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Title

What are they talking about? Content of the communication exchanges between nurses, patients and relatives in a department of medicine for older people – An ethnographic study

Abstract

Aims and objectives: To explore and describe the content of the communication exchanges between nurses, patients and their relatives in a department of medicine for older people in western Sweden.

Background: Information, messages and knowledge are constantly being communicated between nurses, older patients and relatives in the healthcare sector. The quality of communication between them has a major influence on patient outcomes. A prerequisite for good care to be given and received is that there is mutual understanding between the parties involved.

Design: An ethnographic study was informed by a sociocultural perspective.

Method: Data were collected through 40 participatory observations of meetings between nurses and older patients and/or relatives which covered 135 hours of nurse-patient-relative interaction, field notes, 40 field conversations with 24 nurses and 40 field conversations with patients (n=40) and relatives (n=26). Five semi-structured interviews were conducted with nurses. An ethnographic analysis was performed.

Results: The analysis identified three categories of content of the communication exchanges: medical content focusing on the patient's medical condition, personal content focusing on the patient's life story, and explanatory content focusing on the patient's health and nursing needs. The content is influenced by the situation and context.

Conclusions: Nurses would benefit from more awareness and understanding of the importance of the communication content and of the value of asking the didactic questions (how, when, what and why) in order to improve the patients' and relatives' understanding of the information exchanges and to increase patient safety.

Relevance to clinical practice: Nurses can use the communication content to create conditions enabling them to obtain a holistic view of the patient's life history and to develop an appropriate person-centered care plan.

Keywords:

communication content, ethnography, nurses, older patient, person-centered care, relative, sociocultural perspective

What does this paper contribute to the wider global clinical community?

- The study presents the content of the communication exchanges between nurses, older patients and relatives in a new context: department of medicine for older people.
- The study highlights three types of content: medical, personal and explanatory. If nurses reflect on the communication content the communication can be more successful and provide a basis for social interaction. The social interaction becomes stronger when nurses use personal and explanatory communication content.
- The study underlines the value of nurses being aware of the impact the content of the communication exchanges and the use of didactic questions can have on the participation of older patients with multiple chronic conditions and their relatives.

Introduction

Information, messages and knowledge are constantly being communicated in the healthcare sector. Research indicates that it is crucial for older patients' well-being that they and their relatives are treated with respect and kindness. It is also important that they perceive the communication exchanges to be honest and trustworthy (Nygren Zotterman, Skär, Olsson, & Söderberg, 2016).

Nurses generally initiate the communication exchange and therefore determine its content (Fukaya, Suzuki, & Shitita, 2004; Wadensten, 2005). The present study focuses on the content of communication between nurses, older patients and their relatives. The study is a part of a larger ethnographic project whose overall aim is to examine nurses' communication with older patients and relatives in a department of medicine for older people in western Sweden. The project was requested by the department involved as they perceived a need for improvement in the communication exchanges with older patients and relatives.

Research shows that communication problems are the single biggest cause of nearly 70% of sentinel events in hospital settings (WHO, 2009). Communication exchanges, transfers of knowledge and handovers between providers are central to optimizing patient safety (WHO, 2009). According to the Swedish Patient Safety Act (SFS 2010:659), the healthcare system must strive to reduce healthcare injuries by, among other things, establishing safe and trustful communication between healthcare providers and patients. The content of the communication should be adjusted to the particular situation and affects the knowledge needed by patients and relatives to understand the information received and to make their own decisions about care issues (Tobiano, 2015). Nurses should communicate empathically and responsibly and take advantage of the patient's experience and knowledge in order to achieve a holistic view of the patient, including all relevant physical, mental, social, existential and cultural aspects. This holistic view has similarities with person-centered care (Ekman et al., 2011). Person-centered

care means that nurses focus on the patient's story and knowledge about their experiences and life situation and respect the patient's values, preferences and expressed needs, thus making the patient more involved in their own care (Ekman et al., 2011; Edvardsson, 2015).

Understanding is a prerequisite for the patient to be able to participate and act on the basis of given information (Fleischer, Berg, Zimmermann, Wüste, & Behrens, 2009; Tobiano, Marshall, Bucknall, & Chaboyer, 2015). The increased number of older patients with multiple morbidity (Christensen et al., 2009) and the shortened times of care within the Swedish hospital healthcare sector place high demands on the communicative ability of nurses as communication with older persons involves various challenges, such as visual impairment or hearing problems (Le May, 2005). Knowledge, awareness and understanding of the importance of the communication exchanges are necessary to improve patient safety, increase patient participation, and promote person-centered care.

Background

Previous research

Research shows that nurses consider being present, confirming and having time, as well as having experience of communicating, to be important factors for achieving good communication with older patients and relatives (Strang, Henoch, Danielson, Browall, & Melin-Johansson, 2014). According to Persson and Friberg (2009), communication starts a process in which it is important to create space for the patient's questions. Research also indicates that older patients and their relatives want the attending nurses to have a positive attitude that invites to communication and shows real interest in understanding the patient's and relative's perspectives on their situation (Calvin, Frazier, & Cohen, 2007; Nygårdh, Malm, Wikby, & Ahlström, 2012). Communication exchanges between nurses and patients have been

found to promote faster patient recovery (Caris-Verhallen, Kerkstra, & Bensing, 1997; Nygren Zotterman et al., 2016).

Research on the perspectives of nurses and older patients has been carried out in various healthcare contexts. Studies focusing on retirement homes indicate that the patient's health and illness, with a focus on the older patient's physical limitations, are the most common topics of discussion (Fukaya et al., 2004; Wadensten, 2005). It is important to discuss the patient's physical limitations because multiple chronic condition combinations increase with ageing alongside other normal ageing changes such as diminished hearing, vision and conceptual ability (Le May, 2005).

Other major discussion topics concern the surrounding environment, for instance the older patient's living quarters, and past events in the patient's life experience (Fukaya et al., 2004). Studies focusing on oncology departments show that the content of communication concerns existential issues related to the meaning of disease, suffering, life and death. Another major discussion topic concerns practical treatment issues, for instance why some nursing activities are performed in a certain way (Strang et al., 2014). In the case of follow-up talks with women treated for breast cancer, communication is often about symptoms and concerns (Clayton & Dudley, 2009). Research shows that the content and structure of communication with patients with an increased risk of cardiovascular disease are important because such patients interpret information in their own way, making it particularly important to achieve understanding between nurses, patients and relatives (Persson & Friberg, 2009).

Previous research has indicated that the content of communication between nurses, adult patients and relatives has been studied in different care contexts such as retirement homes, and surgical and oncology departments. However, the communication exchanges between nurses, patients and relatives in the context of departments of medicine for older people have not been studied. This study addresses this gap in the research.

Aim

The aim was to explore and describe the content of the communication exchanges between nurses, patients and their relatives in a department of medicine for older people in western Sweden.

Method

Design

The study adopted an ethnographic approach with a sociocultural perspective as its theoretical framework. Ethnography describes ways of life and patterns in a culture through a systematic method of observing, documenting and analyzing (Hammersley & Atkinson, 2007; Walford, 2009; Silverman, 2016) and the sociocultural perspective assumes that human beings are social creatures acting in a cultural context (Vygotsky, 1987; Wertsch, 1991). The sociocultural approach is appropriate as it is based on the view that the communication event is a phenomenon occurring in a cultural context and is based on social interaction, meaning that the relationship between thinking, communication and physical activity is situated.

Theoretical framework

The basic idea in a sociocultural perspective is that language and thinking, functioning as mediating tools, are crucial for the individual's ability to understand the world and to act in it (Vygotsky, 1987; Wertsch, 1991). Language and thinking combine to generate some kind of message about the world. Communication cannot be separated from how activities are carried out (Wertsch, 1991). By learning to use language and thinking the individual becomes able to understand specific situations and to develop learning together with other individuals (Vygotsky, 1987). When healthcare communication is viewed from a sociocultural perspective, it is perceived as institutional communication that is an active creation process during which

there is interaction between the different parties involved, and as an exchange of meanings based on the institution's environment as shaped by culture, history and individual social activity.

Every communication exchange has a purpose and those involved have expectations and some kind of preunderstanding (McCabe & Timmins, 2013). The focus is to jointly create meaning and understanding during the exchange. When interpreting the content of communication, the parties involved use their cultural, historical, institutional and social experiences (Vygotsky, 1987). It is through communication and interaction with others that the individual acquires knowledge and skills. Social situations are occasions for learning. Knowledge is not developed by merely describing reality; knowledge emerges through consciousness and reflective thinking and interpretation carried out with other individuals (Vygotsky, 1987).

Setting, participants and recruitment

The field work was performed at two wards of a department of medicine for older persons with multiple chronic conditions in western Sweden. The wards are similar in design and appearance. Each ward offers 24 care places and is staffed with 21 nurses who work in day-, evening-, and night shifts with about three nurses on duty every shift.

Departments of medicine for older people are department to which patients, 75 years and older and believed to be in need of regular medical inpatient care, are admitted due to acute illnesses or exacerbation of chronic conditions, of which heart failure, acute and chronic respiratory problems, pneumonia and urinary tract infection are the most common. The wards carry out diagnostic tests, treat medical diseases and develop continued care plans for the patients in collaboration with various healthcare providers (physicians, nurses, enrolled nurses, occupational therapists, physiotherapists and counselors).

Contact was made with the department and ward managers to request permission to carry out the study. After receiving the managers' written consent, an information and consent process was initiated directed to nurses attending ward and information meetings. Informed consent forms were placed on a table in each ward's staff room, so that nurses could take their time to consider whether or not to participate. Nurses could place their signed informed consent forms in a dedicated file folder that was openly available in each ward's administrative office. Twenty-four of the 42 nurses volunteered to participate (57% of the two wards' total nursing staff). The 18 remaining nurses, and consequently the patients under their care, were not involved in the study. The ages of the participating nurses ranged from 23 to 63 years. Their professional nursing experience ranged from three months to 36 years and they had worked in the ward for between three months and seven years. Four of the 24 participating nurses were specialists in care for older patients with multiple chronic conditions, meaning that these nurses had completed an additional 60 higher education credits (HEC) of courses after the basic nursing program (three-year program of 180 HEC).

The patients and their visiting relatives were recruited by the first researcher on the basis of participating nurses' work schedules provided by the ward manager. Patients in palliative care or who were critically ill were not invited to participate. The eligible patients and their relatives received both verbal and written information about the study. In particular, they were informed that the focus was on the nurses and on communication content. They were assured that their care would not be affected if they did not want to participate. All of the patients and relatives agreed to participate and signed an informed consent form. (Four of the patients gave their informed consent in tape-recorded form because of paralysis.)

Data collection

The data were obtained through participatory observations, field notes, informal field conversations and tape-recorded interviews. The first author conducted the observations over an 11-month period, from October 2015 to September 2016, in order to have ample opportunities to study the content of the communication exchanges between nurses, patients and their relatives in the normal clinical context. Before the participatory observations started, the first author worked full-time in the wards for two weeks in order to become familiar with the nurses, the routine work and the premises.

When research is carried out in a hospital ward, it is important that the researcher fits into the environment (Hammersley & Atkinson, 2007; Silverman, 2016). To this end, the researcher wore a blue hospital tunic with a standard name plate.

Participatory observations were made at 40 occasions and covered a total of 135 hours of nurse-patient-relative communication. The observation sessions lasted from three to five hours and took place at different times, on different days and in different places such as patient rooms or meeting rooms to obtain as complete a picture as possible, as recommended by Silverman (2016) and Hammersley and Atkinson (2007).

During the participatory observations, which were recorded using a dictaphone on the researcher's person, field notes with reflections were written down. On some occasions it was not possible to take notes during the actual observation, the field notes were then written as soon as possible in the ward after the actual observation.

Forty informal field conversations with nurses (n=23) and patients (n=40) and/or relatives (n=26) of 5 to 15 minutes duration were carried out in the final phase of each observation. The informal conversations contained questions about the previous observation, about the content of communication, and were recorded with a dictaphone.

Upon completion of 30 participatory observations, five semi-structured one-on-one interviews (Silverman, 2006) were conducted separately with nurses to get a deeper understanding of the data obtained during the observations. The interviewed nurses were recruited on a voluntary basis after receiving verbal and written information at ward meetings. Informed consent forms were made available in each ward's staff room, so that nurses could consider whether or not to participate. Signed informed consent forms could be submitted in a file folder that was available in each ward's administrative office. An interview guide was drafted based on the patterns and potential themes that emerged during the analysis of the participatory observations and field notes. The interviews were conducted in a room adjacent to the ward, lasted for 20 to 40 minutes and were tape-recorded.

Data analysis

Data collection and data analysis were conducted simultaneously according to ethnographic research inspired by Hammersley and Atkinson (2007). During the participatory observations the first author wrote down reflections (field notes) that served as a basis for the subsequent interview questions.

During the period of the participatory observations, the field notes and the verbatim transcribed texts of the recorded observations and field conversations were read to obtain a sense of the content of the communication exchanges between the nurses, older patients and relatives. This initial analysis showed that the content of communication varies and from this starting point preliminary hypotheses about content were formulated which guided further observations and analysis. In this phase of the analysis, the following preliminary themes relating to the content of the communication exchanges between nurses, patients and their relatives emerged: medical condition, patient's life situation, and pedagogical approach.

Once the participatory observations and interviews had been completed, the field notes, transcribed participatory observations, field conversations and interviews were analyzed again as a whole to give the preliminary themes content and meaning. The purpose was to find variations, differences and similarities in the empirical data and thereby to find categories. First meaning units with connection to the themes were identified, coded and related to the categories (Silverman, 2006). As the analysis progressed, the preliminary themes were given content and they took final form when all the data had been analyzed and sustainability achieved.

The research group continuously discussed the data collection, data analysis and emerging content categories until agreement was reached (Hammersley & Atkinson, 2007).

Ethical considerations

In accordance with the Declaration of Helsinki (World Medical Association, 2013), the nurses, older patients and relatives involved in this study received verbal and written information before providing their informed consent to participate. The information contained a presentation of the study's purpose and methodology, explained how its results would be presented, and underlined that participation was entirely voluntary. It was also made clear that participants were free to leave the study at any time without explanation. Written informed consent was given by all participating nurses, patients and relatives. The confidential information gathered during the study is protected from access by unauthorized persons. The study was approved by the regional ethical review board in Gothenburg (Ref: 584-15).

Trustworthiness

The choice of different data collection methods enabled a method triangulation which ethnographic studies often use to test the validity of emerging data and to ascertain that the data

obtained through participatory observations, field conversations and interviews relate to the same phenomenon (Hammersley & Atkinson, 2007; Silverman, 2016). As regards the study's credibility, detailed descriptions of the participants, setting, method and results have been provided. In the results, quotes have been provided to strengthen the confirmability (Silverman, 2006). The study's dependability is strengthened by the fact that the participatory observations were made at different times and places in the wards and by the detailed presentation of the method used (Silverman, 2006). In order for readers to determine whether the study's findings are transferable to other contexts examples and interviews are provided.

The interviews were conducted in Swedish and translated by a native English and Swedish speaking translator. The focus in the linguistic revision was on the content rather than translating verbatim.

Results

The analysis identified three categories of content of the communication exchanges between nurses, older patients and their relatives: medical, personal and explanatory.

Medical content

It became apparent during the field work that the medical content was a major part of the communication exchanges between nurses, older patients and their relatives. Nurses provided and received information about the patient's health and sickness. Generally, the content concerned medical information about diagnostic tests, medical conditions and medications. Nurses wrote journal entries about the patient's disease states and were responsible for the proper conduct of treatments, diagnostic tests and medical prescriptions. The medical content was therefore an important part of the communication exchange and a daily recurring element in the nurses' duties. *"The most common thing I inform about is why they have been*

hospitalized, the disease, what we are going to do and what we need to think about during the workday” (Interview 4).

The treating physician may have ordered medication changes, which then become communication subjects, especially in the afternoon during visiting hours. Communication then involved questions from the patient and relative about, for instance, the medication, dosages and frequencies. In the following situation, the nurse has begun her evening shift, is walking around and checking on the patients, while distributing medicine:

Nurse: Here it says one tablet daily. Patient: Yes, in the beginning it said ‘when needed’. Nurse: In the beginning? Patient: But then the leg started swelling. Can these cause swelling too? Nurse: Not that I know. Patient: Because when I took weaker tablets there was no swelling in my legs. Nurse: Because they should prevent swelling. Patient (making an unhappy face): Yes, that’s what they are supposed to do, but if you read this (showing a medicine information and warning sheet and handing it to the nurse). Nurse: Yes, the medicine sheet. Patient: Yes, then I think ‘Why does it say this?’ They are supposed to help against that and not cause swelling. Nurse: It’s all written there. There are many side effects, but most are rare. Patient: Yes, it speaks of the vomiting and I think it’s quite common (showing another medicine from her bag). Nurse: But you aren’t taking those now? Patient: No, I’m not taking them now, but I asked my husband to bring these medicine jars to show you (Field Note 17).

Diagnostic tests of various kinds are another topic of medical information communication. The wards covered by the study performed both emergency and standard diagnostic tests and nurses were often tasked with informing patients and relatives of the test results. The following situation taking place in a patient room illustrates the information provided by the nurse to the patient and relative regarding test results and future tests. The nurse greets the older patient and relative and stands by the bedside:

Nurse: The X-ray and CT [Computed Tomography] showed nothing. The results were good. Patient: That’s good. Nurse: Yes. We also did a pulmonary X-ray examination and it showed some fluid. Patient: Oh. Nurse: But there’s no reason to worry. We’ll run a blood test. That’s why the physician switched the antibiotics. So you’ll receive it directly in your bloodstream (Field Note 20).

Medical information communication could also concern information about the patient’s disease state, symptoms, the physician’s diagnoses, or about treatment methods and further

diagnostic tests needed based on the diagnosis or disease. The following situation illustrates a nurse meeting with a relative to inform about the patient's condition:

Relative: Have you discovered what happened? Nurse: Yes, we found that she had a urinary tract infection. We also noticed that she was very tired and had a weakness on the right side, hand and arm, so we suspected that something else had also happened (Field Note 11).

When the nurses provided information about the patient's disease state, treatments or examinations, both past and future, they generally used medical terminology. Sometimes the patient and relatives did not understand what the nurse was talking about. The following field note describes a communication exchange between a nurse and a relative, about the care received by the patient, in which the nurse uses medical terminology without ensuring that the relative understands them:

Nurse: One can say that it was a minor TIA [Transient Ischemic Attack] in the brain.
Relative: A what? Nurse: It may have been a stroke, but a transient and very fast one.
Whatever happened, we don't know if it was a TIA or stroke. Relative (looks up): Oh.
Nurse: We suspect that it was a TIA because of the way she reacted. Relative: What?
Nurse: However, I think she is doing better right now. She is feeling tired, but then, she has had a urinary tract infection (Field Note 11).

Personal content

Personal content was characterized by the nurse showing interest in the older patient and their relative in order to get to know and understand the patient's life situation. The nurses tried to create a good and meaningful meeting by getting to know the patient, for instance by asking about personal interests. The following quote illustrate this:

I try to create a good care contact, a good meeting. I ask about their [patients] personal interests. Sometimes they like to sing or draw and then we talk about that for a while. By asking this I also get to know the person (Interview 2).

The content was mostly about the patient's concerns, needs and problems. Content also covered the patient's current life situation, the planning of the patient's return to home, and

what kind of help and support the patient wants and needs at home. The following quote illustrates a situation where a nurse asks about the patient's needs before going home:

Nurse: How are things at home? Patient: Just fine. Nurse: Do you get any help at home? Patient: Yes, a nurse comes with my insulin twice a day, and sometimes she flushes my catheter. Nurse: That's good. Maybe you need some more help? Patient: With what? Nurse: I mean with food and so, maybe cleaning. Patient: Let me think about that. Nurse: All right we'll talk again tomorrow (Field Note 37).

By engaging in chit chat, nurses could approach the patient as a person and talk about and listen to the patient's life story or everyday events. Nurses often do not know in advance what will surface during personal communication. The following situation is an example of a nurse initiating communication with small talk and then switching to asking about the patient's post-operative pain. The nurse greets the patient who presents the relative present. The nurse kneels down in front of the patient:

Nurse: Yes, you told me that your husband was a handsome fellow. Patient: Yes, I did. You look alike. The patient looks at the relative (grandson) and nods. Patient: Yes, you and grandfather. Relative: Yes, granddad. Yes, that's possible. Nurse: Yes, she told me earlier. We talked about different things and where your last name comes from. Yes, and you were operated in ... not very long ago. Patient: No. Nurse: How is your pain? Patient: Yes, it's just fine (Field Note 22).

When the communication content covers needs and problems, nurses asked questions about how the patient was feeling in order to get a picture of the care situation. The following field note describes the interaction between a nurse and a patient who are speaking of the patient's back pain. The patient is sitting on the bed and leaning over the bedside table:

Nurse: Is it feeling worse than usual? (The nurse places her hand on the patient's arm.) Patient (staring down on the table): Yes, right now it is. For a moment both are silent. Nurse: It's worse?! Patient: Yes, right now it is (Field Note 3).

During personal communication, nurses were very attentive, in particular as regarded the patient's concerns, in order to make the patient feel safe and cared for. Such communication often began with the nurse asking about "*how the patient is feeling at the moment*" (Interview

4). The following field note describes communication about the patient's concerns. When the nurse enters the patient's room, the patient is sitting halfway up in bed:

Nurse (tilting her head and blinking): Hi, how are you feeling? Patient: They said I was going to get one of those tranquilizing tablets. Nurse: Are you feeling uneasy? Patient (looking down at the table): Yes, a little. Nurse (looking at the patient): Do you often feel like that? Patient: Yes, it usually comes over me in the afternoon, but not always. Nurse: I see. It begin in the afternoon. Is it something special you think about... (Field Note 8).

Explanatory content

Explanatory content was characterized by nurses attempting to increase the patient's and relative's knowledge about the patient's disease, care situation and related issues. To this end, nurses encouraged them to express their own thoughts using an explanatory approach and asking open-ended and didactic questions (how, when, what, why) regarding the care situation and the disease to obtain a holistic view of the patient's life situation:

Nurse: How are you today? Patient: My leg hurts and I constantly need to pee. Nurse: The peeing is caused by the diuretic medicine. Patient: Yes, I know. Nurse: What's wrong with your leg? Patient: I broke it a year ago. Nurse: How? What happened? Patient: I fell on the bus. I slipped. Nurse: Tell me more about it... (Field Note 10).

The nurses used the didactic questions both consciously and unconsciously as a communication tool to reach the patient:

Nurse: It often happens that it's a diagnostic test or something else that's happening so you explain why, how it works and what to expect (Interview 5).

The patient's home situation and interests were often discussed during the communication exchanges. The nurses tried to adapt their questions to the patient's needs. In this manner, the patient was given the opportunity to process and reflect different experiences and information, thus promoting their understanding of the situation, as illustrated by the following example:

Nurse: You've been here for a week now. Patient (shaking his/her head): But, I haven't been here all the time. Nurse: Yes, you have. In the beginning you were in a bad state. Patient: Yes, I must have been. Nurse: You had an infection, it made you unclear and

confused, when you came here. Patient (smiling): Yes, that was so strange, you know. My memory comes and goes. Strange feeling (Field Note 19).

When attempting to teach the older patients and relatives, the nurses explained various treatment actions, put questions to the patient and relatives and encouraged them to ask questions. The following situation illustrates a nurse explaining to a relative why the patient has trouble eating. The nurse and relative are sitting in a small private room:

Relative: Can you do anything about the food? Nurse: Yes, that's possible. If she wants food that is a little easier to eat, I'll tell the staff. Relative: That sounds great. Nurse: When one has fungus in the mouth, the fungus also moves down to the throat, which makes swallowing more difficult. Relative: Ah, I see (Field Note 28).

Discussion

The aim of the study was to describe the content of the communication exchanges between nurses, older patients and their relatives in a department of medicine for older people. The result showed that in medical content exchanges nurses usually used medical terminology. If the patient was anxious, nurses used personal content exchanges in order to discover the patient's concerns and needs. Personal content includes chit chat about the older patient's life story. When the nurses felt that there was a need to explain the patient's health, medical needs and situation to the patient, they used explanatory content. The content provided depends on the patient's and relative's understanding and needs of information and knowledge.

The bulk of the medical content communication exchanges related directly to the ward's healthcare mission. The wards in question provided emergency medical care services to older persons with multiple chronic conditions. The information most commonly provided by the nurses related to their routine work, such as disease symptoms, test responses and drug changes, consistent with what was found in Wadensten's (2005) study from retirement homes (i.e. persons of similar age and healthcare needs as the persons covered in this study). It happened that nurses provided medical information without trying to provide the patient and relative with

an opportunity to understand the overall disease situation, which hampered their meaning creation process. In a sociocultural perspective, meaning cannot be transmitted but is created during the interaction between people (Vygotsky, 1987). The likelihood of having a negative interaction with an older patient increases by five percent with each added year of age (Barker, Griffiths, Mesa-Eguiagaray, Pickering, Gould, & Bridges, 2016). When misunderstandings appear in the communication exchange, there is a risk that meaning will not be created and that older patients and relatives misunderstand the disease situation, which in turn may cause unnecessary anxiety. Similarly, not being able to understand words used by nurses in the medical communication exchanges, for instance medical terminology, can also decrease the patient's and relative's level of understanding and can also increase their level of anxiety. This can reduce the confidence in the nurse and thus create an obstacle in communication. It is important to use language that patients and relatives understand (Olsen, Østnor, Enmarker, & Hellzén, 2013). However, sometimes it is also important not to avoid medical terms in communication if the patient and/or relative expect such language. Nurses should ask patients and relatives if they are interested in exact terminology (Henderson, 2003).

Eighty-one percent of staff-patient interactions are initiated by staff (Barker et al., 2016). As it is common for nurses to start the communication exchange, they usually control its content (Fukaya et al., 2004; Wadensten, 2005). Nurses are involved in the largest proportion of staff-patient interactions in wards (Barker et al., 2016) and therefore have a special responsibility to inform and teach older patients and relatives and to provide them with a sense of safety (International Council of Nurses, 2012). It is therefore important that the institutional culture allows the persons involved in the communication exchange to understand the situation (Vygotsky, 1987).

It emerged that chit chat, as a form of personal communication, is a way to approach and interact with older patients in order to get to know and understand their life situation, health

and care needs. To bridge the gap between nurse and patient, chat communication can help to build a relationship (Millard, Hallett, & Luker, 2006). A person's inter-personal skills are developed and shaped by his or her social and cultural experiences together with the values the individual develops throughout life in interaction with others and in their profession (Vygotsky, 1987). When nurses start asking questions and follow-up questions, the communication exchange shifts to a person-focused communication exchange with an increased interest for the patient as a person (Edvardsson, 2015), thus promoting a sense of partnership and more open communication (Ekman et al., 2011). By chatting with and listening to the patient, nurses get to know the patient's life story and can create a closer relationship with older patients. In this way, it is possible for nurses to achieve mutual commitment and understanding with the patient and relative (McCabe & Timmins, 2013). The language is therefore an important tool for creating interaction between the parties involved (Vygotsky, 1987).

During explanatory communication exchanges, nurses focused on increasing the patient's and relative's understanding of and meaning creation regarding the care situation by using the didactic questions (how, when, what, why), thus encouraging them to reflect about the situation. According to Ekebergh (2007), understanding of the care situation can be achieved by means of reflection, which, in turn, enables patients and relatives to express their thoughts and ask questions. By adapting the content of the medical and health situation information to the specific context nurses can provide both older patients and relatives with an opportunity to understand the message. In the sociocultural perspective, learning takes place through the process and context in which the individual is located. Knowledge thus develops through consciousness and reflective thinking (Vygotsky, 1978), like a living process.

If nurses deliberately reflect on the communication content they can be more successful in their communication exchanges with older patients and relatives and can provide a basis for social interaction between the parties. The social interaction becomes stronger when nurses use

personal and explanatory communication content. Such communication can enhance the social interaction, which enables older patients and relatives to understand and learn about the care situation, and also promotes the development of person-centered care.

Study limitations

There is a risk that the researcher's presence during a participatory observation affects the situation (Hammersley & Atkinson, 2007; Silverman, 2016). The observed party may modify their behavior in response to their awareness of being observed. To reduce this risk, the first researcher tried to become a familiar face in the wards by working alongside the nurses for two weeks prior to commencing the field work.

According to Silverman (2016), past experiences may influence a researcher's perceptions and thoughts about a present phenomenon. In this study, all but one of the researchers have training and experience as nurses. This background can be an advantage when understanding and interpreting the nurses involved in the study. Any risk that this familiarity would lead to loss of nuances was reduced by the facts that one researcher had no nursing background and that the research team constantly maintained a conscious and critical approach to its understanding of the data. As the research team was cross-professional, it is believed that the team maintained a wide range of perspectives in its analyses and discussions.

The field work involved in this study was limited to two wards in a Swedish department of medicine for older people. General conclusions can therefore not be drawn.

Conclusion

The study's findings provide a description of the content of the communication exchanges between nurses, older patients and their relatives. Nurses would benefit from being more aware of the content of the communication exchanges and of the usefulness of the didactic questions

when trying to enhance how older patients and their relatives understand the information provided. The results show that the nurses' communication generally contains three different contents: medical content relating to the patient's medical condition, personal content aiming to discover the patient's concerns and needs, and explanatory content to increase the patient's and relative's understanding of the patient's health and medical needs.

Relevance to clinical practice

Nurses who are aware of the importance of the content of their communication exchanges can more easily obtain a holistic view of the older patient's life situation and draft an appropriate person-centered care plan. It is therefore of high clinical relevance that nurses increase their awareness in this respect, which could be achieved through education, peer review and focus group discussions.

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