do in nursing.
(N1, Interview 4)

N: Not Task 2, for nursing like sometimes we have to write about the patients. So blood investigations, we have to compare, like yesterday, the haemoglobin was this much, like 10 or 11, and after giving blood transfusion, like after giving two initial blood transfusion following that, the blood results went up to 11. So a little bit.

C: So you think that seems a little more relevant, [Task] 1 to actual nursing maybe.

N: To some extent, yes, plus when they are doing evaluation in that time as well, we can use it like, previously the patient condition was like this, and after giving medications it's become better or worse or didn't help at all. (N2, Interview 4)

Task 2, on the other hand, assesses the extent to which a candidate can write a clear, relevant, well-organised argument, giving evidence or examples to support ideas, and using language accurately. Candidates are expected to: present and justify an opinion; present a solution to a problem; compare and contrast evidence, opinions and implications; and evaluate and challenge ideas, evidence or an argument. However, there is almost no need for extended writing, expressing – for example, personal opinion or reflection – in nursing practice.

Even if we have to write something, for example, a family discussion or something, all the time you are asked to avoid being personal. So, we focus on giving explanations of numbers and situations without giving our personal opinion about something. So it's very unlikely that we have to write something like this in our daily clinical area. (N3, Interview 4)

It's part of the nursing where you obviously you can do your own reflection but, if you ask me, do we do this in the hospital? Not really. I mean we do this in the university, part of the reflection about the patients' care, and about how the patients feel about the care being provided…That's the way I look at it.
(N1, Interview 4)

This participant, who trained outside the UK, found no evidence of academic styles of writing in UK hospitals.

> *I look at the English nurses' writing because sometimes that's how you learn you kind of what's the English nurses do and I haven't seen them writing such kind of level actually. Sometimes I should say they write the way they talk.* (N1, Interview 4)

On these grounds, one participant suggested that Band 6 IELTS, which does not test the ability to construct an extended text, might be more appropriate for nurses than Band 7.

> *The writing it's not something we do, with a lot of detail…So, looking at that, looking at the bands I think Band 6 looks like a good basis.*
> (N3, Interview 4)

Nevertheless, one participant felt that being able to write in an academic or semi-formal/neutral style can be of some use to nurses.

> *I think it is useful in a way where you have something as part of an indication. Sometimes you need to write in academic style of writing, so in that sense probably might be useful.* (N1, Interview 4)

The imperative for brevity, succinctness, and economy means that nurses write notes for the most part, rather than complete sentences. By contrast, the IELTS writing paper requires candidates to write their answers in full sentences. Candidates are expected to write clearly and fluently, to structure and link the information and their ideas appropriately. Notes or bullet points are not permitted: thus one writing skill that is essential for nurses is not tested.

> *You cannot [write at length] in nursing…you don't have the time…because there's more going on when monitoring the patient.* (N1, Interview 4)

The IELTS writing paper is marked according to four criteria:

1. task achievement/response
2. coherence and cohesion
3. lexical resource
4. grammatical range and accuracy

Each criterion is discussed below in relation to nursing practices in writing.

5.4.1 Task achievement/response

As stated above, Task 1 seems to be the most relevant to the writing that nurses have to engage in. It assesses the extent to which candidates can give a well-organised overview of the visual information in the graph, table, chart or diagram, using language that is appropriate in its register and style.

Depending on the task type, candidates are assessed on their ability to: organise, present and possibly compare data; describe stages of a process or procedure; describe an object, event or sequence of events; or explain how something works. In comparison, Task 2 appears less relevant. It assesses the candidate's ability to give and justify an opinion, discuss the topic, summarise details, outline problems, identify possible solutions and support what they write with reasons, arguments and relevant examples from their own knowledge in an extended essay format.

5.4.2 Coherence and cohesion

The IELTS criteria for scoring both tasks emphasise logical progression and effective use of cohesive devices. Paragraphing is also important for Task 2. It would be difficult to avoid logical progression in nurse record-keeping, given that the records are expected to maintain a chronological sequence with the time of an event or action stipulated. The use of cohesive devices to connect sentences and paragraphing is of little importance in nurses' writing. Extended writing is inhibited by the constraints imposed by spaces available in forms, charts and tables etc.

5.4.3 Lexical resource

As they progress through the IELTS bands at each level, candidates are expected to use an increasingly wide range of vocabulary, achieve greater precision, demonstrate awareness of style and collocation, and be familiar with less common lexis. These criteria, however, relate to general, non-technical vocabulary, whereas nurses write within a medical/healthcare register with a predominantly technical lexis, and precision is achieved through the accurate use of relatively high frequency formulaic phrases, medical terminology, and numbers.

5.4.4 Grammatical range and accuracy

Candidates are expected to demonstrate increasingly complex syntax at the higher band score levels, and with a greater degree of accuracy, including in the use of punctuation. At level 7, they must use 'a variety of complex structures, produce frequent error-free sentences, have good control of grammar and punctuation but may make a few errors'.

As has been demonstrated above, these writing skills are very different from what nurses are required to do: they must be brief and succinct; accuracy is not a matter of complex syntax, but of precise reporting of the time of an event and what occurred, and recording quantities, the names of medicines and the patient's medical condition. When nurses check written records for accuracy, they are looking for lexical or numerical errors, rather than those of punctuation or syntax.

6   DISCUSSION

6.1   Language requirements for overseas nursing practitioners

Nurses are the centre of the network of communications surrounding patient care. They communicate regularly with the patients and mediate between patients and their family and friends and between patients and medical and non-medical staff. They have to be competent in using different registers, lay and medical, and to mediate between the two in tense, emotive situations. They have to be able to perceive when indirectness is required to avoid conflict and to have knowledge of appropriate turn-taking conventions.

Nurses are responsible for patient care during their time in the hospital. They have to be competent to use English to elicit information about the patient and their medical history, mediating between prompts on checklists and forms and the cultural and linguistic understandings of the patient; orient the patient to the hospital and its procedures; assess a patient's condition; gain their trust and cooperation; relax and reassure them; and deal with them appropriately if they are agitated or abusive. This entails selecting appropriate language to request, inform, check, exemplify, explain, advise, instruct, refuse, insist, apologise, promise, comfort, assure and engage interactively with patient's responses, requests and concerns, use indirectness to mitigate the force of what they say, and to be able to engage in social conversation. These communicative demands are more challenging when collocutors do not share a common language.

Nurses also have to deal with medical staff internally at different levels in the hospital hierarchy. As the patient's advocate, this can involve frequent requests for repetition and clarification, which may appear confrontational to the interlocutor. It may also incur challenging authority, which would normally necessitate conflict avoidance in order to achieve favourable outcomes for patients. Nurses need to be able to work collaboratively with the medical team to discuss patient treatment and care, and with other nurses, co-constructing talk when checking information and procedures, helping patients to mobilise, and negotiating responsibilities. They may need to support and give instruction to healthcare assistants or agency staff. Nurses also need to be able to relax with colleagues, chat and employ humour in culturally appropriate ways.

Communication is further complicated when there are multiple participants, as for instance, when the nurse is dealing with patients or members of their families as overhearers in a medical conversation, or including patients when talking to medical and non-medical staff. This requires the sensitivity to know what information to select, how to structure the talk to be comprehensible to both parties, and the appropriate register to use.

Nurses may need to communicate with patients, doctors and nurses who are not proficient in English. They have to be culturally and linguistically 'open', sensitive to any misunderstandings between doctors, nurses and patients, able to take the initiative, and use repair strategies to aid communication in the interest of patient safety. If patients have minimal or no English, nurses may have to draw on available institutional resources, and develop their own.

Listening is involved in all the interactions discussed above. As Morse and Piland (1981) report, nurses stress the importance of listening. It is particularly crucial at handover because written records contain the essential medical information, but may not contain all that is said, which could be of importance to the incoming nurse, and may be difficult to decipher. Nurses have to be able to listen carefully and note relevant information. They also have to be able to check understanding in communications with medical staff and patients. Apker et al. (2006) also highlighted the importance of active listening with members of the healthcare team. They need to respond to indirect, as well as direct, requests from patients, and gauge a patient's mood and condition from their talk.

Although much more limited in scope than larger studies aimed at gathering data for language tests such as O'Hagan, Manias et al. (2013) and Epp and Stawychny (2002), nurse's detailed local accounts of daily routines and incidents reveal additional practices, such as crosschecking or challenging the actions of doctors and other nurses, and dealing with indirectness in emotionally charged situations concerning the patient and those close to them.

Listening is challenging because nurses have to understand a range of accents; patients with speech difficulties, which may be due to medication or physical impediments; medical staff whose faces are not fully visible because they are reading from texts or screens; and staff, patients, and their relatives and friends on the telephone. The latter may be employing indirectness because they are talking about an emotionally sensitive subject.

Requirements for reading do not seem to be so demanding for nurses, on a day-to-day basis, though they may need to deal with more challenging material to fulfil re-registration requirements to provide evidence that they have engaged in continuing professional development activities. Nurses need to be able to use and comprehend, for the most part, figures, routine medical terms, abbreviation, formulaic language and notes, and may need to search for specific information about a drug or procedure using paper-based reference material, or the Internet. They have to be able to read handwritten and computer records. Some abbreviations differ across cultures, but nurses can seek help from the Internet, or colleagues, or the hospital may supply a glossary to interpret them.

More challenging reading, e.g. of journal articles appears to be optional. However, according to *The Prep Handbook* (Nursing and Midwifery Council 2011), which is the post-registration education and practice guide for all nurses and midwives, they are expected to engage in 35 hours of learning activity during the three years prior to renewal of registration. The revalidation of the Prep, scheduled for October 2015, is a commitment to ensuring more rigorous checking of the Prep requirements. In order to fulfil these requirements for professional development, nurses may need to read relevant research publications.

Writing is not demanding with regard to complexity and length. However, nurses need to be clear, succinct and accurate. They transfer notes into tables and checklists, paper information to the computer and vice versa. They have to record their actions in patient records, but this must be in brief notes, or connected narrative. More demanding is the incident report, which would be 'knowledge telling', rather than 'knowledge transforming' required for academic writing (Bereiter & Scardamalia 1987). McNamara (1996) identified the limited demands on written communication compared with listening and speaking for health professionals. Epp and Stawychny (2002) made the same observation with regard to reading and writing for nurses.

Nurse communications are clearly challenging, more so if the nurse comes from a different cultural and linguistic background. Nurse reports of their communication practices reflect the social and political pressures in a hospital environment. Pressures of time are evident in the emphasis on brevity and clarity, checklists and abbreviations. The importance of accountability is demonstrated in the focus on record-keeping, checking, and asking for and providing clarification and confirmation. Communication in all skill areas involves 'therapeutic', 'medical routines', which may be easy to learn.

However, social chat, which is highly valued for therapy, distraction and the promotion of calm and well-being in the nurse accounts, can pose challenges for nurses from cultures that adopt a more 'task-based' approach to patient care (Candlin 1997; O' Hagan et al. 2013). Nurses whose primary language is not English can find it difficult to establish a professional identity, and make small talk to put patients at ease (O'Neill 2011; Deegan & Simkin 2010; Walters 2008; Omeri & Atkins 2002). The pragmatics of small talk in nursing practice is culturally related (O'Neill 2011).

Conflict avoidance and challenging authority, which nurses deal with in these contexts, could also be culturally problematic for some nurses. An additional particular difficulty would be the mediational role that nurses perform, switching between registers in the same communicative event with patients and medical staff.

Moreover, although speaking, listening, reading and writing have been discussed separately in order to make comparison with the IELTS requirements, they are markedly integrated in nursing practices.

6.2   IELTS and the language needs of practising nurses

The picture that emerges from the research into nurses' perspectives on their own communication and language use has been described at some length in the preceding sections. In this section, a number of key points that contribute to answering research question 2 are briefly reiterated.

6.2.1   Speaking

The speaking test does assess some aspects of communication that nurses engage in, such as talking about everyday topics (which they use in social conversations with patients and staff), and structuring information from notes on a topic, which would, in their case, be about the medical history of a patient, treatments and their effects, and the current patient's condition. Also, responding to prompts for information from other members of the medical team. Nonetheless, there are a number of vital aspects of nurse communications, identified in the research, that are not covered by the test. These include the competencies to:

- elicit personal information from someone in a formal situation, using prompts and requests for clarification, and, possibly, other more indirect means
- reassure someone who is anxious
- initiate a social conversation
- request action from a superior, a peer, or someone in their care, and deal with refusal
- challenge the actions of a superior
- participate in team decision-making
- translate lay talk into a specialist register and vice versa
- use language collaboratively with a peer, to negotiate responsibilities, issue instructions, and check information.

Crucially, in the IELTS speaking test, the communication is asymmetrical, managed by the examiner, who controls the introduction and closure of topics. There were no instances of candidates initiating, changing or closing topics in Ducasse and Brown's (2011) study of candidate performance in the IELTS speaking test. By contrast, in nurses' communication with patients, the nurse is typically the more powerful collocutor. Nor does the test format allow candidates to demonstrate their ability to select appropriate registers for communication with collocutors of equal and unequal status to themselves, or to engage in conversations with more than one collocutor, which are all necessary practices for nurses.

Communications in the IELTS consist of question and answer or topic prompts from the examiner, so the candidate cannot demonstrate the ability to use face-saving language to refuse a request, and avoid conflict when challenging someone of higher status; or to use features of spontaneous social conversation, for example, eliciting, commenting, back-channelling and interactive topic management, turn-taking, and checking

understanding, all important in nurse communications. The absence of many important features of social conversation in the IELTS speaking test was noted by Seedhouse and Egbert (2006).

6.2.2 Listening

The listening paper, by contrast, tests many aspects of listening that were identified by the research as important in nurse communications. As described in Section 5.2, the test assesses listening for detail, listening for a general understanding, and listening for specific information, using a range of response formats that nurses have to deal with in their listening, such as labelling a diagram, and completing forms, notes, tables, and summaries, in response to information given. The test contains items that require listening to one or more people. Nurses need to understand talk delivered by one person, particularly at handover, but also in taking instructions from another staff member. They also have to be able to comprehend talk between a number of individuals, social conversation between patients and families, and formal discussions involving members of the medical team.

The IELTS candidate hears the spoken material once only. Nurses must be able to understand spoken English in real time at the point of utterance, so to this extent the test assesses an essential listening skill for nurses. There is no assessment, however, of the closely related skill of seeking clarification and/or confirmation of important information. This ability is necessary for many communications in nursing, and it has particular relevance for overseas-trained nurses who are new to the UK and unfamiliar with the range of accents, well beyond the different Anglophone accents used in the IELTS test, that they are likely to encounter. While it would be impracticable to include even a representative sample of non-standard varieties of English in any listening test, it is possible and desirable for a test of nurses' communicative competence to assess candidates' ability to respond appropriately to speech that is not immediately comprehensible.

In summary, IELTS tests much of the listening that nurses engage in, but it does not include the participative listening that is an essential part of their workplace communication.

6.2.3 Reading

Compared to the reading required by the IELTS, the texts nurses have to read at work are shorter and more fragmented, and do not therefore include the range of structural and cohesive devices that are focused on in the test. The lexis and clause- and sentence-level syntax are much simpler. Some of the reading processes assessed in the IELTS test are required by nurses, namely, skimming and scanning the text, and completing tables, charts, notes and diagrams on the basis of what they have read.

There are two very specific areas in which academic reading skills are relevant in nursing. One is in the Overseas Nursing Program (ONP), which has for some time been a requirement for internationally-trained non-EEA nurses to register to practise in the UK. For the ONP, nurses must complete 20 days of protected learning, in addition to a period of supervised practice. The protected learning involves a course of study (normally at a university), as part of which candidates have to read an article concerning nursing practices in the UK and provide a reflective spoken and written response, which forms part of their assessment. Because the ONP is a compulsory requirement for registration, assessing academic reading (and writing) could thus be seen as a measure of candidates' ability to complete their pre-registration training. The ONP is, however, currently being replaced by a computer-based multiple-choice test in the country of origin and a practical exam in the UK; no further information was available during the period of this research.

The other area is continuing professional development (CPD). Some hospitals provide regular CPD seminars, which often involve discussion of journal articles that participants have read beforehand. In addition, a few respondents in the research reported that they read relevant articles in research journals to which the hospital, or they themselves, subscribe. Desirable though these activities are to maintaining professional competence for re-registration, however, they are not substantially reported in the data of the present study, which focuses on daily practices, rather than what nurses do outside their work for self-improvement.

In general, therefore, the academically-oriented reading skills that are tested in the IELTS are only marginally relevant for nurses.

6.2.4 Writing

As with nurses' reading, the writing required in their daily work differs substantially from that which is tested by the IELTS. According to the NMC guidelines, nurses should:

> *record details of any assessments and reviews undertaken, and provide clear evidence of the arrangements you have made for future and ongoing care. This should also include details of information given about care and treatment.* (2007, p. 5)

Nurses are expected, however, to be selective with regard to these details:

> *You should use your professional judgment to decide what is relevant and what should be recorded.* (2007, p. 5)

The data from the research indicate that nurses need to be competent in writing in short texts, rather than in extended and cohesive texts.

Participants described their writing in terms of brevity, succinctness, and capturing essential information. They have to produce notes, not complete sentences: single words, brief collocations, numbers, formulaic sequences, unconnected sequences in a narrative predicated by a time marker. The order, amount, and nature of content are often predetermined, as much of the writing consists of filling in forms, charts, and the like. Nurses do not need to be able to punctuate accurately, construct paragraphs, or use a variety of cohesive devices – all of which are assessed by the IELTS writing Band 7.

According to the NMC guidelines, it is important that writing should be 'easily understood' by people in the nurse's care. Participants in the research cited the stipulations in the guidelines that: 'records should be factual and not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation' (2007, p. 5). Limited vocabulary and simple syntax are essential, by contrast with the 'less common lexical items' and 'a variety of complex structures' stipulated for IELTS writing at Band 7. (The phrase 'less common lexical items' does not, of course imply specialist technical terminology, such as that of the medical register which nurses have to be able use in communication with other health professionals.)

Some apparent correspondences between the language of the IELTS criteria and that of statements by the NMC with respect to writing should not be taken at face value. For example, although the IELTS criteria for Task 2 refer to 'factual information', this is not the same as the factual information that forms the focus of nurses' writing, which has been described in a number of places throughout this report. IELTS writing Task 1 requires candidates to give 'a clear overview of main trends, differences or stages', and 'present a clear position throughout the response'. These are also essential characteristics of nurses' reports on patients' progress. There is a crucial difference, however, in that the IELTS criterion relates to expository writing, whereas nurses write in narrative form.

Consequently, the concept of 'errors' in nurses' writing is very different from that of the IELTS assessment criteria. In the former, it relates to imprecision and inaccuracy of information and the inappropriate use of specific technical terms. Nurses must employ checking procedures to ensure that information is accurately recorded and transferred from one format and/or medium to another. In the latter, 'errors' are incorrect grammatical constructions, and inappropriate use of (non-technical) lexical items.

In summary, as would be expected in the light of the differences in the reading requirements described in the preceding section, there is a rather considerable disparity between what nurses who sit the IELTS writing paper are required to demonstrate and their writing practices as nurses.

6.2.5   Summary

The findings of the research reported here show that the IELTS test assesses certain aspects, predominantly in relation to listening, of English language use that are criterial for successful communication in nursing. In all four skill areas, however, there are many skills required to achieve IELTS Band 7 that are, at most, marginally relevant to assessing whether overseas-trained nurses have the requisite English competence to practise in the UK. Conversely, some language skills and strategies essential for nursing are not tested by IELTS, particularly with regard to speaking.

6.3   Recommendations

Two options are recommended, both of which would require further, more extensive research into nurse communications in the UK.

1. To modify the current IELTS text, including an alternative module in the speaking test, which would assess communicative competence for nursing practice, and consider accepting a lower band score for reading and writing for nurses.

2. To develop a test for non-native English speaking health professionals, who apply to register for practice in the UK, similar to the Occupational English Test in Australia. If an English language requirement were to be stipulated for EEA nurses, a test specifically for nurses would be desirable, given the escalation in demand for nurses in the UK.

7   CONCLUSION

This study does not claim to be comprehensive because it deals with the communication practices of a relatively small number of nurses in a limited number of contexts over a short period of time. Because of the limited scope of the study, permissions were not obtained for direct observation within hospitals and the collection of a broader range of documentation, which would have enabled the triangulation of nurse accounts. Notwithstanding, the data collected offer a rich window on nurse communications, which have been used to examine the adequacy and appropriacy of the IELTS test as an English language requirement for non-EEA internationally-trained nurses. The study is the first of its kind in the UK, but notes similar findings with regard to nurse communications as those discussed in the literature review for the Occupational English Test in Australia and the Canadian English Language Benchmark Assessment for Nurses in Canada.

The conclusion is that while the IELTS listening test seems to be adequate and appropriate, nurses require a much wider competence in spoken English than is assessed in the IELTS speaking test.

They must have a high level of proficiency in the language of social interactions, or pragmatics, in order to speak with a range of interlocutors about a variety of medical, healthcare and everyday topics, in several different registers and for a variety of functions. These skills are tested minimally, if at all, in the IELTS speaking test. The assessment of writing is not directly relevant to what nurses have to do. Some of the requirements for the reading test are relevant, but too demanding as a measure of the reading that nurses regularly have to deal with.

The current study prioritises what nurses do, in order to evaluate test requirements, rather than benchmarking what nurses do to existing criterial descriptors for assessment (O'Neill et al. 2007; Epp & Stawychny 2002). This has enabled the identification of pragmatic aspects of communication that are not accounted for in the current IELTS test, which assesses knowledge for use, rather than language as a social behaviour, the ability to initiate, take turns, and collaborate, in talk with others (McNamara 1996), vitally important in nurse communications. Scores on the IELTS are used to make decisions about the ability of a candidate to deal with the language required in target language use situations, in this case, nursing. This involves social and pragmatic aspects of language that, according to the results of this study, are not adequately assessed in the IELTS.

Recommendations are made for assessment that more specifically deals with what nurses need to do in spoken and written communications. This small-scale study has identified a number of areas where the IELTS test does not seem to assess adequately and appropriately nurses' linguistic preparedness for practice, particularly with regard to pragmatic and social aspects of language. Wette (2012) argues that, in the New Zealand context, lower scores should be accepted on the IELTS, or preferably the OET (Occupational English Test), the ESP test recognised in Australia and New Zealand for health professionals, in order to allow qualified nurses into the country to develop the cultural language practices that they need locally.

However, although this level of local support for language development in the context of practice would be desirable, it cannot be guaranteed in the UK, and given the current financial climate in the NHS, is unlikely to be considered. The recent changes that have been made to the requirements for registration for non-EEA nurses trained outside the UK entail substitution of the support provided by protected learning on the Overseas Nursing Program and supervised practice with a multiple-choice test of knowledge in the country of origin and an OSCE (a practical examination of their nursing skills) in the UK, on successful completion of which nurses are expected to be ready with minimal linguistic skills required for practice.

Considering these recent changes, it seems even more crucial that international nurses should be able to demonstrate that they have communication skills for practice before coming to the UK. A framework has been developed for health educators and supervisors to provide appropriate support for internationally educated health professionals, in nursing midwifery and medicine in London (Health Education North Central and East London 2014), in the workplace, but this has not currently been accepted as a statutory requirement.

Any revision to the current assessment would have to be based on a larger-scale study and involve liaison with health practitioners, as was achieved for the CELBAN (Epp & Stawychny 2002) and, more recently for re-validation of the OET (Elder et al. 2013), and include the perspectives of other stakeholders, e.g. patients and managers. There is a tension between ensuring efficiency, practicality, and accessibility of an assessment; and its adequacy and appropriateness.

As McNamara argues, language assessment is social and political. In the interests of patient safety, and the wellbeing of non-native speaker nurses trained outside the UK, they need to be at the very least minimally linguistically ready for practice.

REFERENCES

Alderson, J. C. (1981). Report of the discussion on testing English for Specific Purposes. In A. Hughes (Ed.), *Issues in Language Testing* (pp. 123–134)*.* London: The British Council.

Alderson, J. C. (1988). Testing English for Specific Purposes – how specific can we get? In A. Hughes (Ed.), *Testing English for University Study*, (pp. 16–28). ELT Document 127, London: Modern English Publications.

Apker, J., Propp, K. M., Zabava Ford, W. S. and Hofmeister, N. (2006). Collaboration, Credibility, Compassion, and Coordination: Professional Nurse Communication Skill Sets in Health Care Team Interactions. *Journal of Professional Nursing,* vol 22 (3), pp. 180–189.

Arakelian, C. (2003). On speaking terms. *Nursing Standard*, vol 17 (44) p. 23.

Bereiter, C. and Scardamalia, M. (1987). *The Psychology of Written Composition*, Hillsdale, NJ: Erlbaum.

Berry, V., O'Sullivan, B. and Rugea, S. (2013). *Identifying the appropriate IELTS score levels for IMG applicants to the GMC register.* London: University of Roehampton and General Medical Council. Available from http://www.gmc-uk.org/Identifying_the_appropriate_IELTS_score_levels_for_IMG_applicants_to_the_....pdf_55207825.pdf

Bourhis, R. Y., Roth, S. and MacQueen, G. (1989). Communication in the hospital setting: A survey of medical and everyday language use amongst patients, nurses and doctors. *Social science & medicine,* vol 28 (4), pp. 339–346.

Brown, J. D. (2008). Testing context-analysis: assessment is just another part of curriculum development. *Language Testing*, vol 5 (4), pp. 275–312.

Buchan, J. and Seccombe, I. (2012). Overstretched and under-resourced. *The UK nursing labour market review for the Royal College of Nursing*. Edinburgh: Queen Margaret University.

Candlin, S. (1997). *Towards excellence in nursing. An analysis of the discourse of nurses and patients in assessment situations,* PhD edition, University of Lancaster, Department of Linguistics and Modern English Language.

Candlin, S. (2002). A triple jeopardy. What can discourse analysts offer health professionals? In C. N. Candlin (Ed.), *Research and practice in professional discourse.* Hong Kong: City of Hong Kong Press.

Council of Europe. (2013). The Common European Framework of Reference for Languages: Learning, Teaching, Assessment. Cambridge: Cambridge University Press

Davies, A. (2001). The logic of testing language for specific purposes. *Language Testing*, vol 18 (2), pp. 133–149.

Deegan, J. and Simkin, K. (2010). Expert to novice: experiences of professional adaptation reported by non-English speaking nurses in Australia. *Australian Journal of Advanced Nursing*, vol 27 (3), pp. 31–37.

Douglas, D. (2000). *Assessing Language for Specific Purposes*. Cambridge: Cambridge University Press.

Ducasse, A. M. and Brown, A. (2011). The role of interactive communication in IELTS speaking and its relationship to candidates' preparedness for study or training contexts. *IELTS Research Reports*, vol 12. IDP: IELTS Australia and British Council.

Duff, P. A. and Roberts, C. (2012). The politics of transcription. *TESOL Quarterly*, vol 31 (1), pp. 167–172.

Elder, C., McNamara, T., Woodward-Kron, R., Manias, E., McColl, G., Webb, G. and Pill, J. (2013). Towards improved healthcare communication: Development and validation of English proficiency standards for non-native speaking health professionals. *Final report for the OET Centre*, Melbourne: University of Melbourne.

Epp, L. and Stawychny, M. (2002). *Benchmarking the English language demands of the nursing profession across Canada.* Centre for Canadian Language Benchmarks.

Fleischer, S., Berg, A., Zimmermann, M., Wüste, K. and Behrens, J. (2009). Nurse–patient interaction and communication: a systematic literature review. *Journal of Public Health,* vol 17, pp. 339–353.

Flick, U. (2009). *An Introduction to Qualitative Research*, 4th edition. Thousand Oaks, Ca.: Sage.

Ford, Y. B. (2009). *Talking about patients: nurses' language use during hand-offs*. (Unpublished PhD.) University of Michigan.

Fulcher, G. and Davidson, F. (2007). *Language Testing and Assessment: An advanced resource book.* Abingdon, Oxon: Routledge.

Garner, M., Wagner, C. and Kawulich, B. (Eds.) (2009). *Teaching Research Methods in the Social Sciences*, Aldershot: Ashgate.

Health Education North Central and East London. (2014). *Supporting safe transition for internationally educated health professionals (IEHPS) working in the NHS in London*. NHS Professional Support Unit.

Hearnden, M. (2008). Coping with differences in culture and communication in health care. *Nursing Standard*, vol 23 (11), pp. 49–57.

IELTS. *IELTS Test Takers Information*. Accessed 9 December 2014 from: http://www.ielts.org/test_takers_information/what_is_ielts/ielts.aspx

Inger, J., Andershed, B., Gustavsson, B., Ternestedt, B. M. (2010). Knowledge constructions in nursing practice: Understanding and integrating different forms of knowledge. *Qualitative Health Research*, vol 20 (11), pp. 1,500–1,518.

Leech, G. (1983). *Principles of Pragmatics*. Harlow: Pearson Education Ltd.

McNamara, T. (1996). *Measuring Second Language Performance*. London: Longman.

McCabe, C. (2004). Nurse-patient communication: an exploration of patients' experiences. *Journal of Clinical Nursing,* vol 13, pp. 41–49.

McNamara, T. F. (1990). *Assessing the Second Language Proficiency of Health Professionals,* PhD edition. Melbourne, Australia: Department of Language and Linguistics, University of Melbourne.

McNamara, T. and Roever, C. (2006). *Language Testing: the social dimension*, Oxford: Blackwell.

Merrifield, G. (2007). An impact study into the use of IELTS by professional associations and registration entities: Canada, the UK and Ireland. *IELTS Research Reports*, vol 11. IDP: IELTS Australia and British Council.

Mislevy, R. J. and Steinberg, L. S. and Almond, R. G. (2003). On the structure of educational assessments. *Measurement: Interdisciplinary Research and Perspectives,* vol 1, pp. 3–67.

Morse, B. W. and Piland, R. N. (1981). An Assessment of Communication Competencies Needed by Intermediate-Level Health Care Providers: a Study of Nurse–Patient, Nurse–Doctor, Nurse–Nurse Communication Relationships. *Journal of Applied Communication Research,* vol 9 (1), p. 30–41.

NHS Employers. (2014). *Consultation document: mobility of health professionals in Europe*. Accessed 11 December 2014 from: http://www.nhsemployers. org/your-workforce/recruit/employer-led-recruitment/ international-recruitment/mobility-of-health- professionals-across-europe

Nursing and Midwifery Council. (2011). *The Prep Handbook.* Accessed 28 November 2014 from: http://www.nmc-uk.org/Documents/Standards/ NMC_Prep-handbook_2011.pdf.

Nursing and Midwifery Council. (2014). *Joining the register*. Accessed 11 December 2014 from: http://www.nmc-uk.org/Registration/Joining-the- register/Trained-outside-the-EU--EEA/

Nursing and Midwifery Council. (2009). *Record- keeping: Guidance for Nurses and Midwives*. Accessed 11 December 2014 from: http://www.nmc-uk.org/ Documents/NMC-Publications/NMC-Record-Keeping- Guidance.pdf

OET. (2007). *About OET*. Accessed 11 December 2014 from: http://www.occupationalenglishtest.org/Display. aspx?tabid=2428

O'Hagan, S., Manias, E., Pill, J., Woodward-Kron, R., McNamara, T., Webb, G. and McColl, G. (2013). What counts as effective communication in nursing? Evidence from nurse educators and clinicians' feedback on nurse interactions with simulated patients. *Journal of Advanced Nursing,* vol 70 (6), pp. 1,344–1,355.

O'Neill, T. R., Buckendahl, C. W., Plake, B. S. and Taylor, L. (2007). Recommending a nursing-specific passing standard for the IELTS examination. *Language Assessment Quarterly*, vol 4 (4), pp. 295–317.

Omeri, A. and Atkins, K. (2002). Lived experiences of immigrant nurses in New South Wales, Australia: searching for meaning. *International Journal of Nursing Studies*, vol 39, pp. 495–505.

O'Sullivan, B. (2011). Language testing. In J. Simpson (Ed.), *Routledge Handbook of Applied Linguistics* (pp. 259–273). Oxford: Routledge.

O'Sullivan, B. and Weir, C. (2011.) Language testing and validation. In B. O'Sullivan (Ed.), *Language Testing: Theory and Practice (*pp. 13–32)*.* Oxford: Palgrave.

Petronio, S. and Sargent, J. (2011). Disclosure predicaments arising during the course of patient care: nurses' privacy management. *Health Communication*, vol 26 (3), pp. 255–266.

Rayo, M. F., Mount-Campbell, A. F., O'Brien, J. M., White, S. E., Butz, A., Evans, K. and Patterson, E. S. (2014). Interactive questioning in critical care during handovers: a transcript analysis of communication behaviours by physicians, nurses and nurse practitioners. *BMJ Quality and Safety*, vol 23 (6), pp. 483–489.

Rubin, H. J. and Rubin, I. S. (2005). *Qualitative Interviewing: the art of hearing data*, 2nd edition. Thousand Oaks, Ca.: Sage.

San Miguel, C. and Rogan, F. (2012). Clinical expectations: What facilitators expect from ESL students on clinical placement. *Nurse Education in Practice,* vol 12 (2), pp. 115–119.

Seedhouse, P. and Egbert, M. (2006). The Interactional Organisation of the IELTS speaking test. *IELTS Research Reports,* vol 6. IELTS Australia and British Council.

Seedhouse, P. and Harris, A. (2011). Topic development in the IELTS speaking test. *IELTS Research Reports,* vol 12. IDP: IELTS Australia and British Council.

Sheldon, L. K., Barret, R. and Ellington, L. (2006). Difficult communication in nursing. *Journal of Nursing Scholarship,* vol 38 (2), pp. 141–147.

Smith, P. A., Allan, H., Larsen, J. A. and MacKintosh, M. M. (2005). *Valuing and Recognising the Talents of a Diverse Healthcare Workforce*. Report from the REOH Study: Researching Equal Opportunities for Overseas- Trained.

Taylor, L. (2001). Revising the IELTS speaking test: developments in test format and task design. *Research Notes*, vol 5, pp. 2–5.

Walters, H. (2008). The experiences, challenges and rewards of nurses from South Asia in the process of entering the Australian nursing system. *Australian Journal of Advanced Nursing*, vol 25 (3), pp. 95–105.

Weir, C. J. (2005). *Language Testing and Validation: an evidence-based approach*. Basingstoke: Palgrave Macmillan.