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Conceptualizing language awareness in healthcare communication: The case of nurse shift-change handover meetings

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Abstract

The paper develops the concept of language awareness (LA) by considering the material-social-discursive nexus of the communicative situation that affords professional practice. It also presents a mixed-methods study that provides a deeper and multi-layered understanding of LA in action and sets out a methodological framework for similar research in healthcare communication. Our study addresses: (i) the need for LA (re)conceptualization in research on healthcare contexts, (ii) the ways in which a mixed-methods approach provides a deeper understanding of both implicit and explicit LA and (iii) the opportunities raised for reflection on practice through researcher-practitioner contact. Drawing on our linguistic ethnography of nurse shift-change handover meetings in a hospital unit, we draw on and expand van Lier's (1998) model by demonstrating the shortcomings of limiting LA to awareness of language as system rather than as activity embedded in particular socio-discursive situations. Regarding nursing handovers, we argue that handover practice and ongoing patient safety not only require the implementation of communication protocols, but also depend on nurses' reflective practice as the different types of interactions address crucially different levels of awareness. We conclude by discussing the theoretical and methodological contribution of our study to the fields of LA and healthcare communication.

Keywords: language awareness; nurse handovers; clinical practice; healthcare communication; professional discourse; linguistic ethnography

Introduction

This paper responds to the recent call to extend language awareness (LA) research beyond language teaching (Cots & Garrett 2018). For our purposes, this raises the following questions:

- How is LA (re)conceptualized in research on healthcare settings, where the main concern is not the acquisition of another language per se but the efficient undertaking of a professional practice mediated through language?
- How does an ethnographically-informed approach provide a deeper understanding of both implicit and explicit LA and point to potential mismatches between behavioral practice and self-declared awareness?
- How does contact between LA researchers and practitioners raise opportunities for reflection on professional practice?

To address these questions, we first discuss the relevance of LA to the study of healthcare communication in the changing circumstances of the ‘new work order’ (Gee et al 1996). Assuming that language cannot be considered outside the material-social-discursive nexus of a communicative situation, we draw on and expand van Lier’s (1996, 1998) work, by (re)conceptualizing LA from a sociocultural perspective. We demonstrate this perspective through our research on shift-change handover communication in a British hospital medical assessment unit (henceforth MAU). In our study, we have adopted linguistic ethnography as our main framework for collecting and analyzing professional discourse (Rampton et al 2015). We combine observational data, i.e. fieldnotes, recordings and transcripts of nurse handover interactions, with elicited data, i.e. an audio-recorded interview with senior nurses and written questionnaire responses from ward nurses on their perceptions of the handovers’ role and function. We thus contribute a new approach to the field that is committed to key tenets of linguistic ethnography, such as critical reflexivity, and evaluates the role and impact of language awareness beyond language learning and teaching. To achieve this, we investigate both implicit and explicit aspects of LA as manifest in handover practice and reflection in interviews with practitioners. Our findings suggest that handover practice and ongoing patient safety require not only the delivery of standardized handover communication protocols, but also depend on nurses’ reflective practice as

the different types of interactions address different levels of LA in clinical settings. We conclude by discussing the significance of our study and, more broadly, of research that brings together LA and healthcare communication studies, as well as further implications for research in this area.

Healthcare Communication and Language Awareness

1. Healthcare communication and the ‘new word order’

Work practices and regimes have undergone radical transformations in response to sociocultural processes associated with an increasingly globalized new economy (Heller 2013; cf. the ‘new work order’ Gee et al 1996). These processes are linked with socio-technological changes that have afforded global workforce mobility and the incorporation of new technologies at the workplace. The new conditions of workplace diversity and technologization bring together challenges: professionals produce new forms of (talk and) texts and interact in linguistically and culturally heterogeneous environments. For example, Duff et al (2000) illustrate the ways in which the training for healthcare support workers orients to particular types of language competence (e.g. grammar, medical terms) and overlooks the interpersonal talk trainees need to develop in interaction with patients of varying competence in English. Against this backdrop, we are witnessing the establishment of a ‘new word order’ (Farrell 2001, p. 57), where ‘communications has become the most demanded competence in an increasingly competence-driven world’ (Roberts 2010, p. 212). Research on language and communication awareness, therefore, is becoming all the more pertinent to the study of healthcare communication and important for care professionals who need to respond to the changing communicative exigencies at their workplace.

Although not explicitly engaging with the LA field, previous research on healthcare communication has foregrounded the role of language in creating power asymmetries in medical encounters, particularly between healthcare professionals and patients. Issues related to the construction, management and negotiation of medical authority in such interactions have been researched from the perspectives of interactional sociolinguistics, conversation analysis and critical discourse analysis (e.g.

Coupland et al 1994; Wodak 1997; Robinson 2001; Keel & Schoeb 2017). While this line of research has argued about language as constitutive of interactional asymmetries that can put delivery of care and patient safety at risk, there has been less attention to language and communication issues in inter-professional communication, particularly in relation to organizational meetings such as clinical handovers. Yet, as Iedema (2009, p. 1702) points out, ‘managing risk and harm is [also] a function of [...] strengthening organizational effectiveness’ which ‘requires appropriate planning, handover and supervision’.

Our study of nursing handovers is placed within this burgeoning research area that investigates language and communication in healthcare organizational meetings. In terms of the approaches employed in current research, we detect two primary orientations: research informed by communication and organizational studies, on the one hand, and research aligned with the aforementioned perspectives of conversation and discourse analysis on the other.

The influence of communication and organizational studies on existing research is evident in their focus on the development and assessment of communication protocols aimed at structuring practitioners’ talk in clinical handovers (Apker et al 2010; Mehra and Henein 2014). The key assumption is that a barrier to effective nursing handovers is a lack of standardization of the process (Halm 2013). To address this, a range of protocol mnemonics have been suggested: ‘I PASS THE BATON’ (Introduction, Patient, Assessment, Situation, Safety, THE, Background, Action, Timing, Ownership, Next); ‘SHARQ’ (Situation, History, Assessment, Recommendations, Questions); ‘5 Ps’ (Patients, Precaution, Plan, Problems, Purpose); Safety Patient Initiative (SPI) with ‘SBAR’ (Situation, Background, Assessment, Recommendation) and its variants (iSBAR, iSoBAR) being amongst the most common (Riesenberg et al 2009). These protocols typically occur between nurses alone at a work station/staff room and contrast with protocols such as CARE (Connect, Ask, Respond, Empathise) conducted at the bedside where patients and carers may overhear and participate (Pun et al 2019).

On the other hand, research informed by conversation and discourse analysis focuses on the actual communicative strategies, styles and discourse modes (e.g. narrative) that contribute to effective handover communication in response to the in-situ needs of particular hospital wards and healthcare teams (e.g. Bangerter et al 2011; Eggins and Slade 2012, 2016). For example, drawing on conversation analysis, Eggins

and Slade (2012) argue about the significance of communicative strategies employed by both outgoing and incoming clinicians while they manage information exchange and interaction in handover events in an Australian hospital. While our study complements this line of research by taking a linguistic ethnographic perspective and sharing a focus on interactional goals and activities achieved through talk, it is original in proposing and developing an LA perspective to the study of nurse handover interaction.

2. Defining (language) awareness

The concept of LA has been largely investigated in relation to educational contexts on the premise that explicit understanding of language and how it works can benefit language learners and teachers (Hawkins 1984; Schmidt 1995). These assumptions are reflected in the Association for Language Awareness's definition of the concept as 'explicit knowledge about language, and conscious perception and sensitivity in language learning, language teaching and language use' (ALA, n.d.). Our paper, though, contributes to the creation of a critical mass that demonstrates the importance of language awareness in other areas of social life and language use, such as healthcare communication. The distinction between language learning and language use may anyway be untenable in the 'new word order' where the workplace has become a 'site where everyone at some stage is new to the environment and has to be socialized into its particular linguistic and cultural environment' (Roberts 2010, p. 214). The time is thus ripe for (re)conceptualizing LA in a manner that considers language in use and responds to the increasing demands in healthcare practice.

While there have been attempts to address awareness in organizational and healthcare research (Endsley 1995; Taylor et al 2014), their focus on situation, rather than language, awareness fails to acknowledge that a situation is a material-social-discursive nexus and it is impossible to consider situation - or language - removed from this nexus. At the same time, their cognitive approach equates awareness with explicit knowledge and overlooks aspects of implicit awareness that are also at play in communication (Cots and Garrett 2018, p. 4; Preston 2018, p. 385). To address this gap, there is a need to acknowledge that there are multiple layers of awareness among healthcare professionals and that language awareness at workplace refers not only to users' knowledge of language as a system but also to their understanding of appropriate

action in particular communicative situations. Our suggestion echoes a long line of theorists, including Lev Vygotsky, Mikhail Bakhtin and Ludwig Wittgenstein, who see awareness as a sociocultural phenomenon arising out of social activity: ‘consciousness begins as awareness of the environment, and is subsequently mediated through linguistic activity, and culminates in mental activity’ (van Lier 1998, p. 134). We are thus interested in locating awareness in the observable organization of situated linguistic and communicative behavior, as evident in the details of talk-in-interaction and interviews with language users in professional settings, and the internalization of these. To tap into both professionals’ *implicit*, i.e. intuitive knowledge, and *explicit awareness*, i.e. metalinguistic knowledge, we draw on van Lier’s (1996, 1998) model that proposes multiple and hierarchically organized layers of awareness (figure 1).

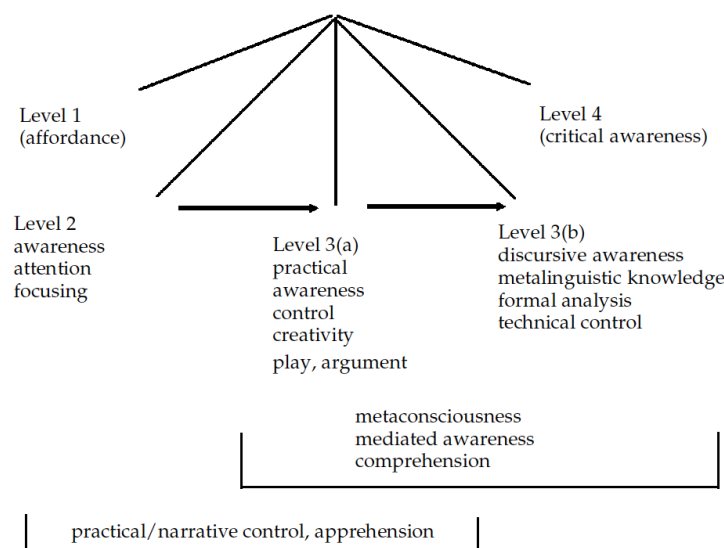


Figure 1. van Lier’s (1998) Levels of Language Awareness

As evident in Figure 1, metalinguistic or explicit awareness (levels 3 and 4) presupposes lower levels of awareness (levels 1 and 2). At its most basic level (level 1), awareness is understood as a general state of being awake and observant in a communicative situation, a prerequisite to afford any interaction. At the next level up (level 2), awareness refers to the ability to focus on elements of the communicative situation. So metalinguistic awareness does not become relevant in van Lier’s model until the third level, labeled ‘metaconsciousness’. Yet the ability to access and use metalanguage and technical terminology to reflect on language use is only one aspect

of this higher level of awareness (level 3b). Level 3 equally refers to speakers' ability to control, play and be creative with language, often manifest in everyday linguistic performance rather than in metalinguistic commentary (level 3a). Finally, van Lier's fourth level of critical awareness refers to the capacity for language learners or users to critically reflect on situated language use as part of wider social and ideological practices (Cots & Garrett 2018, p. 2).

While we use these levels as heuristics for our study of both implicit and explicit awareness, we argue for a (re)conceptualization of LA as awareness of communicative situation, i.e. as awareness of appropriate action in context realized through linguistic and other semiotic means. It is impossible to consider language and professional practice removed from the material-social-discursive nexus that forms a particular communicative situation, such as nursing handovers. What healthcare practitioners *do* and how they understand particular communicative *events or situations* (e.g. clinical handover) underlie LA levels. Our broadening of the definition of LA is also grounded on recent advances in applied linguistics that see 'divides between the linguistic, the paralinguistic, and the extralinguistic dimensions of human communication as nonsensical' and shift the focus of attention from language as a system to languaging as a situated activity (Li Wei 2018, p. 17).

The Medical Assessment Unit in a local British hospital: nursing shift-change handover meetings

The paper draws on research we have undertaken at the Medical Assessment Unit (MAU) at a local British hospital. In the British health system, the MAU operates as a gateway between the hospital's Accident & Emergency unit and more specialized wards. The specific unit is a rather challenging environment for clinicians as they need to provide critical and acute care for patients while dealing with a high turnover. The unit we observed during our fieldwork sometimes hosted up to fifty patients, including twenty new admissions within a twelve-hour period. Typically, with every new shift MAU nurses are caring for potentially very sick patients they have not worked with before and, as a result, they are very dependent on being professionally and personally

well-informed from the transfer of patient information received during handover meetings.

Our study focuses on the type of handovers that take place when there is a change of shift for the nursing team. These meetings require ‘critical communication’ (Iedema et al 2009, p. 133) in order to achieve procedurally: the transfer, reporting and recording of information, responsibility for care, and accountability. We have argued elsewhere (Bartlett et al forthcoming) that these meetings also achieve a great deal of interpersonal and teambuilding work. Despite the significance of such handovers for patient care and safety, to our knowledge in England and Wales nurses do not receive any explicit training but they learn such skills during their daily practice and from more experienced nurses (Hardey et al 2000).

At the hospital, the nursing rota is organized in terms of two shifts per day, with handovers happening at 7am and 7pm. We adopted an ethnographic perspective in order to achieve relative submersion into the setting and maximize our opportunities to learn about the group’s culture and handover practice (Leung 2002). After a long process of ethical clearance from research ethics committees both of our university and the health board, we got permission to enter the field and audio-record interaction on the proviso that we do not impede staff in-ward tasks and we do not capture any patient talk. As a result, our presence had to be contained within a particular space of the ward, i.e. the nurse staff room and station. Our data transcripts were fully anonymized and the ones used for publication cleared by the relevant health board.

Our observation involved three phases. First, before the actual handover event we waited with the nurses in the staff room as the incoming nurse shift arrived and prepared for the meeting. This was a valuable time for us to briefly explain our research and gain consent from staff present and for them to familiarize with our presence in the room. The support from the MAU senior nurses, who had been on board from the very early days of the project, was vital in reassuring the team about our presence and making us feel welcome in the staff room. After the initial phase, the arrival of the nurse responsible for the handover signaled the start of the Safety Patient Initiative (SPI) handover report from senior outgoing nurse to incoming team. Finally, we followed selected nurses outside the staff room and into the ward where we observed the one-to-one handovers of individual bays taking place. Negotiation for audio-recording these one-to-one meetings was more challenging, as staff tended to disperse quickly and towards areas where there was risk of recording patient talk; in addition, there were

instances when we had to renegotiate consent with outgoing bay nurses who had not been present in the SPI. We tried to overcome these challenges by asking permission in advance and targeting one-to-one handovers close to the nurse station; nevertheless, there were days when such recordings were not possible as there were concerns about the intrusiveness of recorders or resistance from individual nurses.

During our fieldwork, we observed twelve handover sessions; for seven of them, we audio-recorded nurse talk during all three aforementioned phases. We also had the opportunity to have informal chats with a variety of nursing staff, including senior nurses, registered and agency nurses, trainees and health support workers. In terms of the ethnolinguistic background of the particular unit's staff, the majority were British, including those appearing in the transcripts. We also undertook a small-scale questionnaire survey to gauge nurses' perceptions of handover meetings, we collected supplementary material (e.g. written documents) used during handover practice, and we audio-recorded a more in-depth one-hour semi-structured interview with the unit's senior nurses after we completed our observations.

Analyzing language awareness in nursing handovers

The study of LA from an ethnographic perspective where observational data of professional practice are combined with elicited professionals' responses on practice raises some methodological challenges: there is a risk of assuming that behavioral practice and self-declared awareness are matching. By adopting a multi-layered approach to LA and using van Lier's (1998) model as heuristics for identifying different LA levels, we step back from this assumption. Furthermore, we organize our analysis in two parts: we tap, first, into awareness displayed through handover practice and, then, into explicit awareness as evident in interviews with professionals. By doing so, our study of LA points to and underlines instances where explicit awareness may be at odds with behavioral practice.

The first part of the analysis focuses on communication awareness (either implicit or explicit) that the practitioners display in action across the three aforementioned phases of the handover. This part brings together findings from our investigation of the fieldnotes and the handover interactions that were analyzed with

conversation analytic tools. Taking a broader view of language ‘to cover any (multi-)semiosis’ (Georgakopoulou 2017, p. 169), we pay attention to the range of communicative resources that can signal LA, including not only linguistic but also paralinguistic (e.g. gaze) and other material means (e.g. paper forms).

The second part examines the interview data with the senior nurses to capture and evaluate their professional reflections on their practice. We acknowledge that participating in an interview is not a routine task for the practitioners and, as a result, the specific task gives the nurses time to reflect on what they actually do. By analyzing the nurses’ responses, we probe further into the implicit - explicit distinction and we focus on *awareness-raising moments* which arguably point to instances where self-declared awareness may not match with professional practice in action. As Cots & Garrett (2018, p. 4) note, ‘awareness-raising tends to involve noticing the gap between what one knows and what one does not know, or what one needs to know, and moving forward from what one knows (old knowledge) to seeing what is new and needs to be learnt’. Informed by linguistic ethnography that advocates critical reflexivity and questions the researcher-researched relationship at various points in the research process (Bucholtz 2001, p. 165), we analyze such awareness-raising moments not only in order to investigate the practitioners’ LA but also in order to identify overlaps and gaps in the practitioners’ and researchers’ awareness of handover practice. As we argue in the discussion, such awareness-raising moments are vital for doing applied linguistic research that resonates with practitioners’ needs and contributes to improving professional practice.

1. Displaying language awareness in nurse shift-change handovers

1.1 Awareness as affordance for professional practice

By approaching awareness as a multi-layered phenomenon, with its most basic level being the mere state of being awake and observant of the immediate environment, all participants in interaction arguably display this level 1 of awareness, unless dozing off or losing consciousness. While we can take this level as given in any form of communication, the study of awareness in healthcare contexts invites us to revisit such an assumption. Aspects of the specific professional environment related to work stress,

intensity and shift patterns challenge practitioners' state of being awake and observant. In fact, one of the participants in our questionnaire survey identified precisely the nurse's state of awakesness ('how awake the nurse is', to quote their words) as a key factor in the communication of a good handover.

Based on our observation, we have identified a range of cues that signal transitions to the state of being observant and attentive to the specific situation and the task at hand. The immediate environment, with its material affordances, offers resources for signaling such transitions. For example, the closing of the staff room door by the nurse-in-charge was accompanied by suspension of other talk and silence from nurses in attendance, together with notable shifts in posture and gaze to signal attention. Other material artifacts such as written documents like the SPI form (figure 2) or the nurse handover sheet were distributed as resources for signaling awakesness and engagement with the handover event. These signals were key for raising awareness about moving into and out of a professional event not only for the practitioners but also for the observer-researchers present in the situation. As a result, awareness, even at this very basic affordance level of being awake and tuned in for interaction, is not given by default but is achieved in situ through material and physical resources (e.g. body posture, door, written documents etc.).

1. 2 Awareness as focusing on particular elements

In addition to a state of awakesness, handovers also call for a higher level (2) of awareness that is associated with the practitioners' ability to focus language production and comprehension on elements related to patients' care. While being awake and tuned in may not be a given but can be easily achieved by all participants (and/or observers), the second level of awareness is more gradable and varied among the nurses present at the handover. It is likely to depend on nurses' prior exposure to the specific situation (i.e. handover) and hospital environment (i.e. MAU), their personal characteristics such as English language competence, and their roles and responsibilities in the unit.

The aforementioned research on handover protocols arguably address communication issues related to this level of awareness. The existing communication protocols aim at assisting clinicians in organizing and, thus, focusing their language production and comprehension on certain topical areas (Malekzadeh et al, 2013; Yang & Zhang, 2015). To take the SBAR handover protocol as an example, clinicians are

encouraged to focus attention on passing over information about the patient's current clinical Situation, a brief history of their medical Background, a tentative Assessment of the current situation, and a Recommendation for future action.

In the handover practice of the nursing staff we have observed, written documentation such as the hospital's SPI form and the nurse handover sheet played a key role in channeling practitioners' attention to and awareness of the key areas covered. For example, Extract 1 illustrates a typical handover, a largely scripted monologue given by a senior nurse responsible for passing on critical information from the ending shift. The senior nurse's handover talk addresses the entire incoming team and conveys clinical information about the on-ward patients, as well as organizational demands, such as noting patients with a 'not-for-resuscitation' order. By juxtaposing the talk with the written document all nurses have at hand during this phase of the handover (see relevant areas in Figure 2), we note that the nurse's talk is structured in talk units that are prefaced by the labels used for the numbered safety briefing topics on the form (see words in bold in Extract 1). This type of signaling, together with the use of the relevant form, enables practitioners to channel explicitly their attention and awareness towards specific elements, while receiving information concerning the patients in the entire ward.

Extract 1:

Emma (outgoing nurse-in-charge):

- 1 we've had no **cardiac arrests** within the last twelve hours (.)
- 2 **not for resus** (.) D5 John Jones (1) D6 Jenny Jones (.) C5 Mary Jones (.)
- 3 no **falls** (.)
- 4 **at risk of falls** (.) A bay bed one and four (.) C bay (.) one three and five (.) and
- 5 all of D bay (1) ((clears throat)) trolleys one two three and five (2.5) seven and
- 6 thirteen (1)

	SAFETY BRIEFING TOPICS	PLEASE TICK	COMMENTS
1	Cardiac Arrest (within 12 hours)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
2	NFR		
3	Falls		
4	At risk of Falls	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Figure 2. Scanned extract from the SPI form used in nurse handovers

While written forms contribute towards raising explicit awareness and attention to the task at hand, our analysis of handover interaction reveals further layers of awareness displayed by certain nurses. We paid particular attention to overlaps and interruptions that are rather rare, yet notable, during the largely monologic safety briefing (SPI) talk. Such overlaps and interruptions often take the form of clarification questions as illustrated in Extract 2. In the specific extract, the outgoing nurse-in-charge is moving towards noting any patients under ‘POVA/Sectioned Abscond/Self Discharge’ (topic no. 5 on SPI form). Rather than quickly running through patient names and beds (Extract 1), Emma provides some background to the patient’s case that justifies his status under the Protection Of Vulnerable Adults scheme. In lines 6-8, there is overlapping talk between Emma and two nurses from the incoming team. Nurse 1 (N1) and N2’s contributions are clarification questions that attempt to disambiguate whether the medical information provided in line 5 concerns the patient or his lodger.

Extract 2:

- 1 Emma urm gentleman on trolley 3 Harry Jones (.) he’s had a POVA (.)
2 initiated (.) urm (.) against his lo:dger (.) his lodger lives with him
3 (.) a:nd takes care of his finances
4 N1 ah yeh
5 Emma ur::m (.) he’s (1) he’s an alcoholic on CIWA-Ar
6 N1 who [the]

7 N2 [the] [patient or the]
 8 Emma [the patient (.)] urm (.) and (.) he was very unkempt this
 9 gentleman (.) urm so A and E have initiated (.) a POVA (.) just to
 10 look at his ho::me (.) u:m (.) circumstances basically (.) and see (.)
 11 you know what else needs to get involved (.)

The clarification questions in Extract 2: ll. 6-8 signal the nurses' attention to the handover talk and demonstrate language awareness, as the meaning of personal pronouns shifts depending on context. The referent of 'he' in line 5 is ambiguous: its referent is not clear from the immediate co-text and, thus, it can be understood to refer either to the patient or his lodger. Their questions also indicate that they are attuned to a shift in Emma's discourse that moves from social background details (living and financial condition) to medical information (alcoholic undergoing CIWA-Ar, i.e. Clinical Institute Withdrawal Assessment – Alcohol revised). Channeling attention towards and disambiguating references to medical conditions are key aspects of language awareness in a clinical setting. Our questionnaire survey also shed light on the key role that questions play in handover interaction as they display listening and attention to the task at hand. In response to our question:

‘What do you contribute to handovers?’

nurses repeatedly mentioned ‘attention and concentration’, as well as ‘listening and asking questions relevant to ward and patient safety’. While nurses appear to be aware of the importance of collaborative interaction in handovers, previous research has overlooked such aspects, with the notable exception of Eggins & Slade (2015, p. 198) who propose that ‘we need to replace the conventional adage that *a short handover is a good handover* with *an interactive handover is a safe handover*’.

Based on our observation and analysis of nurse-to-nurse interaction, we argue that practitioners orient to and display awareness in terms of channeling and organizing language production and comprehension in relation to patient care areas. We have documented how top-down written documents facilitate shared orientation to topics and sustain practitioners' attention while handover talk moves quickly between safety briefing topics. At the same time, though, we have shown that awareness is also displayed in action as the members of the incoming nursing team, who normally take

the role of listener in SPI talk, also intervene with clarification questions at critical moments. In other words, awareness as to what is relevant and in need of attention at a given moment is collaboratively constructed in and through talk at this level.

2. Awareness as metacommunicative and reflexive practice

While awareness as awakeness (level 1) and focused attention to particular elements of handover practice (level 2) contribute to effective practice in the specific ward, creation of patient safety in medical settings has been associated with concepts such as mindfulness and reflexivity in previous literature (e.g. Iedema 2010). In van Lier's model, such concepts would fall under higher level of awareness that he conceptualizes as metaconsciousness, i.e. *discursive awareness* evident in metalinguistic knowledge, formal analysis and technical control (level 3b) and *practical awareness* manifest in language play, creativity and control in action (level 3a). In both cases, heightened reflexivity in the form of monitoring and adjusting language practice is a prerequisite for a controlled performance.

While observations and audio-recordings may offer glimpses of heightened reflexivity, interview data is a more appropriate source for researching this level of awareness among professionals. In our semi-structured interview, the two senior nurses who routinely chair handovers were encouraged to explicitly articulate their metapragmatic knowledge of professional practice to the researchers, another professional group with limited technical or practical control of the practice, yet aware of language and communication issues in such professional practice contexts.

The interview with the practitioners thus engenders moments where colleagues with varying levels of understanding of a professional activity come into contact. Such moments have the potential of raising awareness for the practitioners, as well as for the researchers. In this section, we analyze the in-depth interview with the ward's senior nurses in order to investigate gaps and overlaps in what the two different groups (practitioners and researchers) understand as nurse handover practice and their awareness of situated language use. Following Cots & Garrett's (2018, p. 4) awareness-raising distinctions of 'what we know', there are three possible scenarios which we illustrate in turn: (i) both parties know; (ii) the practitioner knows but the applied linguist does not know and (iii) the practitioner does not know but the applied linguist does know. We reflect on how (ii) and (iii) present opportunities for both parties to

share knowledge and, more importantly, to shed light on instances where explicit awareness may be at odds with behavioral practice.

2.1 Awareness raising: What we do and don't know

i) LA practitioner and LA researcher overlap (we know-they know)

Let us start by illustrating the 'we know, they know' scenario. One of the key aspects that attracted our attention during our handover observations concerns the social talk in which nurses engage in the staff room while waiting for the official handover to start. In a related paper (Ylänne et al forthcoming), we showed how the pre-SPI social talk orients to multiple goals. Our analysis highlighted that the pre-SPI chat is not simply relational talk filling time while waiting; it also contributes to team-building and passing over organizational as well as medical information about on-ward patients through the sharing of anecdotes about events that happened in the previous shift. For that reason, we have suggested that the shift-change handover does not start with the official safety briefing. Instead, pre-SPI social talk is already the first phase of the handover event for the nursing practitioners. The significance of this phase is equally acknowledged by the senior nurses who described these interactions as 'unofficial debriefs', to quote their words. The importance of the talk that occurs outside the formal SPI was highlighted in the interview where we tried to gauge, among other things, the senior nurses' perspective on how they manage to deliver critical and acute care in the challenging MAU environment. Extract 3 is part of the nurses' answer to our first question about how the nursing team manages to care for fifty patients and more than ten admissions in one shift, as observed during our fieldwork. The nurses respond that there are two main factors enabling their practice: adaptability and team working that can both be achieved only through talk and communication. Regarding team-working, Nicola and Susan elaborate as follows:

Extract 3:

- 1 N: yeh yeh and I think that's how we get through it and we will sit in here
2 afterwards but you know after-- not so much me now but I know the
3 girls still do sit in here after and talk about the shift for half an hour and

4 think oh better go home (.)
 5 R2: so after at the end of a shift you--
 6 N: but if you ((inaudible)) just us all chatting
 7 S: it's an unofficial debrief
 8 N: ye:h well we'll even sit-- we even get to know about your personal life
 9 then because when you're out there you don't have any of that there's no
 10 of that kind of interaction so staff-- some staff will get and go straight
 11 away but a lot of the staff will stay and just come in and say oh got to say
 12 about this say about that so it's like unofficial

Nicola and Susan present the nurse social talk that happens in the staff room and outside the time boundaries of their work shift as vital for team building. It is through such team building work that efficient ward management and delivery of care are achieved. This type of social talk takes place in the time period in-between shifts and in the safe place of the staff room. The two spaces, staff room vs. hospital ward, are contrastively presented in Nicola's talk ('sitting in here' ll. 1 & 3 vs. 'being out there' l. 9). The location, time and topics of conversation, such as nurses' personal life on and off duty, afford an unofficial debrief that, together with the safety briefing topics addressed in the SPI form and talk, ensures patient safety.

In the context of our research, interview moments such as the one displayed in Extract 3 illustrate practitioners' reflection on and awareness of practice in the ward's local culture. Awareness of the same practices operating in the specific ward was also raised among researchers through ethnographic observation, reflection and analysis of talk-in-interaction. Interview as research practice has enabled us to see such overlaps in practitioners' and researchers' awareness, even though relevant understandings of the ward's handover practices may have been articulated with different metalanguage and for different audiences in each case.

ii) LA practitioner and LA researcher gap (they know - we don't know)

Interaction between practitioners and researchers during the interview process reveals not only knowledge overlaps but also gaps in the respective group's understanding of handover practice. The interview has provided practitioners with the opportunity to articulate implicit knowledge that has escaped the researchers' attention during

observation or discourse analysis of transcripts. Such moments are key for raising researchers' awareness about the healthcare practice under investigation.

To illustrate such moments, we focus on Extract 4 where Susan, one of the two senior nurses, explains in detail to the researchers what the safety briefing is. The explanation is triggered by one of the researchers who states that they are not aware of the specific practice (l. 2). This prompts Susan to retrieve a copy of the SPI form and share it with the researchers (ll. 3-5). She continues with explaining how information on this form is gathered and what is said during the safety briefing.

Extract 4:

- 1 S: so we all have a safety briefing are you aware of the safety briefing
2 R2: no I'm not
3 S: do you want me to show you a [(.) copy I've] just updated the one
4 R2: [hm please]
5 S: here's one I prepared earlier
((overlapping inaudible talk))
6 R2: thank you
7 R3: oh ok
8 R2: so each staff has one of these sheets then?
9 S: no the coordinator of the unit goes around towards the end of the shift
10 and they gather this information off every qualified nurse and the nurse
11 out in the triage area (.) urm and then they bring that into the safety
12 briefing so they are able to tell the nurses that are coming on duty that
13 you know Mrs so and so in bed two is at risk of falling you need to keep a
14 close eye Mr so and so up in D bay has a got a pressure ulcer (.) urm what
15 grade it is and what we've done about it whether we've ordered pressure
16 mattress-- you know air mattresses and urm this type of thing

In extract 4: ll. 10-12, we are made aware of what the outgoing nurse-in-charge does prior to the start of the safety briefing. During our observation, we had not had access to this practice, as we were positioned inside the staff room and our ethical clearance did not allow us to follow nurses as they moved between the ward bays and interacted with patients. Our position as researchers enabled us access to the pre-SPI social talk

that was happening inside the staff room but made us oblivious of the handover prepping process ongoing outside within the ward bays. It was through such awareness-raising moments during the interview, where we are given information about the wider team's practice, that we began to gain a better understanding of the planning and constraints of the complex handover process.

From Extract 4: ll. 12 onwards, Susan explains what is said during the safety briefing and to whom (i.e. 'the nurses that are coming on duty'). She gets into a performative mode where she delivers safety briefing talk for the researchers present at the interview. The delivery of such performance outside the actual clinical context presupposes an ability to monitor, control and adjust language practice according to specific circumstances. It demonstrates, thus, creativity and reflexivity that are associated with higher levels of discursive and practical awareness (levels 3a and b). Such moments of handover performance in the interview can be revealing of implicit knowledge that remains tacit and, hence, inaccessible to researchers in the analysis of actual handover practice.

By juxtaposing lines 13-14 in Extract 4 with lines 4-6 in Extract 1 where patients at risk of falls are listed during the actual handover, we note that here Susan enriches her SPI performance with an action plan ('you need to keep a close eye') that remains implicit in the recorded SPI talk. We witness a display of awareness not only of the professional script but also of the script's impact into future clinical action. Such awareness-raising moments open a window to researchers for revisiting their own understanding of the clinical practice. Indeed, such instances made us revisit our analysis of SPI talk in Extract 1. Considering Susan's performance during the interview, we have gained a better understanding of the multiple goals achieved by what appears at first as an act of merely fulfilling organizational requirements (a list). As well as addressing the top down organizational demands, such statements can also be understood as indirect commands to other team members and, thus, contribute to the team-based ethos that underpins efficiency in delivery of care and patient safety in the specific unit (Bartlett et al, forthcoming).

iii) LA practitioner and LA researcher gap (they don't know - we know)

In addition to raising researchers' awareness, reflexive performances of handover talk during the interview triggered awareness-raising moments for the practitioners

themselves. Gaps between researchers' and practitioners' understandings of professional practice also arise when analytical insights give access to aspects of language practice that may not be part of the practitioners' explicit awareness. In other words, there is a mismatch between self-declared awareness noted in interviews and behavioral practice documented in audio-recorded interaction.

To illustrate such gaps, we focus on the type of handover that happens after the safety briefing. The post-SPI handover talk involves interaction between two nurses only: the outgoing nurse-in-charge of a particular bay updates the incoming nurse about their patients (usually no more than 5-6). Elsewhere (Ylänne et al forthcoming), we have analyzed one-to-one handover talk and we have demonstrated that post-SPI interaction is much more than simply a transfer of medical information as the nurses move beyond medical and organizational details and orientate towards relational talk. Such relational talk extends into the patients' lifeworld and personal circumstances. At the same time, it has an impact on the nurses' professional and personal well-being by sustaining their professional morale and socialization that appear crucial in a high functioning ward.

When we compare our analysis of the post-SPI data with the staff's reflective comments during the interview, awareness gaps become apparent. In Extract 5, during the interview with the researchers, Susan re-enters the staff room with the nurse handover sheet that is often used in the one-to-one handovers of individual bays (l. 1). From l. 3 and for three and a half minutes, she gets into a performance mode in order to demonstrate to the researchers what this type of handover involves. Lines 3-12 are typical of the type of information Susan provides. The talk appears to orient solely to the transfer of medical information (e.g. 'the intake', 'past medical history', 'for intravenous antibiotics') and related organizational details (e.g. 'bed management', 'reason for the admission'). As Susan concludes herself in ll. 44-45, 'that is a basic handover and there's a lot of information on there and it's pretty much all medical'.

Extract 5:

- 1 S ((re-entering room)) there you go (.) that's what they would use
2 [...]
3 S yeh so as I was saying you know my patient's name is so and so and so
4 and so urm they came in as a I said and it's got the intake and the

5 definition because it's important to know whether the patient's in acute
 6 meds because they would stay here (.) or are they defined for speciality
 7 which means as a coordinator I need to prompt bed management to move
 8 this patient on to make room for my next lot and then the reason for the
 9 admission would be like your chest pain (.) urm past medical history and
 10 the plan so you know after they've been seen by the doctors and the
 11 consultant you know they could say that they're for intravenous
 12 antibiotics ((...))
 ... ((3 min of continuous talk))
 44 and that-- that is just the-- that is a basic handover and there's a lot of
 45 information on there and it's pretty much all medical (1) but you'll
 46 probably find that urm there 'll be a bit of social added into that as well like
 47 Mrs so and so came in oh and her husband's at home (.) you know a bit
 48 concerned about him and they've got a son (.) you know it will go into a
 49 bit of social history as well (.)

What is striking to us is that it is only after signaling the completion of the performance, a pause and some hesitation (l. 46: 'but you'll probably find that urm') that Susan comes to the realization that handover talk may also extend beyond medical information (l. 46: there 'll be a bit of social added). As mentioned before, our analysis of one-to-one handover talk foregrounds this aspect and demonstrates how such relational discourse is very much woven into nurses' medical talk, indicating their orientation to multiple goals at the same time. What appears as part of our explicit understanding of handover practice and their professional practice in action comes only as an afterthought in the practitioners' talk during the interview. Similarly, towards the end of our interaction, Susan laughs and concludes 'we do a lot really, don't we!' It is precisely these reflexive performances that afford what we could call 'light-bulb' moments: while implicit awareness, evident in behavioral practice, appears initially at odds with self-declared awareness, it gradually becomes verbalized in interaction with the researchers.

Concluding Discussion

The analysis of the observational, transcribed and interview data brings us to the conclusion that to be ‘language aware’ in nursing handover practice involves the display of varying levels of awareness. Firstly, nurses display awareness (as affordance) through material and physical means to signal moving into and out of the handover communicative event. We have shown that, whereas level 1 awareness is considered as a given or default in van Lier’s framework, it is achieved in situ (similar to other levels) in clinical contexts where the very state of awakesness can be under strain. Secondly, nurses display focused attention (level 2) to particular safety topics which may be facilitated by written documents and sustained/co-constructed in talk through clarification questions, for example. Thirdly, we suggest that higher level awareness (3a, b & 4) was revealed in the interview data where, amongst other insights, the staff realized that ‘they do a lot’ by (i) giving reflections on what they do to sustain a good working environment with engaged staff morale and team work and (ii) volunteering reflexive performances of hypothetical handover scripts.

Our study of nursing shift-change handovers brings together research from healthcare communication, on the one hand, and language awareness, on the other, and it illustrates how both fields can benefit from such cross-fertilizations. From a theoretical perspective, we have proposed a (re)conceptualization of LA in professional contexts according to which the term refers to awareness of appropriate action in context as realized through appropriate language, as well as awareness of practice misfires in particular communicative situations at the workplace. From a methodological perspective, we have demonstrated the significance of method triangulation that linguistic ethnography offers. The analysis of observational and transcribed data from a conversational analytic approach can reveal only certain aspects of LA that may or may not be part of the practitioners’ self-declared awareness. On the other hand, interviews with practitioners reveal aspects of LA that may not be readily accessible to either the researcher or the practitioner and point to mismatches between implicit and explicit awareness. We acknowledge, of course, that we cannot make claims about accuracy with respect to LA as there is no objective baseline against which ‘truth’ can be gauged. Instead, our focus is on communal, researcher-researched,

awareness that arises as a play off between the various understandings that are achieved through mixed methods and a participatory approach.

Our study also points to the potential of LA-focused research on healthcare communication to contribute to professional learning and support. Cots (2013, p. 5) has problematized the distinction between language learners and language users and pointed out: ‘if one believes that education never stops and that the main goal of education may be for individuals to be able to be critical and emancipate themselves from socially dominant forces that have the power to control all kinds of social practices, then we can say that the development of critical language awareness should be of interest to citizens in general’. Similarly, if healthcare organizational efficiency is contingent upon the ability of clinical teams to self-regulate and respond creatively to unexpected situations in an otherwise highly regulated environment, then critical language awareness is paramount for the emancipation of clinicians as individuals and as professional teams.

For that reason, we see value in awareness-raising moments that can be generated through contact between researchers and practitioners. Unlike handover communication protocols that are proposed for training purposes and raise language awareness in terms of focused attention on certain topics, interaction between practitioners and researchers provides opportunities for reflexive learning and addresses a higher level of language awareness that underpins and mediates professional practice. For example, through reflexive performances of the handover script, the senior nurses were moving from implicit to more explicit awareness of certain aspects of their communication practice (e.g. orientation to patient’s social and personal life). The significance of reflexivity and its potential for the in-situ creation of safety in medical contexts has also been pointed out by Iedema (2010, p. i84) who argues that ‘reflexivity is a fully internalized and socially distributed monitoring of the *safety* gradient of practice.’

As regards future research, it is paramount to pay attention to how awareness about handover communication is complicated by mobility and migration, resulting in multilingual nursing teams in an increasingly globalized world. In the unit we studied, while there was a minority of non-British nurses, the issue of English language competence has never been topicalized as one of the nurses’ concerns and, as a result, we have not addressed it in the current study. Nevertheless, it is an issue that future LA

research on contemporary urban healthcare contexts can turn its focus on, in order to explore further hidden biases and asymmetries in inter-professional communication.

To conclude, through reflection on the researcher-researched relationship we have demonstrated enhanced awareness on the part of each participant and this can be taken up in training to improve practice. In training, then, it is not sufficient simply to teach and rehearse the communication protocols but it is also important to create opportunities for reflexive feedback sessions, as these two exercises address different aspects of professional practice awareness. In brief, our linguistic ethnographic perspective that moves across observational and elicitation data and enables reflexivity on the researcher-researched cycle raised awareness of language as practice for both practitioners and analysts. As applied linguists, we learn something new about talk in interaction in clinical settings, and the nurses brought to conscious awareness practices they, we argue, had long been carried out *under the radar*.

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Transcription Key

- [overlapping talk begins
-] overlapping talk ends
- (.) pause, less than half a second
- (1) pause in seconds
- wo:: elongation of previous sound
- wo-- abruptly ended, cut off sound
- (()) contextual information

All names are pseudonyms