

**Caring about Caring: An Appreciative
Inquiry about Compassionate
Relationship-Centred Care**

Belinda Jane Dewar

**A thesis submitted to Edinburgh Napier University in
accordance with the requirements of the degree of PhD**

**Faculty of Health, Life and Social Sciences, School of Nursing,
Midwifery and Social Care**

October 2011

Declaration

I hereby declare that:

This thesis has been composed by myself.

It has not been accepted in any previous application.

The work of which it is a record has been done by myself.

Belinda Jane Dewar

Candidate

Belinda Dewar asserts the moral right to be identified as the author of this work.

Dedication

This work is dedicated to the friendship and work of Professor
Julienne Meyer and Professor Brendan McCormack whose pride in
my achievement means so much to me.

Acknowledgments

I am indebted to those staff, patients, and families who shared with me their experiences of caring. It was a privilege to hear their stories and to be able to think about them more deeply, learn from them and share them as part of this work. A special thanks to Richard whose commitment to this work has been unfaltering.

To my supervisors, Dr Dorothy Horsburgh, Professor Catriona Kennedy and Professor Mike Nolan. I have greatly appreciated the fact that you believed that I could do the PhD full time whilst working full time. Thank you for your insightful questions and for keeping me on track.

To my good friends Margaret Alexander, Phil Runciman and Fiona O'May for their support in helping me with the last stage of pulling this work together. In particular, thanks for knowing me so well that I don't even have to tell you the bits that I don't like doing.

Throughout my inquiry I was sustained and encouraged by my friends, family and colleagues. I wish to acknowledge the many conversations from which I drew inspiration and to thank you all for your interest, support and encouragement. In particular, thanks go to my dear friends at City University, Jackie Bridges, Mary Flatly, Charlotte Wilkinson and Lucinda Wessel. You listened to my ramblings at several meetings throughout this work and provided support and good questions which challenged, nourished and inspired me.

To the Leadership in Compassionate Care Team who put up with me taking time off for writing, which was greatly appreciated, and to NHS Lothian for providing the funding for me to undertake the PhD.

Finally to the support and love of my family:

to my eldest daughter Jessica, who has taught me more about being appreciative in the face of diversity than she will ever really know;

to my middle child Kirstin, who shared with me her stories about compassion and being a student nurse. The inspiration, motivation and compassion she exudes, make me so hopeful for the future of nursing;

to my son Rory, who inspires me with his creativity, and has diligently helped me with the more artistic and creative elements of this work;

and finally to Alan, my husband. I am grateful for all you are as much as anything you have done. Thank you for creating a retreat for me to think and write, and for helping me to value the person that I am.

ACKNOWLEDGMENTS	IV
LIST OF FIGURES	XI
LIST OF TABLES	XI
1 CHAPTER 1 – THE STORY	1
1.1 Introduction	1
1.2 Overall approach	2
1.3 Relationship of this study to the wider Leadership in Compassionate Care Programme	3
1.4 Personal beliefs and values and their relationship to this study	7
1.5 Background detail of the Beacon ward	8
1.5.1 ‘Climate’ within the organisation	10
1.6 Setting up the study	12
1.7 Overview of the Study	13
1.8 Outline of Chapters	14
1.9 Chapter Summary	15
2 CHAPTER 2 – REVIEWING THE LITERATURE AND EXPLORING CURRENT DEBATES ABOUT COMPASSIONATE CARE	16
2.1 Introduction	16
2.2 Approach used to select the literature	17
2.3 Current political and contextual debate	20
2.4 Identifying the key dimensions of compassion and caring	26
2.5 Knowing the person behind the illness	37
2.6 Interpersonal competence	39
2.7 Relationships	41
2.8 Emotional Connection	43
2.9 Enabling sustainable change in the practice of caring	46
2.10 Key Messages from the Review of the Literature	51

2.11	Theoretical Framework	55
2.12	Use of Terms	56
2.13	Chapter Summary	57
3	CHAPTER 3 - METHODOLOGY	59
3.1	Introduction	59
3.2	Rationale	60
3.3	Paradigm for research	61
3.4	Appreciative Inquiry (AI)	66
3.4.1	Overview of the approach of AI	67
3.5	A Critical Examination of AI	72
3.5.1	Focusing on the positive	72
3.5.2	The notion of power in inquiry	73
3.5.3	Reliance on Language	73
3.5.4	Level of assessment, feedback and evaluation	74
3.6	Action Research (AR)	74
3.7	Rationale for adopting the approach of AI	77
3.8	Research Design	80
3.8.1	The sample	80
3.8.1.1	<i>Staff sample</i>	80
3.8.1.2	<i>Patients and Family sample</i>	80
3.8.2	Integrating participative and supportive processes into the study	81
3.8.3	Ethical considerations	84
3.8.3.1	<i>Consent</i>	85
3.8.3.2	<i>Confidentiality</i>	87
3.8.4	Data generation	88
3.8.5	Phase 1 – Setting the scene and establishing relationships	90
3.8.6	Phase 2 - Discovery Phase – looking for the best of what is happening	92
3.8.6.1	<i>Observation</i>	93
3.8.6.2	<i>Individual interviews/story generation with staff</i>	97
3.8.6.3	<i>Photo Elicitation</i>	101
3.8.6.4	<i>Individual interviews/stories with patients and families</i>	103
3.8.7	Phase 3 - Dream Phase – exploring the ideal for care-giving	106
3.8.7.1	<i>Feedback</i>	106
3.8.7.2	<i>Beliefs and values exploration to create the ideal</i>	107
3.8.8	Phase 4 - Design Phase – developing activities that would help to achieve the ideal	108
3.8.8.1	<i>Developing positive caring statements</i>	108
3.8.8.2	<i>Designing and implementing the activity</i>	112
3.8.8.3	<i>Field notes to evaluate impact of activities</i>	112
3.8.9	Phase 5 - Destiny Phase – implementing, evaluating and sustaining actions	112
3.8.10	Other processes	115
3.8.10.1	<i>Reflexivity</i>	115
3.8.10.2	<i>Action learning</i>	117
3.8.11	Data analysis	118
3.8.11.1	<i>Relationship of analysis to wider LCCP</i>	119

3.8.11.2	<i>Data analysis using Immersion/Crystallisation</i>	121
3.8.12	Assessment of the quality of the research	131
3.8.13	Transferability of data	132
3.8.14	Sustainability of developments	133
3.9	Chapter Summary	133
4	CHAPTER 4 – FINDINGS: DEVELOPING KNOWLEDGE FOR COMPASSIONATE RELATIONSHIP-CENTRED CARE	135
4.1	Introduction	135
4.2	Knowing who I am and what matters to me	136
4.2.1	Knowing how to make a connection and ‘click’ with a person	137
4.2.1.1	<i>A deliberate welcome and a smile costs nothing</i>	138
4.2.1.2	<i>Personal sharing</i>	140
4.2.1.3	<i>Knowing when to use banter, humour and play</i>	142
4.2.1.4	<i>Use of language to reflect personhood and a shared understanding</i>	144
4.2.1.5	<i>Summary of theme</i>	145
4.2.2	Knowing what is important to the person and using that to influence care	146
4.2.2.1	<i>Knowing the little things that matter</i>	147
4.2.2.2	<i>Not assuming how people want to be cared for</i>	153
4.3	Understanding how I feel about my experience	156
4.3.1	Feeling safe and taking the time to ask and tell	157
4.3.1.1	<i>Recognising and sharing your emotion</i>	158
4.3.1.2	<i>Pro-actively seeking out feedback from others – I know you are busy but...</i>	161
4.3.1.3	<i>Going beyond ‘they’ve had a good night’ or ‘we’ve had a good day’</i>	163
4.3.1.4	<i>Supporting people to hear and respond to how others feel</i>	165
4.4	Chapter Summary	167
5	CHAPTER 5 – FINDINGS: RELATIONAL PROCESSES TO ENHANCE DELIVERY OF COMPASSIONATE RELATIONSHIP-CENTRED CARE	169
5.1	Introduction	169
5.2	Work with me so we can shape the way things are done	170
5.2.1	Knowing when you can and can’t do relationship-centred care	171
5.2.1.1	<i>Working with what’s in your control and what is not</i>	172
5.2.1.2	<i>Taking the time to work with processes to get the best experience for all</i>	175
5.2.1.3	<i>Confidence to challenge the way things are done</i>	177
5.2.1.4	<i>Being open and real about expectations</i>	179
5.2.2	Developing ways of working that help to shape the way things are to be done	181
5.2.2.1	<i>Thinking and talking about how we do things and how we can do them better</i>	181
5.2.2.2	<i>Spotting opportunities and knowing the possibilities</i>	183
5.2.2.3	<i>Being proud and sticking to principles of person-centredness</i>	185
5.3	Engaging in appreciative caring conversations	187
5.3.1	Being Courageous	188
5.3.2	Connecting emotionally	190
5.3.3	Being Curious	192
5.3.4	Collaborating	193
5.3.5	Considering other perspectives	195

5.3.6	Compromising	197
5.3.7	Celebrating what works well	197
5.4	Chapter Summary	207
6	CHAPTER 6 - IMPLEMENTING A MODEL OF COMPASSIONATE RELATIONSHIP-CENTRED CARE (DESIGN AND DESTINY PHASE)	209
6.1	Introduction	209
6.2	A model of compassionate relationship-centred care	210
6.2.1	Caring conversations	212
6.2.2	Development of person knowledge	214
6.2.3	Work with me to shape the way things are done	215
6.3	Action cycle one: knowing who I am and what matters to me	216
6.3.1	Developing the action cycle	216
6.3.2	Implementing the action	219
6.3.2.1	<i>Issues of confidentiality</i>	220
6.3.2.2	<i>The emotional consequences of the interaction</i>	220
6.3.2.3	<i>Getting to know who I am and what matters to me over time</i>	221
6.3.2.4	<i>Relevance of the information to care-giving</i>	222
6.3.3	Impact of the process of asking key questions to elicit person knowledge	223
6.4	Action cycle two: supporting staff to engage emotionally	227
6.4.1	Developing the action cycle	227
6.4.2	Implementing the action	229
6.4.2.1	<i>Enabled development of relationships with patients, families and staff</i>	229
6.4.2.2	<i>Seeing both positive and negative aspects of experiences</i>	230
6.4.2.3	<i>Helped staff, patients and families to be involved in shaping the service</i>	232
6.4.3	Key process issues	233
6.4.3.1	<i>Recognition of the therapeutic value</i>	234
6.4.3.2	<i>Supporting people to hear and act on stories</i>	234
6.5	Action cycle three: developing positive caring practices	237
6.5.1	Developing the action cycle	237
6.5.2	Implementing action	239
6.5.3	Impact of action	241
6.6	Chapter Summary	246
7	CHAPTER 7 – DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS	248
7.1	Introduction	248
7.2	Reflections on Methodology	251
7.2.1	Transferability of findings	252
7.2.2	Different levels of engaging with participants	253
7.2.3	Doing research ‘in relation’	253
7.2.4	Developing the role of appreciative inquirer	254
7.2.5	Inquiry as intervention	255
7.2.6	Judging the quality of the research	256
7.2.6.1	<i>Equal access</i>	256

7.2.6.2	<i>Enhanced awareness</i>	259
7.2.6.3	<i>Encouraged and enabled action</i>	260
7.3	On defining compassion	262
7.4	Developing and validating person knowledge in the context of everyday practice	264
7.5	Developing capacity for working with emotions as part of relational practice	272
7.5.1	Expression of emotion within the relationship	273
7.5.2	Expression of both positive and negative emotion	274
7.5.3	Expression of emotion as part of day to day work	276
7.6	Caring conversations the key to enacting compassionate relationship-centred care	280
7.6.1	Developing Relational Capacity	288
7.7	Celebrating and raising the profile of compassionate relationship-centred caring	292
7.7.1	The evidence base, knowledge development and translation	293
7.7.2	Addressing culture, policies and the organisation	297
7.8	Implications for Policy	304
7.9	Implications for Research	306
7.10	Implications for Education	307
7.11	Implications for Practice	308
7.12	Chapter Summary	310
	REFERENCES	315
	APPENDICES	362
	Appendix 1 – Ethical Approval Letter	362
	Appendix 2 – Participant Information Sheets	363
	Appendix 3 – Consent Form	384
	Appendix 4 - Evaluation questions	390

List of Figures

Figure 1 - Appreciative Action Research	79
Figure 2 - A Model of Compassionate Relationship-Centred Care	211

List of Tables

Table 1 - Example of search terms from CINAHL	19
Table 2 - Dimensions of Compassion and Dimensions of Perceptions of Caring	33
Table 3 - Political, professional and practice debates and implications for the conduct of this study	53
Table 4 - Principles of working as an appreciative inquirer	70
Table 5 - Overview of Phases and Data Generation Activities	89
Table 6 - Images and Statements used to Describe Compassionate Care	102
Table 7 - Positive Care Statements and Images	111
Table 8 - Learning from the study using images	113
Table 9 - The Process of Immersion/Crystallisation as applied in this study	122
Table 10 - Example of Discussion and Emergent Analysis of Story	126
Table 11 - Secondary Analysis showing regrouping of sub-themes	128
Table 12 - Secondary Analysis	129
Table 13 - Example of methods to enhance the sustainability of developments	133
Table 14 - Knowledge Domain: Knowing who I am and what matters to me	137
Table 15 - Knowledge Domain - Understand how I feel about my experience	157
Table 16 - Key process: work with me to shape the way things are done	171
Table 17 - Key Process - Engage in appreciative caring conversations	188
Table 18 - Dimensions of caring conversations – the 7 ‘C’s’	200
Table 19 - The ‘All About Me’ Framework	219
Table 20 - Positive Caring Statements	238
Table 21 - Actions to enhance compassionate relationship-centred care	241
Table 22 - Strengths and Limitations of the Methodology	261
Table 23 - Knowledge, Skills and Values to Deliver Compassionate Relationship-Centred Care	282
Table 24 - Relational processes to enhance caring from 3 studies	285
Table 25 - Relationship of Relational Capacity to Caring Conversations	290

Abstract

Background

Compassionate caring and dignity are key priorities in current policy and research agendas and are central to the quality of experience for patients, families and staff. Developing relationships has been identified as a key component in enabling excellence in caring to be realised in practice. However there is little evidence that identifies the processes involved in delivering compassionate relationship-centred care. This study sought to address this gap in the knowledge base.

Aims and research questions

The study's aim was to examine and evaluate processes that enhance compassionate relationship-centred care within an older people care setting in an acute hospital. Key objectives were: to develop an understanding of the concept of compassionate relationship-centred care within the practice setting through exploring the views, perceptions and experiences of staff, patients and their families; to develop, implement and evaluate strategies that promote this concept; to examine the processes that need to be put in place to enable sustainability of these strategies; and to identify the lessons learnt to inform practice, education, policy and research. This study was part of a larger programme of work that aimed to integrate compassionate care across practice and education.

Approach and methods

My role as a senior nurse and practitioner researcher meant that I was in a unique position to be able to capture not just theoretical views of compassion but how this was enacted in practice. To do this the study used the approach of appreciative inquiry. A range of methods was used: participant observation, stories using emotional touchpoints, photo-elicitation, and group discussions to explore beliefs and values. Data were continually fed back to staff participants to involve them in analysis. An iterative and inductive process of immersion crystallization was used to analyse data.

Findings

A key finding was the development of a practice model to support practitioners to deliver compassionate relationship-centred care. This model suggests that, in order to deliver such care, people need to engage in the process of appreciative caring conversations in order to understand a) who people are and what matters to them; and b) how people feel about their experience. This in turn enables a process of working together to shape the way things are done. The findings support the notion that during these caring conversations the practitioner needs to connect emotionally, be curious, collaborative, able to compromise, considerate of others perspectives, courageous and actively celebrate when practices have worked well in order to promote compassionate relationship-centred care. This framework comprises the 7 'C's of caring conversations and makes a unique contribution to the body of knowledge in providing practical guidance as to the 'how' of compassionate relationship-centred care.

Key outcomes of implementing this model were that people felt comfortable to express emotions, developed stronger relationships, were more consistent in delivering

compassionate care practice across the team, and had a sense of learned hopefulness in the face of complex and competing demands.

Conclusions and implications

Implementation of activities in practice to support this way of working revealed that these processes are complex, often requiring the practitioner to take risks and therefore the provision of appropriate support, facilitation and strong leadership are important factors in helping to sustain such practices. The outcomes of this research build upon the existing knowledge base by providing a practice model that specifies how to deliver compassionate relationship-centred care, and they demonstrate the impact of using appreciative approaches to facilitate improvement within health care contexts.

Chapter 1 – The Story

1.1 Introduction

The study upon which the thesis is based sought to examine and evaluate processes that enhance compassionate relationship-centred care within an older people care setting in an acute hospital. Specific objectives were to:

1. explore the experiences of staff, patients and their families in giving and receiving care;
2. develop an understanding of the concept of compassionate relationship-centred care within the practice setting through exploring the views, perceptions and experiences of staff, patients and their families;
3. develop, implement and evaluate strategies that promote compassionate care, both at ward and organisational levels ;
4. examine the processes that need to be put in place to enable these strategies to be sustainable over time; and
5. identify the lessons learnt to inform practice, education, policy and research.

This study was linked to a larger programme of work called the Leadership in Compassionate Care Programme (LCCP). The larger programme was a collaborative initiative aimed at developing compassionate care across education and practice. This chapter provides an account of how this study articulated with the wider programme (LCCP) and identifies the unique elements of this study.

A brief introduction to the approach of appreciative inquiry is provided and a description of my role of appreciative inquirer and practitioner researcher. This involved being a facilitator of change as well as researcher gathering data about the process and outcomes of change. How this was achieved is discussed.

This chapter also provides relevant background information including a description of the context in which the study took place, together with details about setting up the study in the practice setting. A brief account of my personal beliefs and values is given to make these transparent so others can gauge their relevance to the conduct and findings of this study. The chapter concludes with an outline of the remaining chapters in this thesis.

1.2 Overall approach

This study took an appreciative inquiry approach to examine and evaluate processes that enhance compassionate relationship-centred care within an older people care setting in an acute hospital.

Excellent care-giving that is compassionate and relationship-centred is already happening in practice as can be evidenced by, for example, Askham 2008, Commission for Healthcare Audit and Inspection 2006. In conducting this study appreciative inquiry (AI) was the approach adopted because of its focus on working with people to explore the value in what they do and how this can be built on rather than focusing on problems (Cooperrider & Whitney 2000; Kowalski 2008; Reed 2007). AI has a different philosophical stance to more traditional forms of research. Key elements to this approach are its collaborative nature, applicability, and focus on the positive to generate change and development. Thus, in AI, there is an emphasis on supporting people to view the positive aspects and to work with them to understand the meaning of this in the context of practice. The focus is to work with people through the phases of discovery (finding out what is working well), dream (exploring where people want to be), design (developing activities to support achieving the dream) and working to sustain these developments (destiny) (Cooperrider & Whitney 2000).

Although some authors would argue that AI is a form of action research (Cooperrider and Srivastva 1987), with its emphasis on changing practice through participatory and

democratic processes, a limitation of AI is said to be its lack of emphasis on processes of continuous reflection and action (Egan and Lancaster 2005). Lack of attention to these processes has resulted in few reported studies reaching the destiny phase of AI (Reed 2010). In action research continuous reflection, feedback and action are explicit and it is for this reason that whilst AI was the main approach used in this study, it was combined with these key elements of action research. How this was achieved and its legitimacy in this study is described in more detail in Chapter 3.

Mills, Bonner and Francis (2006) stress the importance of reflexivity in this type of research and clarification of the narrative of the researcher. In this account I acknowledge my own subjectivity as a researcher and choose to write myself into the account. For this reason the study is written in the first person and addresses not only issues related to the topic under study – compassionate caring, but to the process of change and the relationships between researcher and participants.

1.3 Relationship of this study to the wider Leadership in Compassionate Care Programme

The study is set within a larger programme called the 'Leadership in Compassionate Care Programme' (LCCP), a three year programme undertaken by Edinburgh Napier University and NHS Lothian with a vision to establish compassionate care as an integral aspect of all nursing care.

The impetus for the programme across education and practice was initially led by the Head of the School of Nursing, Midwifery & Social Care at Edinburgh Napier University who, for both personal and professional reasons, felt there was scope to develop the compassionate element of nursing both within the curriculum and practice. Within NHS Lothian the issue of compassionate care was seen as a priority following a report by an External Reference Group (NHS Lothian 2006), commissioned in response to specific episodes where care in two hospitals was seen to have been deficient. At the heart of

reported dissatisfaction was a lack of respect offered by services and the impact this had on the personal dignity of older people. Amongst the findings there was a sense that, whilst technical aspects of care were being dealt with effectively, the caring fundamentals appeared neglected. It was felt this was linked to a number of interrelated issues including values of care, communication, professional preparation, and the leadership and responsibility of care providers at strategic, managerial and clinical levels. The recommendations from this report were, in part, the stimulus for the LCCP.

Following a series of collaborative meetings within education and practice the programme secured funding from a private benefactor. The word ‘compassion’ was deliberately aligned to this programme. Compassion is a term used widely to denote empathetic attitudes and caring behaviours towards those in difficult or vulnerable positions. Further debate about its meaning is explored in Chapter 2.

The larger programme has four strands which are:

1. embedding the principles of Compassionate Care within the undergraduate curriculum at Edinburgh Napier University;
2. supporting newly qualified nurses during their first year in practice;
3. supporting development of leadership skills in Compassionate Care; and
4. establishing NHS Lothian Centres of Excellence in Compassionate Care (Beacon Wards).

It is within the fourth strand that this study is set. Four Beacon wards were identified in June 2007 from a range of specialties (acute stroke, continuing care psychiatry, respiratory medicine, and care of the elderly). They were selected because they had already demonstrated ways of working that exemplified a caring and personal touch in the way in which the whole team interacted with patients and families. Wards were judged on a portfolio of evidence that met a set of criteria based on the following themes:

- caring environment;
- ward/team management; and
- staff management/governance.

It is within one of these wards, an acute medical ward caring for older people, that I worked with the multidisciplinary team as a senior nurse and a practitioner researcher to develop this study over a period of two years from January 2008-January 2010. Three senior nurses worked in other Beacon Wards and were employed, like myself, by the NHS Board. The Lead for the wider programme of work was employed by the University and took overall responsibility for the 4 strands of work situated in the LCCP.

Initially my role as a senior nurse within one Beacon ward for a period of two years focused on:

- exploring what was happening with regard to compassionate care;
- role modelling compassionate care;
- working with staff to identify development opportunities in delivering compassionate care;
- supporting staff to implement change; and
- supporting staff to share their learning and development beyond the Beacon ward.

The main research question of the Beacon strand of the wider programme was to identify how a joint NHS and academic action research project in Compassionate Person Centred Care impacted on staff provision and patient experience of in-patient care. The Beacon strand of the wider programme had similar aims to my study, thus all senior nurses were concerned with understanding compassionate care from the perspectives of patients, families and staff and developing practice to enhance compassionate care. An explicit objective of my study that differed was to examine the processes that need to be put in place to enable sustainability of these strategies.

For the duration of the study I combined the roles of PhD student and senior nurse where I had responsibility as an educator and practice developer. Thus I was a student and practitioner researcher carrying out my PhD and a team member of the wider LCCP programme where I had a responsibility to work in the way described above and to feedback emergent findings to the LCCP team as well as contributing to the other 3 strands of the wider programme. Thus the findings from my work in the Beacon ward contributed to my study and to the wider programme.

In addition, because of my past experience as a researcher, I was encouraged to take the lead in developing methodological aspects of the wider programme. This meant that during the course of both my work in the wider programme and my study, I initiated and developed particular methods. For example, I initiated and promoted the use of emotional touchpoints and the development of the positive care practices, within the context of the Beacon ward in which I worked and fed back findings about both process and outcome to the wider LCCP team. The LCCP team considered these developments and subsequently adopted these methods in the wider programme.

I was also able to carry out further analysis of the data from the Beacon ward which was not directly fed back to the LCCP and which formed the core of the PhD. I generated this analysis independently.

So although this study was part of the LCCP, the unique difference between the wider programme and my PhD is the additional analysis which enabled me to generate a model of compassionate relationship-centred care which addresses the gap in the body of knowledge about 'how' compassionate relationship-centred care can be enacted and sustained in practice.

This thesis therefore explores the concept of compassionate care and how it can be developed, implemented, evaluated and sustained through AI strategies.

1.4 Personal beliefs and values and their relationship to this study

The approach of AI adopted in this study is informed by the paradigm of relational constructionism. Within this worldview the researcher is seen as part of the study rather than apart from it. This study required therefore that the researcher embraced reflexivity. Pope and Mays (1999) suggest that sharing personal and intellectual influences at the outset of any research enhances its credibility by enabling the reader to judge this in the context of the findings. This section explores personal aspects that relate to the present study.

My professional background was that of a nurse, educator, researcher and practice developer. I had worked in a number of senior roles across higher education, practice and policy. I thus was able to draw on a wide range of knowledge to inform this study.

Reflecting on times when I myself received compassionate care as a relative I have valued when staff spent time getting to know me and the relationship that I have with the person they are caring for.

In my professional life I am committed to a philosophy of caring that includes developing a vision with the team, valuing each other in a way that builds on people's strengths, working 'with' and 'for' people rather than 'on' them, and having the courage to stick up for what I believe in and supporting others to do this.

My previous research experience has challenged the inequities of power that can exist between educator and student or practitioner and patient ((Dewar 2005; Dewar, Dickie & Morrison 2003a; Dewar & Walker 2001; Walker & Dewar 2000) and has focused on how to unpick and share complex caring acts so that they are acknowledged (Dewar & Macleod Clark 1991). An approach to research that supports working with people to uncover the knowledge used in practice was necessary in this study.

I am reminded also of the enormous pleasure I have had over the years in caring for and about others and being cared for myself. This belief in the reciprocity that exists in the caring relationship has drawn me to the theory of relationship-centred care.

In summary, my beliefs and values that stem from my experience and influence the study include:

- considering the needs of staff, patients and families in the care-giving relationship;
- valuing learning that includes examining core beliefs and assumptions;
- recognising the importance of a common vision to the process of change;
- acknowledging that knowledge and power need to be shared;
- valuing tacit knowledge; and
- exploring what is important to the person within the caring relationship.

Having outlined the beliefs and values inherent in my approach to this study, I now briefly describe the background to the study and key considerations in setting it up.

1.5 Background detail of the Beacon ward

The ward was a 24 bedded mixed-sex medical ward caring for older people, physically located in a tower block on the first floor of an acute hospital. The beds were laid out in units of four bays of 4 and 8 single rooms.

The ward's charge nurse had been qualified for nine years and had experience as a staff nurse in a range of specialties including stroke care. He had been in the position of charge nurse for four years.

The charge nurse was supported by 18 qualified nurses, 12 clinical support workers and a part-time ward clerk. A number of staff had been on the ward for a considerable period of time. Other staff tended to stay on the ward for between 1 – 2 years. The ward was

allocated students, up to three at any one time. Although there was a core of five nurses who did permanent night duty, the ward operated internal rotation to nights. There was not a heavy reliance on bank staff during the time of the study, with the exception of times when a particular patient required 'constant care', and extra resources had to be negotiated with management to secure this. Staff on the ward worked primarily 'long days' i.e. 07.30-20.00 hrs. A team of six nurses started the shift in the morning and continued throughout the day.

Patients on the ward were generally very frail, with multiple medical diagnoses including dementia, Parkinson's disease, heart disease and diabetes. Often the reason for admission was increased confusion or falls. The average length of stay was 4-6 weeks, but for some patients this was longer, particularly if they were terminally ill or were awaiting nursing home placement.

Two consultants worked closely with the team. They were supported in their role by two junior doctors who were on a three monthly rotation. The turnaround of the medical staff was quite short in relation to the time it takes to establish relationships and promote good team working. Despite this challenge, nursing staff did seem to develop and maintain good working relationships with the medical staff. The consultants were enthusiastic about the study and keen to support developments. They met with me at key points throughout the study to give feedback on data and provide reflective comments about the process of the study.

The allied health care professionals associated with the ward included a dietician, social worker, chaplain, pharmacist, physiotherapist, and an occupational therapist, as well as a range of specialist nurses e.g. palliative care nurse, infection control nurse. They all expressed a keen interest in learning about the progress of the study, with some taking part in data generation activities and actions.

The ward's clinical nurse manager changed three times during the course of the study as a result of organisational restructuring. Although all the managers linked to the ward seemed keen to support the study and met with me on a regular basis, the focus of their involvement was very much about information receipt rather than participation.

1.5.1 'Climate' within the organisation

During the period of the study the hospital was under pressure to improve efficiency and effectiveness. Charge nurse meetings were dominated by how well wards were doing in relation to finance, audits, sickness, health and safety and complaints. Compassionate care was put on the agenda as a standing item along with these other items which demonstrated commitment by the nurse manager to share learning across the other areas in the unit.

Attending 'bed meetings' was a requirement of the charge nurse when he was 'on' for the unit. These twice daily meetings focused on meeting targets about discharge of patients. The great pressure to meet these targets might have mitigated against any real concern by those running the meetings about special circumstances that meant a person was unable to go home. The four hour target for movement of patients from A&E put pressure on the wards to discharge patients. Patients had to be discharged to the discharge lounge by 10.30 am. Scores about how well the ward had done with this particular target were fed back on a routine basis. During the course of the study information came to the ward that they had to get patients to the discharge lounge by 8:00 am. The ward team was unable to meet this target since breakfast was not delivered to the ward until 8:00 am. It seemed that decisions about targets were often made in isolation and independently of other needs or activities within the ward. So whilst staff acknowledged the need for such targets, they were often disappointed by their lack of involvement in the decisions that were made to realise them in practice.

Running alongside this, the service that the ward provided was subject to regular audits for health and safety, hand-washing, infection control, and the new PEAT (Patient Environment Action Team). Staff were given regular feedback about their MRSA and C Difficile rates, the number of patients they moved to the discharge lounge on time, sickness rates and annual budgets. Audit was increasingly the responsibility of the charge nurse. The ward did not always meet audit targets and the processes used to give feedback were not necessarily consistent with an appreciative approach.

Leadership was a key factor in relation to developing practice in this study. My reflections on the charge nurse as a leader were that he had an enthusiasm and energy for nursing conveyed in his open style of communication. He seemed committed to the principles of person-centred care. He focused on the positive and was willing to try new ideas. His passion for learning was infectious. Reflecting on his own leadership he felt an area of development was to gain confidence in confronting issues as he felt he rarely addressed issues head on with the team, preferring to speak to individuals privately if there were matters of concern.

Some staff felt insulted by the need for scrutiny on the topic of compassion whilst others felt excited that a study focused on something which they believed lay at the heart of nursing. This reaction is important to acknowledge as it set the 'tone' of the setting in which the study was to progress.

Although the ward had met the criteria of a Beacon ward, (see page 5), it is important to note that in many ways, it faced the usual challenges of sickness, routine practices that were not necessarily carried out in the best interests of the patients, conflicts within the ward team that made changing practice difficult, and demanding and challenging care issues.

A number of other values-based projects were being undertaken within the organisation which reflected both desire and commitment to embrace different paradigms that enhance

quality of caring, and commitment to staff development (Senior Charge Nurse Leadership Programme, 'Releasing Time to Care', 'Connect in Care: programme supporting learning and practice development in care for older people).

1.6 Setting up the study

The study began in January 2008 (3 months after the LCCP began). During the first few months I prepared the proposal for submission to the University Ethics Committee and began to make contact with the ward to which I had been allocated.

In addition I spent time developing relationships with staff and orientating myself to the site. Although I could be seen as an insider, because I was employed by the National Health Service (NHS), in many ways the staff saw me as an outsider as I had no previous relationship with them. Meyer (2001) argues that in action research the researcher's role is to act as insider and to be part of a team to facilitate and monitor change. My role therefore was akin to a new member of the team, but as an insider.

I spent time on the ward, initially working as a 'pair of hands' and attending meetings to familiarise myself with the care staff and the routine of the ward. I was aware that this was crucial for a study that would involve me gaining staffs' trust in order that they might share the rationale for their actions. On the whole their reaction to working with me was positive. They were often initially anxious about me coming to work alongside them but became accustomed to this overtime as our relationships developed. This 'settling in' period took two months. Staff who were more uncertain about the project took longer to feel comfortable with data generation activities. I tried hard to make connections with all staff and this involved making a point of attending, for example, nights out and sharing a bit about myself as a person during discussions.

1.7 Overview of the Study

The main data generation activities started in April 2008. During the first four months I worked to find out the best of what was happening on the ward which is consistent with the principles of AI (Cooperrider, Whitney & Stavros 2003). This involved initial interviews with all staff, including medical staff, allied health care professionals and domestic staff, together with observation, patient, family and staff stories and informal discussions recorded as field notes.

In the initial interviews I clarified the purpose of the study and asked participants about their expectations and what they hoped for from the study. Generally people were unsure about what to expect, and had never been involved in research. They were anxious that after having been awarded Beacon status for compassionate caring I would find out that they were not really as compassionate in their caring as they thought and somehow this award would be taken away from them. Staff thus felt enormous pressure to do well. It was notable that when they were asked what they hoped for from the study many said they would like to be able to say to others what it was they did well.

During the study I made efforts constantly to feed back in the moment emergent data and my reflections on these, as I was keen to re-evaluate my analysis in the context of their perspectives. This was important in gaining trust from the participants in that it showed I was genuinely interested in their rationale for the care they gave rather than judging them by some predetermined set of criteria about best practice. This proved to be challenging throughout as there was very little time within the day to have discussions. I had to consider a wide range of feedback and dissemination strategies which are discussed more fully in Chapter 3.

The study progressed through a number of phases where we worked to find out what worked well in relation to delivering compassionate relationship-centred care. We found that if staff worked hard to develop knowledge about who people are and what mattered to them, and understand how they felt about experiences, then they could work together

to shape the way things were done. They did this through engaging in appreciative caring conversations. A number of activities were developed and evaluated to enhance the development of these processes (see Chapter 6).

The details of the data generation methods used, the findings uncovered, the analysis of why practices happened and the contribution of this analysis to the wider body of knowledge is detailed in the following chapters. An outline of these follows.

1.8 Outline of Chapters

Chapter 2 explores debates from policy, research and practice in relation to the concept of caring and compassionate care. It highlights key dimensions of the concepts explored in this study and identifies what is currently known about these dimensions. It suggests that key developments are needed to address current debates particularly in relation to the ‘how’ of compassionate care and supporting people to develop skills to deliver this in practice. It identifies the theoretical and methodological framework that underpinned this study.

Chapter 3 discusses the approach of AI as it is applied to health care research. Little has been written about the use of AI in the health care context, particularly in a busy in-patient setting. This chapter clarifies the aims and objectives of the study, the methods used and the participants who were involved, the data generation activities and the methods of analysis.

Chapter 4 is the first findings chapter that draws on data from the discovery phase of AI. It identifies two knowledge domains: *know who I am and what matters to me* and *understand how I feel about my experience*. It suggests that we need to develop knowledge about both domains to deliver compassionate relationship-centred care.

In Chapter 5 further findings from the analysis of data from the discovery and destiny phases of AI are presented as two key processes that enabled practitioners to deliver compassionate care and helped to develop practice. These are *working together to shape the way things are done* and *engaging in appreciative caring conversations*.

Chapter 6 synthesises the findings and presents a model of compassionate relationship-centred care. It goes on to describe the development, implementation and evaluation of three action cycles that tested out elements of this model in practice.

Chapter 7 is the final chapter where the findings and key elements of the model for compassionate relationship-centred care are discussed in the context of theory about the development of person knowledge for caring in nursing, building and sustaining relationships, and changing practices and cultures in order to develop and sustain compassionate relationship-centred care. It highlights the implications of the findings for policy, practice, education and research.

1.9 Chapter Summary

This chapter has provided background to help the reader understand the study's context. It has outlined the relationship of this study to the wider Leadership in Compassionate Care Programme (LCCP) and described the structure of the thesis. In the next chapter a literature synthesis distilling the policy, professional and practice debates around compassion is presented, to further contextualise this study, locate its theoretical framework and provide a rationale for its methodology.

Chapter 2 – Reviewing the literature and exploring current debates about compassionate care

2.1 Introduction

The purpose of this chapter is to explore current debates about compassionate care and to identify gaps in the existing body of knowledge. The intention is not to produce a comprehensive review and methodological analysis of the literature but rather to consider the relevant policy and practice context and explore current debates around some of the key messages underpinning the concept of compassionate care and related ideas. This in turn helps to determine the theoretical model guiding the study. Accessing and reviewing the literature was continuous throughout the study.

The purpose of the chapter is to:

- explore what is meant by the concepts of compassion and caring;
- identify the areas of debate in the literature related to these concepts;
- establish what is known (or not) about the topic as identified in the literature; and
- identify a theoretical and methodological framework for the study.

This chapter therefore highlights some of the influences that may have impacted on myself and participants in shaping the focus of the inquiry in the context of practice.

This chapter begins by describing the approach used to select the literature. This is followed by a brief overview of the current political and contextual debate on compassionate care. Next the key dimensions of compassion and caring are identified, with particular reference to what patients perceive to be important. Drawing on theoretical and research accounts, as well as opinion pieces, some key issues about compassionate care are then highlighted, with emphasis on the factors that promote its application in practice. These include: Knowing the person behind the illness; Interpersonal competence; Relationships, Emotional Connection and Enabling sustainable change in the practice of caring. Consequently, the chapter highlights current thinking about compassion, particularly the key processes that might support delivery of compassionate care in practice. It highlights a noticeable gap in our understanding of **how** to deliver compassionate care in practice that the study aimed to address. Finally the theoretical and methodological framework guiding this study is presented.

2.2 Approach used to select the literature

In the literature, the term compassionate care is used interchangeably with other concepts (e.g. dignity) to describe the quality of care. Reviews of the literature in health and social sciences face the problem of a growing volume of work from a range of professional disciplines and subject areas (Evans 2002); for example, in relation to my study there is the plethora of literature around the concept of caring. The search uncovered over 5000 items about caring in CINAHL from 2000-2008. Given the number of concepts relevant to caring, a pragmatic approach was taken and a broad exploration of a number of concepts was undertaken. This approach is supported by Griffiths and Norman (2005) who suggest that a broad topic review is appropriate for a doctoral thesis. Furthermore in participatory approaches there is an emphasis on ensuring that the policy, professional and contextual background are described in sufficient detail to enable readers to judge the relevance of the findings to their own area of practice (Meyer 1999). The emphasis here was therefore on locating relevant policy, professional and practice literature that would illuminate the key debates and messages pertinent to the concept of compassionate care in

nursing rather than a detailed analysis of individual empirical studies. The approach adopted therefore deliberately sought to be inclusive of a range of different types of literature e.g. policy reports, news commentary, research articles.

The pragmatic and inclusive approach taken to select the literature was limited to published works written in the English language. The main indexing terms with appropriate truncation and combinations in the abstract included: ‘compassionate care’, ‘compassion’, ‘compassion and caring’, ‘patient experience’, ‘perceptions care and caring’, ‘change processes’, ‘relational practice’, relationship-centred care,’ ‘person-centred care’, and ‘dignity’. The number of hits for different concepts is presented in Table 1.

Table 1 - Example of search terms from CINAHL

Key word/concept	Hits from CINAHL 2000-2009
Compassionate care	91
Compassion	488
Dignity	1545
Dignity and older people	878
Patient experience and car*	293
Excellence and car*	40
Interpersonal skills and car*	127
Person-centred care	92
Patient centred care	152
Relationship-centred care	7
Relational practice	12
Emotion and car*	382
Relational and car*	502
Changing practice	97
Cultural change	118
Transformational change	29

Medline, CINAHL, PsycLit and Index to Theses were the principal sources used to identify policy documents, theoretical and research literature, discussion and opinion pieces and news commentary. In addition to the keyword searching in databases, articles (e.g. Snow, 1991) were identified from scrutinising the reference lists of selected papers (snowball technique). This was particularly useful for identifying relevant policy items and news commentaries not picked up using the search engines. Further, there was the need for some hand searching of relevant journals that did not appear on the databases used e.g. *Journal of Action Research*. Articles recommended by colleagues who were carrying out work in a similar area were accessed. Experts were also followed up to

locate other published and unpublished work. Where possible, searching prioritised existing literature reviews as this helped to provide a synthesis of up to date literature in the field.

The initial search was undertaken from 2000-2008 and thereafter on a quarterly basis to 2011. This period was chosen to limit the number of citations that would have to be reviewed, but was also based on the assumption that important references identified earlier than 2000 would be picked up by snowball searching. The literature up until 2008 is explored in this chapter, whilst later work appears in the discussion of the findings (Chapter 7).

Once selected, abstracts were reviewed for relevance. Numerous sources were discarded at this stage, for example, those articles which only mentioned the topic briefly or referred only to specific interventions (e.g. mindfulness), without exploring the meaning of the intervention.

Over 500 items were obtained for review and critical appraisal. Approximately 40% were research reports, 30% policy documents and the remainder included news reports, anecdotal accounts and opinion pieces. The next section distils what they revealed about the current political and contextual debate about compassionate care and care-giving.

2.3 Current political and contextual debate

There was increasing emphasis in policy, practice and research about the importance of the caring dimension in healthcare at the time of this study (Darzi 2008; DoH 2005; DoH 2008a; DoH 2008b; DoH 2008c; SEHD 2006a; SEHD 2006b; SGHD 2007). This can be seen in the number of policy documents between 2005-2008 that emphasised strengthening the climate for care, promoted models of practice that were centred around relationships, and the need to nurture and sustain core fundamental person-centred caring skills and values.

This caring dimension has been articulated in National Policy as respecting dignity (DoH 2006). For example, nationally, ‘Dignity in Healthcare’ received wide attention following a National Dignity Challenge Campaign, launched by Ivan Lewis, the Care Services Minister, in November 2006. Other campaigns to protect the dignity of patients were subsequently developed (Levenson 2007; RCN 2008).

Dignity, until recently, has been the term used in policy, research and practice to describe what is needed if quality care is to be achieved. More recently however, the term compassion has become the focus of political attention. It is not clear why this is the case. Bold statements appear in recent policy documents highlighting the centrality of compassion. For example, in the preface to the draft NHS constitution, which sets out certain core NHS values, including respect and dignity, compassion, and working together for patients, it states “[*The NHS*] touches our lives at times of most basic human need, when care and compassion are what matter most”. (DoH 2008a, p.1). So compassion is now a defining value of the NHS yet what this means in practice has not been clearly defined. It could be argued that without greater clarity compassion could become a political slogan with little application in the real world of healthcare practice.

Other high profile programmes, such as the ‘King’s Fund Point of Care Programme’ have also embraced the term where they state:

When people are ill in hospital and depend on others to look after them, it is of fundamental importance to them and their families that they will be cared for with kindness and compassion by everyone they come into contact with. (Goodrich & Cornwell 2008, p.1).

Furthermore in a report by the National Nursing Research Unit in England (Maben & Griffiths 2008), the term compassion was used explicitly from the outset where the authors stated “*the need for compassionate nursing is as strong as it has ever been*” (Maben & Griffiths 2008, p.5).

Compassion, rather than dignity, therefore has been used increasingly in policy and research discourse (Darzi 2008; DoH 2008a; Maben & Griffiths 2008). Whichever term is used, it is clear that the relational dimensions of caring have priority within the political context of health care and yet there is little explanation about why the shift to the term ‘compassion’ has occurred, what this means to the people giving and receiving care and how compassion can be supported in practice.

Growing emphasis on dignity and compassion has been driven by growing concern that nurses have ‘lost their way’ and that the quality of care is not consistent across the country (Maben 2008a). The most common causes of complaints are related to the attitudes of staff, cancellation or delay of outpatient appointments, and communication/information to patients (Healthcare Commission 2007; Healthcare Commission 2008). There was evidence that the numbers of complaints have risen (this may reflect greater empowerment of people to make their concerns known rather than an increase in deficits in care), particularly complaints about interpersonal transactions and relationships (Patient Association 2008). The media often report such events, laying the blame firmly with the service providers (Dickson 2008 cited in Dreaper 2008; Gibson 2008). This often sparks further debate in the policy arena.

However, debates about compassion were also evident within the profession of nursing itself. Practitioners described concerns about the quality of care, often in quite vivid terms (Wright 2008; Youngson 2008). In a 2008 journal series in the *Nursing Standard* called ‘unthinkable nursing’, Wright provided a commentary which highlighted the ‘abuse’ that was happening in the health service which may not hit the headlines. He referred to small acts, such as a wet bed left unchanged and a drink persistently put out of reach as “the slow drip of inhumanity” (Wright 2008, p.20).

Against the backdrop of the changing culture in healthcare, there is however no doubt that much has also been achieved in relation for example to, improved quality of care for increasingly complex conditions (Commission for Healthcare Audit and Inspection

2006), excellence in care provision and innovation (Askham 2008), and undertaking groundbreaking research in relation to caring (Healthcare Commission 2008). In addition, others have argued that, in the main, the NHS has a committed and caring workforce, which is highly motivated to care for patients with humanity and decency (DoH 2001; DoH 2008b, Youngson 2008). So whilst it is recognised that good care may not be consistent across the NHS, these positive aspects are rarely mentioned, alongside the negative, in justifying the need for change. Yet it may be through an analysis of what works well in practice that we may better understand the processes that support effective quality care.

In addition, there is concern about how person-centredness, a related term, translates into practice. The Joseph Rowntree Foundation (Innes, Macpherson & McCabe 2006) highlighted that despite policy developments highlighting the importance of a more 'person-centred' approach to care, there has been little attention given to the role played by frontline workers in facilitating or delivering on these policy imperatives.

Commentary about reasons for deficits in quality care and the difficulties in delivering high quality care have been related to the changing culture within which health care professionals work (Corbin 2008; Deutsch & Sherwood 2008; Maben, Latter & Clark 2006; Youngson 2008).

These authors have identified key aspects that highlight a change in culture:

- a strive for greater efficiency and cost effectiveness and a focus on increased throughput;
- greater ease with sharing information through technology yet limited opportunities for care discussions at work;
- higher expectations of the public;
- a move away from 'professional knows best' and an emphasis on partnerships;
- decreased contact between professionals and patients;
- tensions between goals of the organisation and goals of the individual;

- multiple relationships between multiple providers; and
- a focus on evidenced based practice, national standards, clinical outcomes and protocols.

The above seem to convey contradictory messages. On the one hand there is greater emphasis placed on efficiency, productivity and systems that can be applied universally to all patients; on the other more attention is given to the concept of individuality. This can create tensions for practitioners about how best to realise both aspirations. These tensions relate to the different drivers for key priorities such as; person-centredness, dignity, compassion and patient experience. For example, political drivers for dignity are complaints, with the most common causes of complaints being interpersonal issues (Healthcare Commission 2008). Conversely, the professional driver for dignity probably relates to the desire to deliver high quality care at a time when there is ever increasing emphasis on greater efficiency. This results in strategic tensions within health care organisations where there is a drive for effectiveness and efficiency, meeting targets and managing performance, versus a desire to refocus on fundamentals and to improve the patient experience. Whilst both approaches may be needed, the challenge is how to achieve the appropriate balance. Isles and Vaughan Smith (2009) argue the need for both transactional and relational paradigms of care. Transactional approaches are characterised by patient as consumer, professional as provider, reflection on facts and figures, and a focus on efficiency and effectiveness; whilst relational approaches are characterised by covenantal patient and professional relationships, focus on thoughtful, purposeful judgment, reflection on feelings and ethics, and an emphasis on quality of the moment. They argue the need to find ways to allow each paradigm to flourish so that they can co-exist.

For health care professionals, these authors argue that tension results because the agenda for care is imposed on them, resulting in pressure to deliver only care that is evidence-based, a belief that taking a risk may lead to litigation, and pressure to focus on care processes rather than the patient experience. They describe the result as an:

Uncomfortable clash between two views of professional identity: the autonomous practitioner making a valuable contribution to society through interpretive application of their expertise versus a depersonalized unit of economic resource whose productivity and performance must be constantly measured and enhanced. (Isles & Vaughan Smith 2009, p.8).

A further tension exists regarding how compassion can be measured. Some critics are concerned about the emphasis on measurement of compassion and argue that this focus could undermine any real change in caring (Freshwater & Stickley 2004; Hunter 2005). Statements, for example, in the press, which identify the need to measure compassion by the amount of smiles from nurses typify this criticism (Clout 2008). The challenge is how the outcomes of compassion can be presented in such a way that they will be recognised as important and meaningful to nursing (Reed & McCormack 2007). Work has been undertaken to ensure that improvements that ‘matter’ are measured. For example, Griffiths *et al.* (2008), put forward an argument for three sets of indicators to measure quality: safety, effectiveness and patient experience. The patient experience dimension has two subcategories: communication and compassion. They argue that specific questions must be identified to properly reflect patients’ experience of compassionate nursing.

From a consideration of the above the key issues in the policy, professional and contextual debate around compassionate caring can be summarised as:

- Whilst there is an increased value placed on compassion and caring there is little understanding of what this looks like for people who give and receive care;
- Compassion has been identified as a core value in a healthcare climate that is dominated by productivity, efficiency and effectiveness. This raises questions about whether it will only be valued if measured; and

- There is a greater emphasis placed on analysis and debate about care processes that are not acceptable. An analysis of processes that enable compassion to be delivered and sustained in practice may present a more complete picture to inform meaningful progress.

I demonstrate in this study the opportunity within the clinical world to embrace a number of different ways of promoting and demonstrating the impact of caring. In order for this to be realised there needs to be a clearer understanding about what the term compassion means to those giving and receiving care if different caring practices are to be developed.

2.4 Identifying the key dimensions of compassion and caring

This section examines the concept firstly from the literature that explores its conceptual dimensions and then from the perspectives of the people who give and receive care in the context of healthcare.

Compassion has been defined in the conceptual and philosophical writing as:

A deep awareness of the suffering of another coupled with a wish to relieve it
(Chochinov 2007, p.184);

A relatively intense emotional response to the serious misfortune of another. The response is a 'suffering with' the other and includes a concern for the other's good (Snow 1991, p.197);

To have pity for the suffering of others and a desire to free the sufferers from the pain (Jormsri et al. 2005, p. 587); and

A deep feeling of connectedness with the experience of human suffering that requires personal knowing of the suffering of others, evokes a moral response to the recognised suffering and that results in caring that brings comfort to the sufferer (Peters 2006, p.39).

The last definition identifies the centrality of emotions, knowing the person and the outcome of acting in a compassionate way. One of the tensions in these definitions, as the concept is applied to nursing, is that compassion is linked to the concept of suffering, and includes both the ability to perceive suffering and an active desire and response to alleviate or reduce it (Schantz 2007; Schultz *et al.* 2007). Thus its premise is on noticing suffering. Not everyone would describe day to day acts of compassion as being preceded by noticing suffering. Suffering could be seen as a strong behaviour usually associated with some sort of extreme crisis. This is evident in the quote above that stresses that it is a response to the '*serious misfortune of another*' (Snow 1991). People may notice potential vulnerability and this is why they decide to act in a particular way. Indeed it is important to note that in Snow's consideration of the concept of compassion she believes that the person identifies with the feelings of another or with their vulnerability (Snow 1991). She prefers the notion that we respond to vulnerability as this provides a rational basis for people choosing to relate in compassionate ways. There is further scope to explore the term as it applies to nursing practice. So, although there is a lack of conceptual clarity in the literature, the majority of conceptualisations include emotion, action and suffering.

Compassion has therefore been described as a three-part process that includes:

1. noticing or attending to the suffering of another;
2. feelings that resemble empathic concern involving someone imagining or feeling the condition of the person who is suffering; and
3. an action or response aimed at relieving the suffering in some way (Dutton *et al.* 2006).

The emphasis on emotion is important as this is not always explicit in related terms such as dignity and person-centred care, but it tells us something about what is needed to help people to act in compassionate ways. This dimension will be explored later in the chapter.

In addition to the three aspects mentioned above, the literature emphasises the relational nature of compassion (Sabo 2006; Sanghavi 2006; Paulson 2004). In other words it revolves around the way in which we relate to other human beings. It is not so much about what we choose to do **for** other people but what we choose to do together **with** them. It thus implies a level of reciprocity and interdependence. Furthermore, the emphasis on this relational aspect deliberately seeks to avoid paternalistic care (Von Dietze & Orb 2000).

A further tension that exists, in defining the term compassion as it is applied to nursing, is that there are a number of other ideas implicit within the concept, for example, wisdom, humanity, love, empathy, and dignity (Sabo 2006; Sanghavi 2006; Von Dietze & Orb 2000). The term dignity is often used synonymously with compassion and personalised care (Manley & McCormack 2008). Common themes from the literature on dignity include control, privacy, and presentation of self (Baillie 2009). Dignity relates to maintaining personal integrity, identity, self worth and self respect (Baillie 2009; Matiti & Trorey 2008; Walsh & Kowanko 2002). Seen in this way, compassionate care could be the way in which dignity can be achieved and maintained. An important distinction could be that dignity is a key outcome of compassionate care.

Theoretical models of caring also include compassion as a key element (Leininger 1991; Roach 1992; Watson 1997). Similarly, broad concepts such as person-centredness, holistic care, and relationship-centred care describe approaches to caring, and compassionate care is often included as part of these approaches. The abundance of related terms and the overlap in descriptions could result in confusion for the practitioner.

Making explicit which dimensions of patient care comprise compassion is challenging due to the often ‘invisible’ nature of this work. Liaschenko and Fisher (1999) discuss the fact that relational practice is not recognised as work. Pearson (2006, p. 22) talks about the ‘invisibility’ of small acts of compassion as “*simple not clever; basic not exquisite; peripheral not central.*” Such acts are thought to be important but in reality have little status to those managing and developing services. They are often more noticeable by their absence. The ‘invisibility’ of the concept has significant implications for its recognition and assessment in practice. Thus, before any progress is made with measurement dimensions and processes of this concept need to be made more visible.

It seems easier to define compassion when nurses tell stories about ‘extreme’ cases such as a person dying or being particularly ‘demanding’ or aggressive. Liaschenko, Oguz and Brunnquell (2006), in discussing the disadvantages of focusing on what they term the ‘tragic case’ approach, identify two types of moral issues: ‘crisis’ or ‘day to day’. They describe the ‘day to day’ moral issues as housekeeping issues. These issues are not life threatening and do not tend to elicit ‘impassioned stances’ on controversial matters. Rather they are concerned with:

...the kind of people we are, and working out what to do with the practical problems we face on a daily basis in a way that preserves integrity and honour and in a way that is meaningful to people’s lives (Liaschenko, Oguz & Brunnquell 2006, p.673).

So whilst the term ‘housekeeping’ may not be helpful, as it could imply routine and unskilled work, the quote above elaborates and gives an indication of the expertise required to act in this way.

The notion of ‘extreme cases’ relates to an earlier point about ‘high profile’ events, often discussed in the media, which become the catalyst for debates in the policy world. The way that compassion is expressed in the literature does not necessarily relate to the everyday acts that constitute nursing practice. The act of feeding, bathing, dressing and

visiting, for example, are not in themselves necessarily compassionate actions but it is the way in which these are carried out that defines the compassionate element of these acts. Furthermore linking compassion with the way to act in crisis situations seems at odds with the messages in the policy documents that argue for compassion to be a defining value applicable to all care. There is scope for a closer examination of the way in which compassion is expressed in day to day acts.

What is clear from anecdotal accounts is that the action that is referred to as compassionate, and is cherished and remembered, is often 'small'. For example, providing a pile of soft facecloths for a family to wipe the continual blood that was oozing from their son's facial wounds (Pearson 2006), lifting each wheel of the trolley over a joint in the floor to avoid jolting the body of a young woman who had fractured her spine (Youngson 2008) are acts that are described as having a profound impact on the patient and family. These acts were carried out in the context of routine care but are rarely articulated or measured. Furthermore, there is a paucity of work that helps us to understand the processes that are at play that enable enactment of these acts.

Compassion is also seen as a moral virtue, and it can be assumed that compassion is something that every nurse does. It is seen as the 'right' way to behave and that if this does not happen, then you have failed. The moral pressure is summed up by Schantz (2007), where he states that compassion is:

...a necessary result of being human and that human beings feel insulted when they are accused of lacking compassion because it implies that they are "non human beings" (Schantz 2007, p.3).

Seeing it as the right way to behave can limit further exploration of the term. Indeed Gordon and Nelson (2005) argue that we need to move beyond the virtue script in nursing to a knowledge script, whereby we articulate more fully the knowledge that underpins such concepts. Dimensions of the knowledge that underpins caring will be explored later in this chapter.

Key dimensions of compassionate care drawn from the conceptual and discussion papers cited above and listed below include:

- it is a subjective experience;
- the quality of the relationship is fundamental to delivering compassionate care;
- it is about relating to the needs of others;
- it requires you to acknowledge the person behind the illness;
- it is about human experience and preserving integrity for the individual;
- the need to recognise suffering and vulnerability; and
- it requires emotional connection and interpersonal skills.

(Cash 2007; Congressi 2006; Crigger, Brannigan & Baird 2006; Jull 2001; Kanov *et al.* 2004; Kim & Flaskerud 2007; Macleod & McPherson 2007; Milner 2003; Peters 2005; Peters 2006; Schantz 2007; Schulz *et al.* 2007; Torjuul, Elstad & Sorlie 2007; Von Dietze & Orb 2000; Youngson 2008).

Despite some of the challenges in articulating the concept, what is consistent across the literature relating to compassion is the complexity and multifaceted nature of the term. Relationships, emotional connection, interpersonal skills and knowing the person behind the illness seem to be key processes that enable compassion to be realised in practice, although this has not been empirically tested.

The synthesis of key dimensions of compassion presented above relates to the conceptual and theoretical literature on compassion. In trying to understand what compassion means to those who are giving and receiving care within the healthcare context, selected literature that examined patient and family perceptions of the related concepts of caring and dignity was explored, since there was no literature that examined explicitly patient or

family perceptions of compassion.

Dimensions of caring that are valued can be identified in literature related to the experiences of caring as perceived by patients, families and staff. The value of the patient experience to inform caring practices has been emphasised in both policy and research literature (Bassett 2002; Darzi 2008; SGHD 2007). Thus, there have been a number of studies that have examined patients' perceptions and experiences of caring, and elements of caring, for example dignity. Key themes from a selected sample of the vast literature on experiences of caring are highlighted below.

Methodologies used to explore patient experiences of care and dignity have been mainly qualitative and have focused on a range of care settings, including older people care settings Karlsson *et al.* (2004), acute care settings (Hsieh *et al.* 2004; Matiti & Trorey 2008), palliative care (Johnston & Smith 2006) and midwifery (Nicholls & Webb 2006).

Although it could be argued that a caring approach or maintaining dignity may be expressed differently depending on the individual's attitudes, beliefs and perceptions, certain key dimensions are repeatedly referred to within these studies. Key dimensions on the experience of 'good care' as perceived by patients include:

- being able to express emotion such as suffering ;
- being valued and recognising the needs of the individual;
- being offered choice and opportunities to be involved and feeling that you have some control about decisions;
- respect for privacy and discretion;
- kindness, warmth and being genuine;
- taking the time to be with the person; and
- staff communicating information.

(Chochinov *et al.* 2002; Johnstone & Smith 2006; Matiti & Trorey 2008; Walsh & Kowanko 2002).

These dimensions seem consistent with the conceptual elements of compassion defined earlier. Table 2 illustrates this consistency.

Table 2 - Dimensions of Compassion and Dimensions of Perceptions of Caring

Dimensions of compassion (Cash 2007; Congressi 2006; Crigger, Brannigan & Baird 2006; Jull 2001; Kanov <i>et al.</i> 2004; Kim & Flaskerud 2007; Macleod & McPherson 2007; Milner 2003; Peters 2005; Peters 2006; Schantz 2007; Schulz <i>et al.</i> 2007; Torjuul, Elstad & Sorlie 2007; Von Dietze & Orb 2000; Youngson 2008).	Dimensions of caring as perceived by patients (Chochinov <i>et al.</i> 2002; Johnstone & Smith 2006; Matiti & Trorey 2008; Walsh & Kowanko 2002).
<ul style="list-style-type: none"> • it is a subjective experience. • it requires you to acknowledge the person behind the illness. • it is about human experience and preserving integrity for the individual. 	<ul style="list-style-type: none"> • being valued and recognising the needs of the individual.
<ul style="list-style-type: none"> • the quality of the relationship is fundamental to delivering compassionate care. 	<ul style="list-style-type: none"> • being offered choice and opportunities to be involved and feeling that you have some control about decisions. • taking the time to be with the person; and

<p>Dimensions of compassion (Cash 2007; Congressi 2006; Crigger, Brannigan & Baird 2006; Jull 2001; Kanov <i>et al.</i> 2004; Kim & Flaskerud 2007; Macleod & McPherson 2007; Milner 2003; Peters 2005; Peters 2006; Schantz 2007; Schulz <i>et al.</i> 2007; Torjuul, Elstad & Sorlie 2007; Von Dietze & Orb 2000; Youngson 2008).</p>	<p>Dimensions of caring as perceived by patients (Chochinov <i>et al.</i> 2002; Johnstone & Smith 2006; Matiti & Trorey 2008; Walsh & Kowanko 2002).</p>
<ul style="list-style-type: none"> • the need to recognise suffering and vulnerability. • it requires emotional connection and interpersonal skills. 	<ul style="list-style-type: none"> • being able to express emotion such as suffering. • staff communicating information. • respect for privacy and discretion.
<ul style="list-style-type: none"> • it is about relating to the needs of others. 	<ul style="list-style-type: none"> • kindness, warmth and being genuine.

Most of these studies have depended on patients' self report and few have examined the dimensions of caring from the perspective of those patients who have difficulty in communicating, for example those with cognitive impairment or altered states of consciousness. This has implications particularly for an inclusive methodology that captures experiences with less reliance on speech.

There are also few data in relation to either the experiences of family about caring or indeed the outcomes of caring for families (Finfgeld-Connett 2008).

Literature that has explored relatives' perceptions of care has stressed the importance of the following:

- respect for the patient as a human being;
- involvement of the relative in patient care;
- meaningful communication; and
- environmental issues such as privacy

(Gallagher & Seedhouse 2002; Jacelon 2003).

Although expressed more broadly, these dimensions are consistent with patients' perceptions. Staff perceptions of caring and dignity have been explored in more recent literature. Their dimensions resonate with those identified by patients and relatives but additionally include presence, tenderness, comfort (Bassett 2002) and being professional, knowledgeable, and skilful (Green 2004). Notable is the inclusion of the professional behaviour of the nurse as a key component. The professional/knowledge dimension has been rarely identified in the context of caring behaviours, with some authors commenting that these behaviours, whilst important, are often taken for granted and therefore not specifically articulated (Bassett 2002; Matiti & Trorey 2008).

What is relatively absent from the literature to 2008 is the type of environment that nurses need to experience themselves in order to deliver compassionate care. Literature tends to privilege the needs of the patients in relation to caring. A debate in the caring literature suggests the need to focus our attention on caring for nurses in that, "*nurses need to feel safe and cared for so they in turn can care for patients*" (Smith 2008, p. 368). If, as some authors suggest (Finfgeld-Connett 2008; Gallagher 2004; McQueen 2000), one needs to work in a compassionate care environment in order to be able to deliver compassionate care, there is a need to explore how compassion can be achieved for staff, patients and families and to consider if the interpersonal processes suggested by the empirical work focusing on patient perspectives, are similar to those that would help to support staff to receive compassion from other colleagues.

Nouwen, McNeil and Morrison (1982, p. 4) suggest “*Compassion asks us to go where it hurts, to enter into places of pain, to share in brokenness, fear, confusion and anguish*”. Although stated over 30 years ago this resonates with contemporary thinking about compassion as illustrated in the definitions on page 26/27. Stickley and Freshwater (2002, p. 7), when discussing the importance of love in the therapeutic relationship, suggest that love (often seen as an attribute of compassionate care), implies going beyond the limits of a nurse’s role. They state that “*To go beyond limits means to give more of oneself, to do things one is not asked for or paid for and to do this with an attitude of pleasure aiming to be good*”. This raises questions about how health care professionals can be supported to do this, and indeed is this possible and appropriate for everyone, particularly in the current context of health care.

Key issues in debates about the meaning of compassion and care as they relate to nursing can be summarised as:

- the overlap between and synonymous use of concepts can be confusing and limit understanding;
- the concept is talked about at a level of principle but there is little understanding about what helps to promote it or how to do it;
- compassion is complex and difficult to articulate making recognition and assessment a challenge;
- in an eagerness to define and measure compassion we may ignore complexities of the concept resulting in the wrong dimensions being measured e.g. smiles;
- the concept is often defined in relation to crisis situations and seen as context dependent which is at odds with the centrality of this concept to all care;
- the moral imperative behind the act of compassion may have impeded systematic appraisal of it as it applies to nursing;
- compassion has been viewed primarily as a process for enhancing care for patients rather than something that is important for all stakeholders in the care experience; and

- there is a need to receive compassionate care yourself to enable you to give it to others.

It could be argued that many of the tensions about the meaning of compassion to nursing practice described above could be minimised if we had a clearer understanding about the knowledge, skills and processes that enable delivery of compassionate care. Key processes identified so far that support caring are knowing the person behind the illness, skilled interpersonal relationships, and making an emotional connection with the person. Key messages in selected literature related to each of these processes will be now be highlighted.

2.5 Knowing the person behind the illness

The importance of developing a ‘knowledge script’ for nurses’ work has been articulated in the theoretical work of Liaschenko and Fisher (1999). They developed a model of the knowledge nurses use in the conduct of their work, identifying different types of knowledge; case (biomedical scientific knowledge that is independent of the person/patient), patient (knowledge about the individual’s response or reaction to the illness or disease) and person (knowledge about the person as a unique individual). They suggest that all types of knowledge are important to the work of the nurse but that person knowledge is often not afforded the same status as the other types (Liaschenko & Fisher 1999; Stein-Parbury & Liaschenko 2007). The value of person knowledge has already been articulated in the previous section where respect for the patient as a human being (perspective of relative), acknowledging the person behind the illness (perspective of patient), and valuing and recognising the needs of the individual (perspective of staff) were identified as important. Liaschenko (1997) would argue that person knowledge is essential in order to promote and maintain this individual integrity. She argues however that development of this knowledge takes time and trust which may not be a comfortable

message to hear in the current fast-paced climate of the NHS. She also says that it is not necessarily needed in rapidly changing situations.

Case, patient and person knowledge are all important ways of knowing that inform nursing. Indeed the key dimensions articulated in the previous section do make some reference to these different ways of knowing specifically from the nurse's perceptions of caring. For example, 'being professional, skilful and knowledgeable' may relate more to case knowledge and 'taking the time to be with the person' and 'recognising the needs of the individual' may relate more to person knowledge. Liaschenko and Fisher (1999) identify social knowledge as providing the means by which nurses link case, patient and person knowledge. Social knowledge is the knowledge of human beings in social contexts. Such knowledge enables the professional to connect with and form relationships with patients, which in turn may enhance delivery of care. The concept of social knowledge, used in this way, has not been well developed in the literature. Both person knowledge and social knowledge seem to be key ways of knowing that could underpin the concept of compassionate care, as they imply human connection and the development of relationships.

Although there is little empirical work that examines the process of developing person knowledge, there is recognition that the process of knowing the patient is not a one way street and that patients have appreciated nurses who shared personal details about themselves (Attree 2001). Nurses however can feel that there are risks associated with this type of behaviour. Kim & Flaskerud (2007, p. 932) suggest nurses can be "*...more comfortable repeating glib responses and maintaining a safe distance rather than risking attempts to connect*". Dewing (2004) suggests that whilst all of the person-centred and relationship models for caring emphasise the importance of knowing the person, this is skilled work and a process that demands expertise. It is less clear from the literature what these skills comprise.

This raises questions about what needs to be in place within the care environment to support nurses to risk attempts to connect with and get to know the person behind the

illness and to develop expertise in this domain. It could be argued that connecting with people requires emotional engagement. The place of emotion in nurses' work, as this relates to giving care, will be discussed later in this chapter. However one concept that relates to getting to know the patient is interpersonal competence.

2.6 Interpersonal competence

The human connection dimension of compassion is often defined as 'being with' the patient. The 'being with' dimension of care requires more than technical expertise, and has been described as a form of responsive interaction where people require specific competences in order to deliver this (Schultz *et al.* 2007). Interpersonal competence can be seen to include dimensions such as: informing, explaining, teaching, personal sharing, humour, sensitivity, knowing what to do, 'being with' another human being and nurturing the human spirit. It is concerned with the way in which care is delivered (Fosbinder 1994).

In examining the concept of interpersonal competence Fosbinder's (1994) study used an ethnographic approach to identify elements of interpersonal competence that were valued from the perspective of the patients. Four processes emerged as elements of a framework for interpersonal competence: 'translating', 'getting to know you', 'establishing trust' and 'going the extra mile'. This model of interpersonal competence, called a model of caring, was further developed and tested in practice (Dingman *et al.* 1999). The model comprised the following caregiver actions:

- introduce oneself to patients;
- call the patient by his or her preferred name;
- sit at the patient's bedside for at least 5 minutes per shift to plan and review care;
- use a handshake, or a touch of the arm; and
- use the mission, vision and value statements in planning care.

Although it is uncertain what the last aspect of the model of caring involved, these actions, albeit helpful in making connections with people, seem to ignore the complexities of the concepts of caring or compassion as described in the literature. For example, if connecting emotionally and developing relationships are key elements of caring it is difficult to see how these can be achieved by the above actions.

Further research needs to explore how the important processes developed by Fosbinder (1994) can be developed and encouraged to flourish in the ward environment in a less prescribed way.

Daaleman *et al.* (2008) developed a model in the USA for developing interpersonal processes that promote spirituality at end of life, through interviews with clinicians. They describe three interpersonal processes:

- ‘being present’ – giving attention to the emotional, social and spiritual needs of the person;
- ‘opening eyes’ – understanding the person and their unique experience of their illness and life story; and
- ‘co-creating’ – mutual activity where there is a shared plan of care focusing on humanity and dignity.

These processes seem highly consistent with the key dimensions of compassionate care, particularly in relation to engaging emotionally, knowing the person behind the illness and co-creating through the development of relationships. The authors argue that these processes are fluid interpersonal processes based on mutually recognised human values and experiences, rather than a set of prescribed actions and roles. This adds support to the point made earlier, about the need to consider how to support the development of interpersonal competence that is not reduced to a set of prescribed actions implemented for all individuals, but that reflects the relational complexity of the process. This important dimension of developing relationships is considered in the next section.

2.7 Relationships

In recognising the importance of the relationship in the act of compassionate caring Von Dietze and Orb (2000, p. 172) state:

Compassionate care becomes the moral way of treating the person because the person is more than just an individual. In times of illness or despair, words of advice or the simple caring presence of someone else who seeks to bring consolation, strength, hope, are given not because we are all individuals but because we are all part of the same humanity.

The importance of all three groups, staff, patients and families in the giving and receiving of care has been advocated in relationship-centred models of care. Indeed therapeutic relationships between professionals, older people and families have been considered as central to current care philosophies (Brown Wilson 2007; Dewing 2004; Koloroutis 2004; McCormack 2003, McCormack 2004; Meyer & Owen 2008; NCHR&D Forum 2007; Nolan *et al.* 2004; Tresolini & Pew-Fetzer Task Force 1994; Watson 2006).

In 1994, the Pew Health Professions Commission and Fetzer Institute Taskforce recommended that clinicians embrace ‘relationship-centred care’ which involves communicating openly with patients and practising with a healing and caring ethic. They argue that recognising who we are as practitioners is crucial to delivery of effective care and that “...without such self knowledge a practitioner’s own emotional response to patients may act as a barrier to effective care’ (Tresolini & Pew-Fetzer Task Force 1994, p. 56). They define relationship-centred care as:

Health care that values and attests to the relationships that form the context of care, including: those among and between clinicians and patients; individuals as they care for themselves and one another; clinicians and the communities in which they practise; health care clinicians across various professions; and administrators and managers as they set the environment and resources for care.

(Tresolini & Pew-Fetzer Task Force 1994, p.38)

In the UK, Nolan *et al.* (2006) suggest that interdependent relationships are necessary to create and sustain enriched environments of care in which the needs of all participants are acknowledged and addressed. What is clear from the literature is that delivering compassionate or dignified care is a complex process that involves understanding both what it is like to **give** and how it is to **receive** care. Nolan *et al.* (2004) argue that, whilst respecting the personhood of the patient is essential, adopting a model of person-centred care which privileges individual needs alone is inadequate, and that we need to move to a more humanistic model of care that is personally validating for those **both** giving and receiving care and relate this to relationship-centred care. Thus, Nolan *et al.* (2006) would support the view from the Taskforce that the notion of relationship-centred care should underpin all health care interactions.

However, Nolan *et al.* (2006) believe that nurses and other practitioners need guidance in identifying ways of interacting with patients and their families that best support relationships. With this in mind, the Senses Framework was developed. Originally devised to provide a rationale for staff working with older people in continuing care settings, the Senses Framework has been developed through research in a range of care settings (Davies *et al.* 1999; Davies *et al.* 2007; Faulkner, Davies & Nolan 2006; Nolan *et al.* 2006; Nolan, Davies & Grant 2001). The framework suggests that the best care for older people involves the creation of a set of senses or experiences, for older people, for family caregivers and for staff working with them. They put forward that, to deliver good care, staff, patients and their families have to have the senses of security, belonging, continuity, purpose, significance and achievement met. When the senses are related to the key dimensions people value about caring as identified in the literature discussed above, one can see that there is a strong relationship between these valued caring characteristics and the senses. For example, feeling safe and cared for relates to security, feeling that you matter and that you are not a burden relates to significance and getting to know you, and friendliness and warmth relate to a sense of belonging. Recognition of these senses in compassionate caring work may support a better understanding of the needs of all players

in the care-giving process. A way of understanding the needs of others is to appreciate how they feel. This requires people to connect emotionally.

2.8 Emotional Connection

If, as the literature suggests, interpersonal competence, connecting with people and developing relationships are key to effective caring, then authors have argued that a degree of emotional connection is necessary for this to happen e.g. Graber and Mitcham (2004). Indeed the emotional aspect of caring is seen to be vital to the caring relationship (Bolton 2000; Brown Wilson 2007; Staden 1998).

Some authors argue that compassionate caring requires that caregivers must be willing to take emotional risks (Sanghavi 2006). Emotional attunement is therefore crucial to the act of caring (Barker & Barker 2004; Benner 1984; Benner, Tanner & Chesla 1996; Finfgeld-Connett 2008; Kooker, Schoultz & Codier 2007; Smith 1992).

Literature on emotional work has highlighted that the professional and the organisation may respond in different ways to the emotional demands of work. Menzies Lyth's work in the 1960s was important in suggesting how institutional processes develop to reinforce mechanisms of defending against anxiety (Menzies 2001). She was able to demonstrate how processes such as those designed to manage workflow also served a deeper psychological function in providing subconscious means of defence against anxiety. Some of these work practices protect the staff but are insensitive to patients. For example, with task orientation, relationships with patients can be affected due to reduced contact time. Other authors, more recently, have identified mechanisms like 'playing the game' (Hunter 2005) and sticking to 'unwritten rules' (Maben, Latter & Clark 2006) as ways of coping with some of the emotional demands of work.

Emotional labour is a term used to describe the way in which professionals can respond to the emotional demands of work. It is described as "*The induction or suppression of*

feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial safe place” (Hochschild 1983, p. 7). The concept of emotional burden has been used when the effects of emotional labour get too much. A related term ‘compassion fatigue’ has also been used to describe the stress and strain and weariness of caring for others (Bush 2009; Sabo 2006; Thomas & Wilson 2004). Other authors note that some view engaging with patients in such a way that promotes openness and closeness as unprofessional, resulting in loss of professional objectivity (Barnard 1995; Macleod & McPherson 2007).

There can therefore be tensions for the nurse around the ‘right’ way to behave in response to the emotional dimensions of caring.

The emotional dimension of caring so far has focused on this as a response to witnessing suffering or vulnerability. More recently Stickley and Freshwater (2002) debate the moral problem nurses face in institutional settings where there is tension in delivering compassionate care to all patients and families alongside fair distribution of care. The emotional consequence of the challenges of providing ‘good care’ is rarely discussed in empirical studies.

A further area of debate relates to the rather negative conceptualisation of emotion work in nursing. Bolton (2000) criticises the narrow negative conceptualisation suggesting an interesting interpretation when the nurses in her study described their work as ‘emotional’. She explores the notion of emotion as a gift that nurses share with patients, suggesting that this brings enormous satisfaction to the work of nurses. Others, in commenting about the emotional labour of caring, have recognised the positive effects of emotional work, particularly when deep connections are made (Huynh, Alderson & Thompson 2008). This is supported by authors who argue that caring is not an emotional burden but a privilege which practitioners enjoy and which gives them job satisfaction (Graber & Mitcham 2004; Kim & Flaskerud 2007; Pearson 2006; Youngson 2008). Graber & Mitcham (2004) discuss how, in their study, clinicians felt that the expression of compassion sustained and supported them rather than tiring and weakening them. This

raises questions about how nurses can be supported in meeting the challenge of emotional labour so that emotional burden can be minimised and the positive effects of expressing and engaging emotionally with staff, patients and families can be encouraged and supported. There is thus a need to explore and cultivate specific interpersonal processes that help expression of emotion in the context of the caring relationship.

The literature suggests that professionals do detach themselves emotionally from patients and families for a number of reasons, including cultural, personal and organisational. There is evidence that the nurse and the organisation adopt a number of coping strategies to help deal with the emotional world of health care (Maben 2008b; Maben, Latter & Clark 2006; Macleod & McPherson 2007). Any study that seeks to examine compassionate care in practice and implement strategies to enhance this needs to take cognisance of the emotional risks associated with this work, namely the possibility that it might ask professionals to dismantle their coping strategies that protect them against the emotional labour of health care.

In summary, debates about the processes of developing knowledge about the person, interpersonal competence, relationships and emotional attunement that enable delivery of compassionate care suggest that the processes are:

- important yet are often afforded little status, raising questions about their importance and the extent to which they are recognised and valued;
- skilled, complex and multifaceted and yet little is known about the support that is needed to develop competence;
- situational and relational and therefore strategies that support development need to move beyond prescriptive linear solutions.

In this chapter the focus has been on exploring caring in relation to the individuals within health care teams. Other authors have suggested that we need to focus on examining the systems and processes that promote an ideology of caring in the wider organisation (Dutton *et al.* 2006; Thomas 2008; Youngson 2008).

Youngson (2008) for example presented, from his own personal and professional expertise, an action plan for compassion that he claims needs to be realised across health care organisations. This included the following:

- declare compassion as a core value;
- reward rather than punish compassionate care;
- hone compassionate and relationship skills;
- create a safe place for deep conversation in the workplace;
- challenge models of professionalism; and
- define compassion as a management and leadership competence.

What these action points emphasise are ways in which processes need to be embedded within the organisation itself. This highlights the need to consider how this might be achieved. The ‘how’ needs to be understood in relation to conceptual models for change presented in the literature. These are explored in the next section in order to provide further background to the theoretical and methodological framework underpinning this study.

2.9 Enabling sustainable change in the practice of caring

The predominant model of change within health care organisations tends to focus on developing strategies, structures and processes to affect change. The model pays little attention to the relational aspects described above that appear crucial to the working of these structures and processes. For example, vigorously promoted policy initiatives aimed at solving the perceived ‘caring problem’ such as ‘Releasing Time to Care’ (NHS Centre for Improvement and Innovation) and the Schwartz rounds (Goodrich and Cornwell 2008) go some way to acknowledge the importance of caring but do not necessarily support frontline staff to develop sustainable real time strategies to ensure high quality care in day-to-day practice. There is increasing evidence in the literature

about the importance of the patient experience (Buster 2008) yet we know little about how to explore this meaningfully in practice. There is a need to examine compassionate care within care settings to understand the processes that enhance the relationships necessary for its delivery, and to explore how these can be made more transparent in day to day practice and become part of the organisations' priorities (Baillie 2009; Whitehead & Wheeler 2008).

The following section focuses on conceptual frameworks for change, and reviews of action research (Waterman *et al.* 2001), practice development (McCormack *et al.* 2007) and evidence-based practice (Schouten *et al.* 2008) in the health care context.

Factors that influence implementation of evidence-based practice include a receptive context, having a model of change to guide implementation, adequate resources, staff with the necessary skills, stakeholder engagement, participation and commitment, the nature of the change, systems in place to support the use of evidence and demonstrable benefits of the change (Dobrow, Goel & Upshur 2004; Hakkennes & Dodd 2008; Prior, Guerin & Grimmer-Somers 2008; Schouten *et al.* 2008; Thompson *et al.* 2007; Wensing, Wollersheim & Grol 2006). While there is considerable research examining which factors help support implementation, there is little regarding how these factors operate and are achieved in practice.

Much of the literature in the area of change and practice improvement reports lists of success factors operating at different levels that support implementation of evidence into practice. Greenhalgh *et al.*'s. (2004) conceptual model for evidence-based practice suggests that successful implementation of innovations includes:

- decision making devolved to teams on the ground;
- support, commitment and involvement of senior management;
- widespread involvement of staff at all levels;
- few job changes;
- availability of timely high quality education;

- dedicated funding;
- effective communication and networking across organisational boundaries; and
- timely and accurate feedback about the impact of implementation and adaptation of the innovation to the local context.

Whilst this list of factors or conditions provides important practical information to guide the setting up of change initiatives in the health care environment, it does not fully address the complexity of the relationship between factors, nor the methods that are useful to support, for example, effective communication.

Other conceptual frameworks that guide implementation of evidence-based practice have focused more on the interplay of different dimensions (Dobbins *et al.* 2002; Nieva *et al.* 2005; Nutley, Davies & Walter 2003; Rogers 2003). One such framework, the Promoting Action on Research Implementation in Health Services (PARIHS) suggests that:

Successful implementation is a function of the relation between the nature of the evidence, the context in which the proposed change is to be implemented, and the mechanisms by which the change is facilitated (Kitson, Harvey & McCormack 1998, p. 150).

This conceptual framework combines three core elements of evidence, context and facilitation, along with “*low to high*” conditions for each dimension, to provide guidance to staff, assessing what needs to be done to implement research evidence into practice. The framework indicates that implementation would be most successful in cases where evidence is high, i.e. derived from randomised controlled trials or systematic reviews, the context is receptive to change and there is appropriate facilitation to enable that change (Harvey *et al.* 2002). However, skilled facilitation, i.e. helping and enabling rather than telling or persuading, can modify and eventually overcome the effects of a low scoring context (Harvey *et al.* 2002).

Ross, O'Tuathail and Stubberfield (2005, p. 527) discuss the challenges however, of using a conceptual model to guide the change process. They suggest "*It can be challenging, as it oversimplifies the dynamic, chaotic, unpredictable nature and complex emotional and personal characteristics of relationships*".

The complexity of relationships in implementing evidence to bring about change in practice is acknowledged in the systematic review of action research by Waterman *et al.* (2001). They identify eight factors pivotal to the success of the action research process: participation, key persons, action researcher/participant relationship, 'real world' focus, resources, research methods, project process and management and knowledge. Through analysis of these factors the complexity and unpredictable nature is acknowledged, as well as recognition of the emotional and personal characteristics of relationships. For example, when reviewing the literature around partnerships in action research, the authors discuss how participation can lead to shifts in relationships which the researcher and participants can find difficult to manage. From this they argue that monitoring as well as sensitive management of relationships is crucial.

Another approach to implementing evidence in practice and promoting cultural change is practice development. A realist synthesis was undertaken to provide a systematic review of evidence on practice development (McCormack *et al.* 2006). This review examined strategies that could help to support the development of practice. There is strong evidence in this review to support the importance of participatory, inclusive and collaborative methodologies to support change, so that changes in culture and context occur. They discuss a range of enabling methods, including development of a shared vision, values clarification, reflective learning, and feedback. The involvement of a range of stakeholders has an important impact on sustainability and success, in particular the involvement of management. Although this synthesis provides important indicators for potential success of practice development, there is little evidence to inform indicators for sustainability over time. In addition there is a need to strengthen the evidence related to the impact practice development has on patient outcomes.

What both action research and practice development advocate, with their emphasis on facilitation, engagement to promote ownership and feedback, is a more transformational approach to development. Newman and Hughes (2007), in a review of initiatives implemented to transform the delivery of social care, would support the implementation of such approaches when they argue that too much emphasis has been given to achieving change using transactional mechanisms, and there is a need to adopt transformational approaches that support people to reappraise the values that underpin their practice. The tension for policy however, is that these approaches to change take time and require a skilled level of facilitation.

There is little literature that informs us about the role of the service user in bringing about change or using evidence in health care. McCormack *et al.* (2006) highlighted that, although there is universal acceptance of the need for service user involvement in the change process, there is little evidence of this happening in a proactive way and that much of the involvement currently would come under the ‘consultation’ end of the involvement continuum.

Involvement of all key stakeholders in the change process has been articulated in the approach of ‘experience based co-design’ as a methodology for bringing about change in the NHS (Bate & Robert 2007). Indeed the NHS Institute for Innovation and Improvement (www.institute.nhs.uk) and the ‘King’s Fund Point of Care Programme’ (King’s Fund 2009) have specifically focused on the patient, family and staff experience of giving and receiving care as part of change programmes. Although not extensively evaluated, this approach to change provides a useful model about the role of the patient and families in the change process. It is based in the paradigms of action ethnography and draws on theories from change, design and learning. The methodology stresses the need for implementation, spread and sustainability, and early evaluation work suggests that these aspects are being achieved. The emphasis in this approach to change is co-design through a variety of methods such as stories and observation. Rather than being patient-led it argues for leadership of change to be shared by patients, families and staff, acknowledging the strengths of each of these groups to this process. This approach offers

a realistic way in which to involve patients and families in the change process, one found to be lacking in the systematic reviews presented here on action research and practice development.

From the above, it can be seen that there is an emergent emphasis in the literature on improving practice, on the importance of relationships, both between different stakeholders and between the different dimensions important for changing and developing practice. Given that compassionate care depends on the existence of good relationships, it is vital that any study trying to improve compassionate care should use methods that are compatible with this. Identifying the importance of relationships and identifying a range of factors that support sustainable change is not enough. We need to know more about how to achieve relationships in everyday practice and in the context of approaches to participatory research. This study makes an important contribution to the body of knowledge by addressing this particular gap in understanding.

2.10 Key Messages from the Review of the Literature

The key messages in relevant policy, practice, theoretical and research literature related to care-giving, compassion, relationship-centred care and the promotion of sustainable change in care-giving are:

- The literature on defining the complex and multifaceted nature of compassion in the health care context is far from complete and tends to emphasise this in the context of crisis situations. There is scope for empirical studies to examine the concept as it applies to day to day nursing, and it is suggested that it may be through exploring its meaning in the context of everyday practice that a clearer understanding of the concept can be reached;
- There is increased value placed on compassion and its measurement in policy, professional and practice debates yet little understanding of the processes that support its development for people who give and receive care. There is a need to

understand these processes if attempts to measure this concept are to be successful;

- Studies that report findings about care-giving describe dimensions that are valued by staff, patients and families, such as respect for the person and involvement in decision making. However studies have yet to clarify the relational processes involved in delivering compassionate care. Thus more process-orientated studies that are practice based, action orientated and that explore shared meaning in practice from the perspectives of all those involved are required;
- The processes necessary for the delivery of compassionate care are said to be important yet are often afforded little status. Therefore research that not only explores these processes but that also enables them to be articulated, acknowledged and celebrated is required; and
- Transformational approaches that emphasise the relational nature of change are necessary if changes in care delivery are to be achieved.

These key messages are important in setting the context of this study, identifying key areas of debate, clarifying what is known about the topic and highlighting the further research that is required. Table 3 summarises the political, professional and practice debates identified in this chapter and considers their implications for the conduct of this study.

Table 3 - Political, professional and practice debates and implications for the conduct of this study

Policy debates	Professional debates	Practice debates	Implications for this study
Increased attention to the value of compassion in current policy yet little attention to what the concept means.	Compassion is a core value of profession yet little knowledge about how to promote and sustain this.	Multiple terms used to describe concept of and quality of care confusing to practitioners.	Need to examine the concept as it is enacted in practice to understand the processes that enable compassion to happen in practice.
Emphasis in policy is on productivity, efficiency and effectiveness so how does compassion, which is complex to describe in discrete terms, fit into a culture dominated by measurement?	Definitions suggest it is multifaceted, complex and requires expertise, yet it is often seen as the 'right' way to behave and rarely subject to a proper analysis about what systems and processes would support development in practice.	On the one hand it is valued by practitioners and patients in their accounts of caring yet it is rarely recognised, valued and articulated by practitioners clearly to inform priorities in service development.	Need to find ways of presenting and celebrating the concept so that it can be articulated more clearly in policy professional and practice debates.
The perspective of the patients has increasing weight in policy imperatives (e.g. person-centred care and patient experience programmes) but this ignores the relational aspect of care-giving where the perspectives of all stakeholders	Increasing recognition that in order for professionals to deliver compassionate care they need to feel safe and cared for so that they can care for patients.	How can compassionate care be achieved for patients staff and families? Are the processes that enable compassionate care for patients similar to those that would support staff to receive	Need to develop a clearer understanding of compassionate care as it relates to patients, families and staff and to understand the types of environments that nurses need to experience themselves in order

Policy debates	Professional debates	Practice debates	Implications for this study
need to be considered.		compassion from colleagues?	to deliver compassionate care.
High profile negative events are often the catalyst for policy debates resulting in ‘knee jerk’ responses aimed at sorting out problems.	Focus on practice that is not working ignores important processes that underpin practices that work well.	Compassion is seen by practitioners as a moral virtue, therefore criticism of compassion in practice can result in feelings of failure and demoralisation which in turn can limit its promotion.	Need to articulate specifically what happens when compassionate care works well.
Contradictory messages in current policy with emphasis on systems that can be applied universally to all patients whilst on the other hand attention is given to individuality.	If the culture of caring requires that both relational and transactional paradigms are needed what needs to be in place to support practitioners to embrace both paradigms?	Tension for practitioners in delivering compassionate care to all patients and families alongside fair distribution of care.	Need to define key processes that enable compassion to happen in everyday practice so these can be integrated into, routine practice for example existing audit processes.
Current policy initiatives that aim to support the development of caring tend to focus on transactional approaches. Tendency in policy to go for ‘quick fix’ solutions to problems.	Professional education can be dominated by sets of competencies that are required to deliver compassionate care. This quick fix solution not always sustainable in practice and ignores relational dimension of practice development.	Support needs to focus less on set of prescribed actions and more on initiatives that reflect the relational complexity of compassionate care.	Need to pay attention to the relational dimension of change to develop systems and processes that help people to act in compassionate ways with one another that relate to ‘real time’ practice and are sustainable.

2.11 Theoretical Framework

This chapter has explored existing discourse about and current insights into the delivery of compassionate care from a range of published material. Synthesising the literature reviewed in this chapter has identified a number of areas where there is a need to expand and deepen knowledge about the delivery of compassionate care. The key messages are summarised above.

The concepts that underpin the theoretical and methodological framework informing this study relate to the topic of compassionate care and the research paradigm within which the study is situated.

In particular the concepts that underpin my exploration of compassionate care consider the types of knowledge used to inform nursing (Liaschenko and Fisher (1999). If, as the literature suggests, different types of knowledge, including person knowledge, are important in caring there is a need for more empirical work that examines the nature of this knowledge and how it is used in practice. In particular we need to better understand the processes that are required to support the development, acknowledgement and celebration of such knowledge in the everyday world of practice.

Therapeutic relationships between professionals, older people and families have been considered as central to current care philosophies and theory (McCormack 2003, McCormack 2004; Nolan *et al.* 2004; Tresolini & Pew-Fetzer Task Force 1994) yet there is limited empirical evidence to inform practitioners how to develop and sustain such relationships. Key constructs such as interdependence and reciprocity are central to theory about relationships in health care but there is little understanding of the shared meaning of these terms for practitioners, patients and families. The construct of relationships extends beyond the individual person receiving care and needs to consider relationships between practitioners, patients and families.

The theoretical literature concerned with changing practice suggests that an understanding of the relationships between key stakeholders and between differing forms of evidence/knowledge and how they are facilitated within a given context are central to the success of sustainable change within health care (Kitson, Harvey & McCormack 1998; Waterman *et al.* 2001). Change can only be understood with reference to context and the process of inquiry (Kitson, Harvey & McCormack 1998). Therefore, in a study that seeks to bring about change through the development and implementation of strategies to promote compassionate care, there is a need to:

- Include all key stakeholders in the research process;
- Examine the relationships between the different actors;
- Consider the researcher and the research process as integral to the process of change;
- Respect and work with a range of perspectives; and
- Understand compassion through an analysis of how it is enacted within a given context.

The paradigm of relational constructivism embraces all of the elements identified above and is the theoretical framework adopted in this study. This is described in more detail in Chapter 3.

2.12 Use of Terms

A debate highlighted in this chapter relates to overlap of terms used to describe good quality care. It is not the purpose of this study to specifically compare terms such as dignity, compassion, empathy or indeed to identify interrelationships. Rather this study deliberately uses the term ‘compassion’ because:

- it is the term used by the wider Leadership in Compassionate Care Programme (LCCP) of which this study is part; and

- the term compassion specifically tells us something about the way in which care is given and this seems highly appropriate since there is a lack of evidence in the literature about ‘the how’.

The term compassion has been specifically linked to relationships in the title of this study – ‘compassionate relationship-centred care’ - since relationships between professionals, older people and families are considered central to current care philosophies (Brown Wilson 2007; Dewing 2004; Koloroutis 2004; McCormack 2003, McCormack 2004; Meyer & Owen 2008; NCHR&D Forum 2007; Nolan *et al.* 2004; Tresolini & Pew-Fetzer Task Force 1994).

2.13 Chapter Summary

This chapter has explored current debates in the literature related to the concepts of caring and compassion and identified gaps in the knowledge base. It is clear that compassion, dignity and person-centred practice are at the forefront of the policy agenda, and their importance is widely recognised by practitioners. Debates focus on what can be done to achieve these policy and professional aspirations for care for all patients across all health care settings. There is a danger in the current health care climate, which is dominated by productivity, efficiency and effectiveness, that quick fix solutions will be sought to sort out the ‘caring problem’. A plethora of literature to 2008 has identified key dimensions of caring which are broadly consistent with the theoretical and conceptual understandings of compassion. In addition, some processes have been highlighted that would enable caring to be enacted, such as, developing interpersonal competence, and supporting people to take emotional risks in order to make connections with their patients to form meaningful relationships. These dimensions and processes highlighted in the literature do give some insight into what is needed in practice to deliver compassionate care. However, there is more scope to examine the concept of compassion as it relates to all stakeholders, that is patients, families and staff in the context of relationships and practice. In addition studies focus on describing processes rather than examining caring

in the context of implementation in everyday practice. This review has identified that literature lacks detail about how to deliver compassionate care. This study sought to address this gap.

Furthermore the literature suggests that 'quick fix' solutions characteristic of transactional approaches to change, that do not take into account relationships and context, may not always result in sustainable developments. Theories about the knowledge nurses use within their work and relationship-centred practice inform this study together with the worldview of relational constructionism that provides important guidance about how to generate knowledge and develop practice in relation to compassion.

Chapter 3 examines the methodology and methods of data generation and analysis used in this study.

Chapter 3 - Methodology

3.1 Introduction

Based on consideration of the literature and identification of key concepts, the primary aim of this study was to explore, develop and articulate the meaning of compassionate relationship-centred care and strategies that would enhance the delivery of such care in an acute hospital setting for older people using an appreciative inquiry approach. The objectives were:

1. to explore the experiences of staff, patients and their families in giving and receiving care;
2. to develop an understanding of the concept of compassionate relationship-centred care within the practice setting through exploring the views, perceptions and experiences of staff, patients and their families;
3. to develop, implement and evaluate strategies that promote compassionate care, in the context of practice, both at ward and organisational levels;
4. to examine the processes that need to be put in place to enable these strategies to be sustainable over time; and
5. to identify the lessons learnt to inform practice, education, policy and research.

This chapter begins with an introduction to the paradigm of relational constructionism as the worldview that underpins Appreciative Inquiry (AI). It then discusses both the approaches of appreciative inquiry and action research and highlights similarities and differences between them in order to present a rationale for foregrounding appreciative inquiry as the approach used in this study. Details are then given about the ethical implications particular to this study. The methods used for data generation and analysis,

throughout the phases of AI are discussed and the chapter concludes with a discussion about strategies used to enhance the quality of the research.

3.2 Rationale

From the literature synthesis presented in Chapter 2 key messages emerged that informed the research paradigm and methodological approach chosen for this study. There is a lack of clarity about the meaning of the term compassion and how this is enacted in everyday practice (Youngson 2008). Furthermore, there is a need to understand the processes that support the development of compassionate care from the perspectives of those who give and receive care in the context of practice (Kitson, Harvey & McCormack 1998; Nolan *et al.* 2006; Waterman *et al.* 2001). In addition, much of the previous empirical work focuses on theoretical accounts of caring and compassion, rather than examining processes in practice and stimulating change within the clinical environment to enable us to articulate not just what the concept means but how to deliver compassionate care (Baillie 2009; Whitehead & Wheeler 2008).

These key messages from the literature review provide a rationale for conducting a study that uses a methodology that helps to explore the concept of compassion in the everyday work of practitioners, focuses on uncovering the elements of processes that work well, examines the concept as it occurs in relationships and has a commitment to stimulate change.

Choice of paradigm for research is also influenced by the researcher's beliefs, values and feelings about the world and how it should be studied (Denzin & Lincoln 2005). My beliefs and values as a researcher have already been articulated in Chapter 1. A summary of these includes considering the needs of staff, patients and families in the care-giving relationship, working collaboratively with people, sharing of knowledge and power, and the importance of unpicking tacit knowledge. In addition, I have had experience of using a range of quantitative and qualitative research approaches in previous studies and thus had in-depth knowledge about the strengths and limitations of such approaches. In

particular their limitations in producing knowledge that supported practitioners to understand why particular situations happened, and how to bring about sustainable change.

Furthermore, as the selected ward for this study had already been awarded Beacon status for excellence in compassionate care giving, a methodological approach was required that was not only empowering, but also examined positive care practices. Roger and Fraser (2003) argue that AI is an appropriate methodological choice when the intention is to identify strengths and build courage.

It is important to reiterate that the study was part of a wider programme of work that had already made certain decisions about methodology, notably the use of an action research approach. However, the wider programme embraced the concept of appreciation in its design. Thus although there was a different methodological emphasis with AI being to the foreground in my study, both approaches have similar philosophical underpinnings and were not considered to be antithetical (see pages 76-79 for fuller discussion).

3.3 Paradigm for research

It is important, when carrying out research studies, that the researcher clarifies both the epistemological and ontological framework to enable readers to judge the relevance of the methodological approach (Mantzoukas 2004). In this way, I wanted to identify the study's underpinning tenets from which judgment about its quality could be made.

There is a range of assumptions embedded in different paradigmatic frameworks that need to be articulated. What follows in this section is a description of these ontological and epistemological assumptions to help the reader understand the paradigmatic position in which this study is based.

There is increasing recognition that there are different ways of developing knowledge. The epistemology of positivism, where methods to generate knowledge are objective and independent of the world they are researching, may not fully help us understand the complexities of health care practice, since much of practice cannot be explained in a way that is linear and based on cause and effect (Susman & Evered 1978). Chapter 2 has already identified the complex and multifaceted nature of the concept of compassion and caring and the need to understand this in the context of its application.

An alternative approach is the interpretative model. Central to the interpretive paradigm of knowledge generation is an individual's interpretation of the world and their interaction with others so as to establish social norms (Mason 2002). The search is for meaning and understanding, and whilst the researcher takes account of the participants' perspective, this is still judged against the researcher's frame of reference (Carr & Kemmis 1986). Critics of this approach argue that it fails to examine the origins, causes and results of people adopting certain interpretations of their actions and thus falls short of addressing the theory practice gap (Carr & Kemmis 1986; Swanson & Chenitz 1982).

Much of the debate about the value of different worldviews in guiding inquiry focuses on the way science is interpreted. Gergen (1978) argues that science should not be about finding social laws that aim for prediction and control, but that science should strive for a generative capacity and by this he means:

Capacity to challenge the guiding assumptions of a culture, to raise fundamental questions regarding contemporary social life, to foster re-consideration of that which is 'taken for granted' and thereby furnish new alternatives for social action (Gergen 1978, p.1346).

The epistemological stance taken in this study is that knowledge is not pre-existing or fixed or stable. Rather, knowledge is produced through practices, interactions and experiences. Thus a methodological approach that allows examination of the concept of

compassion in the context of its application with a range of social actors, namely patients, families and staff was considered essential.

A more pluralistic view of knowledge generation is embraced by contemporary philosophers and scientists where a wider range of philosophies can underpin knowledge generation (Carper 1978; Gibbons *et al.* 1994).

Social constructionism is a world view that underpins participatory approaches such as action research and appreciative inquiry (Gergen 1999; Gergen & Gergen 2003). Within this paradigm much of our understanding of the world is said to be a reflection of our perceptions of the world of which there are multiple interpretations. This worldview advocates that one view is not superior to another. Individual thought is influenced by social processes which produces knowledge. Knowing is viewed as taking place through interaction within a social system, and is therefore created in the context of its application. This world view acknowledges that to describe, measure or change how one views reality requires the interaction of various factors, such as language and cultural expression. Rather than trying to focus on truth in the sense of objective thoughts, the focus is on looking at ways in which people socially construct their world.

Hosking (2002), however, offers a critique of social constructionism. She argues firstly that, in social constructionism, the scientist positions himself outside the inquiry, thus maintaining the subject – object distinction and secondly, that this worldview is concerned with a socially constructed product rather than the processes used to achieve this. Hosking also believes there is an overemphasis on the importance of conceptual (spoken) language rather than other forms of language, and what she refers to as co-ordinations, which could be nonverbal communication, and actions. All of these contribute to the social construction of reality. Given this critique Hosking argues for a version of social constructionism, which she refers to as relational constructionism.

In relational constructionism, assumptions about what exists are underpinned by concepts such as co-action and relational practice, which involve people entering into dialogue to

make sense of what is happening (Jonsdottir, Litchfield & Pharris 2004), and embrace the notion of multiple realities. By this they mean that we can present different selves depending on the relationships and the contexts that surround a situation. This worldview redefines the relationship between the researcher and the participants from one that privileges the knower/researcher to a more equal relationship where multiple realities are seen as different but equal. The researcher is viewed as one expert amongst many and is part of the process rather than apart from it (Hammersley 1992; Murphy & Dingwald 2001). This suggested to me that I needed to constantly work together with participants, be open and curious about what was happening and be reflexive so that I was continually examining my role in the context of the research in order to suspend assumptions and be part of the process.

This emphasis on language and dialogue may seem to limit the voices of those who are unable to communicate in this way. Thus a broad interpretation of dialogue is necessary, for example, using visual methods to enable this dialogue. Visual methods used in my study are discussed later in this chapter.

Hosking (2002) explicitly argues against trying to reach consensus and sees relational constructionism as being about including and enabling multiple realities. This is realised in both appreciative inquiry and action research via the aim of empowering people through the construction of their own knowledge in a process of action and reflection. I would argue however, in a study that aims to bring about change and development, that some agreed action in the form of consensus is necessary from a purely pragmatic standpoint. This position was adopted in this study.

This paradigm argues that constructions we make about the world are influenced by cultural and historical knowledge and that these influences are important sources of understanding and interpretation. It argues however that we have a choice in the way we use this knowledge. This preconceived knowledge is not fixed and stable. So constructing knowledge, although filtered by history, policy and culture, happens in the here and now and can change dependent on the situation. Thus, what is constructed is local knowledge.

Development of local knowledge/theory is celebrated in both appreciative inquiry and action research. It could be argued that constructing local knowledge with the participants during the research process is empowering and more likely to lead to sustainable change. This was highlighted in Chapter 2 as a key antecedent to achieving this goal.

Inquiry and intervention are left joined in the relational constructionist paradigm. This recognises the fact that relational processes in themselves construct reality. Inquiry is intervention. Processes of understanding and change can happen simultaneously. The focus therefore is less on developing action *per se*, but rather on careful questioning and listening and this in itself becomes an intervention. Questions that help people to explore possible ways of being in a relationship are important. Thus if the questions asked are designed to open up possibilities, (such as in AI the unconditional positive question is asked) this will influence the way in which people relate and respond to the inquiry. The inquiry and thus intervention may initially be carried out by the researcher. However, through role modelling and collaboration the participants themselves may become the inquirers. Since one of the purposes of the research was to support others to initiate and sustain change, a process of inquiry which in itself aims to be empowering was appropriate to my study.

In summary, key themes in relational constructionism include:

- seeing the inquirer as part of (rather than apart from) the inquiry;
- recognising multiple local-contextual knowledge/practices;
- recognising the influence of knowledge from history, politics and culture and that how we use these depends on the situation and this can change;
- including the inquirers' own knowledge/practice as just one of many communities of practice; and
- seeing inquiry as intervention (where intervention is agreed by the participants) (Hosking 2002).

This emphasis on relationships within this paradigm fits well with the theoretical underpinnings of relationship-centred practice in both care-giving and practice development described in Chapter 2, where this involves acknowledging interdependence, communicating openly with patients, staff and families and creating supportive environments where all of those involved are encouraged to flourish and grow. In addition, recognising who we are as practitioners is crucial to delivery of effective care and “*Without such self knowledge a practitioner’s own emotional response to patients’ needs may act as a barrier to effective care*” (Tresolini & Pew-Fetzer Task Force 1994, p. 38).

The relational constructionist paradigm can be seen to frame or incorporate many different forms of inquiry, including co-operative inquiry (Reason 2004), action research (Meyer 2000), appreciative inquiry (Cooperrider & Srivastva 1987), and approaches to community social psychology (Hosking 1999; McNamee 2002).

It was appreciative inquiry (AI) that was the chosen approach for this study. The following sections give an overview of AI, identify elements of action research that were incorporated into the AI approach and highlight how the principles of relational constructivism are relevant.

3.4 Appreciative Inquiry (AI)

AI is one approach to participatory research. Given that the primary aim of participatory research is to develop “*genuinely well informed action in real time social life*” (Reason & Torbert 2001, p. 5) the emphasis in this study was on:

- attaining practical knowledge and working towards outcomes which are useful in daily life and work; and
- contributing to an enhanced experience of care for patients, their families and staff.

Emphasis throughout was thus focused on working **with and for** practitioners to help them to develop ownership of activities, develop their own understanding of the situation and to challenge for themselves taken for granted assumptions about compassionate caring practice and context. In relation to patients and families the emphasis, when working with and for them, was to help them to develop their own understanding of the situation and to encourage them to contribute to developing action, if appropriate.

3.4.1 Overview of the approach of AI

The literature reviewed in Chapter 2 highlighted a tendency in research and policy to focus on understanding why practice is problematic rather than examining the processes at play when caring works well. I wanted to take an alternative approach.

Mills, Bonner and Francis (2006) elaborate on the potentially negative relational consequences of critical social science which include the silencing of marginal voices, the creation of social hierarchy, and the creation of a culture of negativity where deficit language becomes the norm.

As a result of the perceived drawbacks of focusing on the negative, a number of research methodologies have emerged that focus on a positive approach to the development of knowledge and change. These include future focused research (Walsh *et al.* 2008) and AI (AI) (Cooperider & Srivastva 1987).

AI has been defined as:

A theory and practice for approaching change from a holistic framework. Based on the belief that human systems are made and imagined by those who live and work within them, AI leads systems to move toward the generative and creative images that reside in their most positive core - their values, visions, achievements and best practices. (Watkins & Mohr 2001, pp. 262).

The purpose of AI therefore is *“to generate knowledge within social systems and to use this knowledge to promote democratic dialogue that leads to a congruence between values and practices”* (Kavanagh *et al.* 2008, p. 43).

AI aims to work towards emancipatory transformation (Grant & Humphries 2006; Reason & Bradbury 2001). The approach focuses on exploring with people what is valuable in what they do and how this can be built on, rather than on problems (Cooperrider, Whitney & Stavros 2003). One of the advantages in the use of this approach is that it allows good practice to be defined. The literature reviewed in Chapter 2 has already highlighted that although there is a body of knowledge that identifies the defining attributes of good caring as perceived by patients, staff and families there is little data that develops understanding of the processes that are required to enable this to happen in the context of everyday practice.

The four principles for AI are that inquiry begins with appreciation, and is applicable, provocative and collaborative (Cooperrider & Srivastva 1987). The basic process of AI is to begin with a grounded exploration of the "best of what is" (discovery phase), then through visioning and debate collaboratively articulate "what might be" (dream phase), working together to develop "what could be"(design phase) and collectively experimenting with "what can be"(destiny phase), (Moore 2008). In the design phase, cycles of change are developed and are then implemented in the destiny phase. Some appreciative inquirers have suggested that the destiny phase has moved away from a set of concrete activities or action plans to a more open process where the focus is on empowering, improving and making adjustments towards ongoing change (Egan & Lancaster 2005).

Although AI does not have a prescribed set of methods, those that are most commonly highlighted in the literature are interviews and affirmative questioning, to collect and celebrate the good news stories of a community or organisation. Authors also support use of creative methodologies that would encourage a range of different voices to be heard. In data analysis the emphasis is on co-analysis (Reed 2007). Much of the literature

describing the process in AI advocates one or two away days to discuss issues. This is often not possible in the busy world of health care where it is a challenge to release ward staff for mandatory training. Thus an approach that works carefully with the principles underpinning AI, and at the same time adopts a pragmatic stance in the context of the care setting was important in this study. How this was achieved is considered later.

In AI the topic may or may not be predetermined at the start of the inquiry depending on the context of the work to be undertaken (Cooperrider & Srivastva 1987). In this study the topic was already decided – that of compassionate care. However within this topic there were a number of sub-themes that participants could choose to focus on. So, for example, in this site they talked about their desire to know more about the patient, develop team working and be able to say to others what it is they do well. Work in the field needs to be dynamic, responding to the specific contexts where the project takes place (Coghlan & Brannick 2005). It was not therefore possible to identify at the start of the study what the interventions would be, but rather these were informed by the exploratory work and the context.

Although Hosking (2002) would argue that there should be no attempt at achieving consensus under the principle of valuing multiple realities, there is a need to know what is universally valued within the unit if decisions about what people put energy into taking forward are to be achieved.

Within this AI study I acted as an appreciative inquirer. Questions that focused on what was working and how we could develop these aspects, rather than on problems were important. My role was described in Chapter 1 as that of an ‘insider’ in that I was employed by the NHS and was to be considered part of the ward team. An advantage of the insider role is that it allows access to certain situations and information not normally made available to the outsider researcher and, by being a co-worker, participants are more likely to share the reality of their experiences (Meyer 1999).

In synthesising the literature that describes AI (Egan & Lancaster 2005; Cooperrider & Srivastva 1987; Grant & Humphries 2006; Moore 2008; Reed 2007) I have drawn out key principles that underpin working as an appreciative inquirer. These are illustrated in Table 4.

Table 4 - Principles of working as an appreciative inquirer

Principles of working as an appreciative inquirer
<ul style="list-style-type: none">• Working with the principles of what works well rather than what are the problems• Adopting a facilitative approach that encouraged participation and collaboration• Enabling ownership – which sometimes means re-inventing the wheel• Asking curious questions that are essentially non-judgmental in order to get at the heart of what is going on• A commitment to real-time feedback to develop learning in a deliberate way• Recognising and working with relationships between staff, patients and families in the context of practice• Focusing on local everyday happenings• Allowing the specific detail of the change to emerge over time and in response to the local environment• Using creative and inclusive approaches to engage with people• Developing knowledge in and for practice• Analysing and reporting on the processes of inquiry which in itself is seen as an intervention for change• Supporting people to take local actions forward, evaluate these and share experiences across the organisation

I worked hard in my role to embrace these principles.

AI has been used extensively in organisational development. Positive benefits of this approach include improved co-operation between workers, establishing confidence of individuals and teams, and refocusing the types of questions being asked by the people working in the organisation (Bushe & Kassam 2005; Egan & Lancaster 2005).

In relation to organisational benefits, there is evidence that AI helps to create self-reinforcing learning communities, which not only allows the person to improve their own practice, but by supporting people to articulate the positive, enables them to expand their capacity to see and encourage positive strengths in others. It is argued that this can provide a powerful core that supports the development of a real sense of identity for the unit or organisation (Ludema *et al.* 2003).

There is increasing evidence that AI as an approach is being used as a change methodology in nursing (Carter *et al.* 2007; Reed & Holmberg 2007; Reed *et al.* 2002) but as yet its effectiveness has not been systematically examined and presented. There continues to be a lack of published research evaluating AI across all disciplines (Van der Haar & Hosking 2004).

The lack of systematic evaluation of AI may be due to the fact that it has not necessarily been an approach embraced by academics; rather its development sits firmly with the organisational development world where the emphasis may not be on rigorous evaluation. One could question whether systematic evaluation is indeed appropriate to the paradigm of relational constructivism and approach of AI. It may be that continuous evaluation throughout is more appropriate and needs to be storied as part of the process.

Bushe and Kassam (2005) in a meta analysis of cases that applied AI, found that all 20 cases achieved change in social processes, but that only seven cases achieved transformational change in 'how people thought' and developed what was considered to be new knowledge. Kavanagh *et al.* (2008) suggest interpreting these results with caution however, since the people who were writing the cases were also the consultants to the organisations. That said, it raises questions about the sustainable impact of AI and the

potential importance of raising the profile of evaluation within AI so that it is recognised as a valid approach to health care research. I return to this point later in this Chapter when discussing the attributes of action research (AR).

3.5 A Critical Examination of AI

3.5.1 Focusing on the positive

A criticism of AI is the concern that by focusing on the positive there is a risk of ignoring underlying problems in practice (Reed 2007). However, McNamee (2003) argues that problems and weaknesses are much easier to address if an environment is created where there is freedom from censure and blaming. This is supported in literature that emphasises the value of enriched care environments (Nolan *et al.* 2006). The positive approach of AI thus can be seen as a factor that makes discussions more open and possible (Havens, Wood & Leeman 2006). In addition, others have argued that asking people to describe dreams and wishes can often identify existing weaknesses (Mills, Bonner & Francis 2006).

Others argue that there is something to be lost in an approach that is not critical. This would depend, however, on how the word critical is defined. AI intends to be critical, where critical means a deeper look at and trying to understand what is happening through actively being curious. It could be argued that by challenging the normal negative discourse, as is done in AI, this in itself could be seen as *being critical*.

Grant & Humphries (2006, p. 403) advocate that critique can be a part of AI. They call for a redefinition of the notion of appreciation that encompasses – ‘*to know, to be conscious of, to take full or sufficient account of*’. Appreciation is also about affirmation of different points of view.

Furthermore, it could be argued that not paying attention to the negative does not fully embrace the notion of multiple realities advocated in relational constructionism. Pratt (2002) suggests there is a need to hear multiple realities in a situation, some of which may be negative. In response to such criticisms, Van der Haar & Hosking (2004, p. 1027) suggest that AI does facilitate exploration of the negative by *“being sensitive to multiple constructions of identities and relations and action to open up possibilities”*. In AI the negative is heard, but the response to this is about considering possibilities rather than dwelling on the problem.

3.5.2 The notion of power in inquiry

A further criticism of AI is the relationship of this approach to power. Advocates of AI claim that this approach brings about more equality in the researcher/participant relationship (Gaventa & Cornwell 2001). Indeed there is an assumption in AI that by opening up knowledge production to a range of people, new voices will be heard and the action and knowledge that is produced will be less skewed to the most powerful.

However, it could be argued that AI, with its intentional orientation to looking for the positive, raises the status of this type of knowledge and thus gives it power. How easy is it to openly share other conversations that do not fit into this positive orientation? The extent to which looking for the good in people could be seen to represent a moral authority that is difficult to question is another important aspect of the power debate in inquiry. This raises questions about how easy it is to challenge these beliefs and stresses the importance of continually checking out, challenging assumptions and being open to possibilities. So, although AI focuses on the positive, the way in which the inquiry is facilitated in relation to opening up discussions will determine whether the focus on the positive has had the power to constrain or enable (Van der Haar & Hosking (2004).

3.5.3 Reliance on Language

Many of the examples of AI in the literature rely on discourse as a means of exploring the positive dimensions of experience with people (Carter et al 2007; Havens, Wood & Leeman 2006; Reed 2005). Reality is therefore based on what people say. It could be argued that treating what somebody has said as an empirical fact separates this from context and therefore could be said to be following a more positivistic stance rather than a participatory relational constructionist approach. There is scope to include methods such as observation to strengthen the articulation of the positive in AI. Observation was included in my study.

3.5.4 Level of assessment, feedback and evaluation

A further criticism of AI is said to be the lack of systematic processes used to assess what is currently happening, plan, feedback and develop actions that can then be evaluated. Authors have suggested combining elements of AI and action research to build on the strengths of each approach (Egan & Lancaster 2005). Before discussing key elements of AR that were incorporated into this appreciative inquiry to strengthen the overall approach, the following section gives an overview of AR so that its similarities and differences with AI can be highlighted.

3.6 Action Research (AR)

AR has gained increasing popularity as an approach to health care research (Casey 2007; Hughes 2006; Meyer, Ashburner & Holman 2006). AR has been described as “*The study of social situations carried out by those involved in that situation in order to improve, both their practice and the quality of their understanding*” (Winter & Munn-Giddings 2001, p. 8). It aims to bring about social change through action, developing and improving practice, and at the same time generating and testing practice based theory (Binnie & Titchen 1999; Winter 2003). Although other forms of inquiry may also hold a commitment to social action, in AR it is the primacy of action that is a key characteristic

(Heron & Reason 1997). AI has been viewed as a constructive mode of AR (AR) (Cooperrider and Srivastva 1987).

AR like AI acknowledges that reality is mediated through a range of factors, including language and culture (Reason & Bradbury 2001). In both AI and AR the researcher and participants are encouraged to challenge assumptions about the way in which things happen. This fits well with the worldview of relational constructionism.

The main features of AR include:

- its participatory nature (whereby researchers and participants work together in directing the course of the change and the accompanying research);
- its democratic impulse (whereby participants are seen as equals in the process and are empowered to change contexts in which they work together); and
- its contribution to social science and social change (the knowledge it produces is argued to be of a different kind and more meaningful to practice (Coghlan & Brannick 2005; Meyer 1999)).

These features are consistent with AI. To realise these three elements in the everyday practice of the inquiry, the quality of the relationship between the researcher and the participants is seen to be crucial. It is argued that it is this quality of the relationship that enriches the findings of the inquiry and optimises their use in informing positive practical changes (Bradbury & Lichtenstein 2000; Heron & Reason 1997).

AR emphasises engagement, not only with development and implementation activities, but also with the process of research (Meyer 2006; Reed 2005). A key outcome of AR is achievement of sustainable change through the development of practitioners and practice simultaneously (Kemmis & McTaggart 1988). The importance of the process as well as the outcome of research and the relationship between these is similar to the focus in AI where inquiry and intervention are linked. However reference to this is more explicit in AI.

In addition, both AI and AR require researcher reflexivity so that all aspects of the process of inquiry, including the role and actions of the researcher, are examined (Heron 1996; Heron & Reason 2001). Reflections form a key part of the analysis of the research, thus making transparent developing understandings and decision making in the research process.

The general approach of AR involves data gathering, diagnosis, implementation, and evaluation of the intervention. AR utilises empirical data collection and feedback systems that are rigorously defined and analysed. It does this through an ongoing series of cycles that include planning, action, observation and reflection (Waterman *et al.* 2001). Throughout these cycles, iterative processes of data collection and analysis are carried out and fed back into the setting to stimulate change (Hall 2006). The critical reflection emerging from one cycle leads on to the next planning phase.

The strength of AR has been identified as its focus on the generation of solutions to practical problems and its ability to empower those involved to improve practice (Glasson, Chang & Bidwell 2008). It is seen as a way of bridging the theory practice gap by doing the research as part of practice rather than alongside practice (Munn-Giddings, McVicar & Smith 2008). However, focusing on problems has also been identified as a criticism of this approach (Dewar 2010; Kowalski 2008; Reed 2007), creating a sense of limitation rather than possibility in research work that promotes change (Gergen 1994b; Seligman 1991).

Whilst this argument does seem to have some face validity, there is little evidence in the literature on participants' perceptions about focusing on problems and the resultant impact in studies that adopt problem focused approaches. For example, there have been many successful AR projects that have brought about transformational change (Munn-Giddings, McVicar & Smith 2008). We do not therefore know if problem orientated approaches applied by action researchers dampen down insights that might have been gained through approaches that focus on the positive. Traditional problem solving

approaches to change have shown mixed results in relation to sustaining change over time (Stange *et al.* 2003). There is some evidence to suggest that approaches that focus on strengths and positive elements of individuals and the organisation result in effective and sustainable change (Cooperrider & Srivastva 1987; Cooperrider & Whitney 2000) however, this is not conclusive (Bushe 2007; Bushe & Kassam 2005).

3.7 Rationale for adopting the approach of AI

Appreciative inquiry links to action research in that both emphasise a collaborative and participatory approach that seeks to inform change for the future and takes particular cognizance of the contexts in which people work (Egan & Lancaster 2005). AR and AI are also concerned with organisational dynamics and power (Reed 2007). Both approaches work on the understanding that the organisational context can shape the action and change, and that development of supportive relationships between the researcher and the participants is crucial (Cooperrider & Srivastva 1987; Meyer 1999).

The differentiating features of AI and AR relate to the:

- orientation to the exploration (positive or problem based);
- relationship of inquiry to intervention;
- primacy of action; and
- processes of feedback and evaluation.

A positive orientation to the process of conducting the research is explicit in AI and would support empowerment of staff, and a clearer understanding of the processes that enable good care which was important in this study.

The value of exploring process in the inquiry as well as outcome is central to both approaches, however in AI, there is explicit attention paid to the fact that inquiry and intervention are not seen as separate (Cooperrider & Whitney 2000). This may represent

a slight move away from traditional notions of AR, where the emphasis is on identifying problems and continuously feeding back to develop action, which is then evaluated and reflected on to continue the change cycle (Meyer 1999). This notion of inquiry as intervention, which is the act of asking questions and exploring with people what works well, clearly and explicitly acknowledges the inextricable relationship between the process of research and the outcomes.

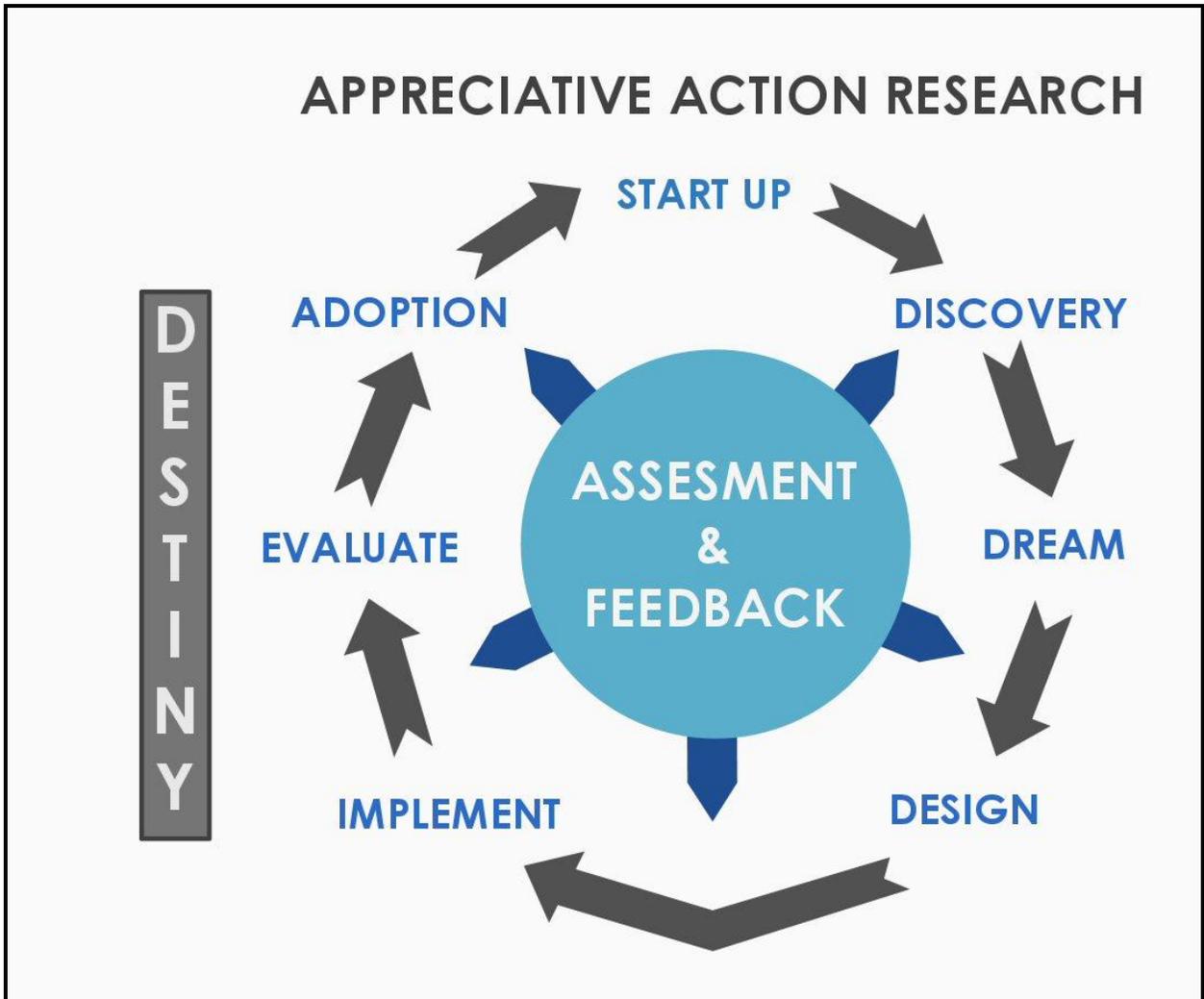
Kavanagh *et al.* (2008) and Bushe and Kassam (2005) argue that AI, although rooted in AR, differs in the emphasis on knowledge generation rather than action, as it is assumed that ideas themselves are powerful vehicles for effecting change in social systems. This depends on how one defines action. From my own experience of using AR, it has felt important and possible both to develop action and transform the way in which people think and that there is value in striving for both (Dewar & Sharp 2006; Hockley, Dewar, & Watson 2005).

The emphasis on facilitated reflection and feedback with resultant change is not as explicit in AI as it is in AR (Egan & Lancaster 2005). This, as I see it, is a weakness of AI as it limits the possibility of articulating achievements and outcomes. In AR the iterative processes of data collection and analysis are carried out and fed back into the setting to stimulate cycles of change (Coghlan & Brannick 2005). So whilst both approaches to research are underpinned by similar philosophical standpoints, it is evident that in each there is different emphasis placed on processes, where they are either made explicit or remain implicit.

Integration of the two approaches has been suggested (Cady & Caster 2000; Egan & Lancaster 2005). The value of integration is said to be to emphasise the positive questions and focus of the AI approach while collecting critical and constructive feedback during the intervention process.

A model that builds on the strengths of each is required. Egan and Lancaster (2005) provide a model where AI and AR are combined (Figure 1).

Figure 1 - Appreciative Action Research



Adapted from Egan and Lancaster (2005)

The model provides support for the discovery, dream, and design steps in AI augmented by the assessment and feedback, and evaluation steps found in AR. Thus, two research approaches, AR and AI, were integrated to provide the research methodology for this study. The study foregrounds AI as the principle approach guiding the study but uses elements of AR to enhance the rigour that is less explicit in AI.

3.8 Research Design

The aim of the study was to explore, develop and articulate strategies that enhance compassionate relationship-centred care in an acute hospital setting using an appreciative inquiry approach. Data generation was carried out from January 2008-December 2009. The study took place in a 24 bedded mixed-sex ward that cared for older people and was called an acute ‘medicine of the elderly’ ward. More specific details of the context are given in Chapter 1.

3.8.1 The sample

Staff, patients and families were invited to take part in the study based on their experiences and knowledge of giving and receiving care within the ward. The sampling is best described therefore as purposive (Creswell 2003).

3.8.1.1 Staff sample

It was appropriate in this study to invite all the nursing team to take part should they wish. These staff made up the core participant group. Thus, it could be argued that the power to guide the direction of the research lay with them. In addition, decisions were made in collaboration with others about which other staff to invite, depending on participants’ experience, knowledge and understanding. Primarily I worked with nursing staff, but informal discussions also took place with allied health care professionals, domestic staff, consultants, and others not directly based in the ward, such as the chaplain and the practice education facilitator. The number of staff in each group who participated in the range of data generation activities varied. Details of numbers are given in Table 5. The total number of staff involved in the project was 40.

Nursing staff agreed initially to participate in the study although some declined to participate in specific aspects, for example one nurse did not want to be observed in practice, and another did not want an interview audio-taped.

3.8.1.2 Patients and Family sample

Potential participants were identified as any patients receiving care in the ward and well enough to participate, and family members whom the patient identified as someone who may want to contribute. Discussions took place with staff to identify patients who, in the view of staff, would be able to participate in an interview and for whom it would be appropriate to initiate an approach. Holloway and Wheeler (2002) argue that gatekeepers to informants/participants may have their own agendas, and that an open and honest dialogue with them is important.

Staff found it difficult to identify patients as they were uncertain about the criteria to use. For example, they might not suggest a particular patient and their family because they were not very forthcoming. They tended to focus on those patients that they got on well with. It was only when I started to work alongside staff and patients, and began to ask questions, such as, ‘what would help this patient to become involved in the study?’ that we began to open up debate about participation. Through time, staff became more confident in identifying patients and exploring involvement with them.

In total, ten patients and twelve family members participated formally in the study. Others were informally involved which included being asked questions during an observation and responding to questions about specific interventions.

3.8.2 Integrating participative and supportive processes into the study

Throughout the study I endeavoured to adopt participative processes and continually reflected on their effectiveness.

Key aspects of my facilitation role relate to what Boud and Miller (1997) refer to in their description of an animateur. To animate can mean to make things move or happen and to give life to, to vivify and inspire. Qualities of an animateur were based on the model of positive interactions developed by the late Tom Kitwood, which include acknowledging people as individuals, consulting them about preferences, working together and being

open to opportunities for the celebration of self (Animarts 2003). The emphasis on positive interactions sits well with the principles of AI. Boud and Miller (1997) identify the following aspects of the animateur role:

- playback what is heard to help people to consider new possibilities;
- develop confidence in others;
- offer new opportunities for understanding;
- engage with and develop existing cultures;
- introduce lateral and alternative perspectives; and
- pose questions.

These aspects served as an important cornerstone on which I chose to develop my existing facilitation skills. In particular, the skill of asking the unconditional question was important throughout the study and continually trying to stay open to comment and criticism.

Patients and families were, on the whole, primarily involved in interviews that explored their experience of caring and their suggestions about what would help to make an experience the best it could be. Thus their participative role in the study was primarily about finding out and feeding back emergent findings and exploring with them their relevance and meaning in the context of future caring. Due to the nature of their illness and the length of time they were on the ward they did not participate in wider discussions. This level of participation would be different in other contexts, such as care homes, where the residents remain in the care setting for extended periods of time.

Staff were extremely busy and I had to spot opportunities for discussions about the progress of the work, renegotiate consent, establish their perspectives, enable them to contribute to the direction of inquiry and feed back emergent findings. Informally, this often involved me 'striking deals' with staff, which included agreeing to work as a 'pair of hands' in order to get time for small group meetings.

A core group of staff, including the charge nurse, were recruited to the study and acted as lead communicators. We were fortunate to be given a half day out of the ward to discuss roles and expectations. Following this, we met on a monthly basis where possible. Key ideas and information from meetings were recorded and placed in the communications folder for all staff to read.

In addition, it was important that staff members could take part in various data generation activities and analysis. Staff were invited to join me in all data generation activities, take opportunities for reflection on the process, and identify their learning needs. I initially led data generation sessions but, through time, staff who felt more confident began to take the lead. This way of working seemed to fit well with the AI principle of inquiry and intervention being linked. In addition, it recognised the value of practitioners as researchers of their own practice (Rolfe 1996) and lent support to the issue of sustainability.

A range of ways of communicating ideas and issues was developed to invite participation which included:

- meetings with the core team;
- written updates in the communication folder;
- key messages and questions from emergent findings displayed in strategic areas on ward to promote discussion and comment (e.g. coffee cupboard door, off duty folder, paper tablecloth on handover meeting table with coloured pens and post-its for comments);
- using short sharp focused time slots at end of handover to read, for example, a patient story; and
- informal discussions on a daily basis with staff.

I drew upon my past experience of AR and the literature related to ARer roles (see for example: Meyer (2001); Webb (1989)) and ensured that I had support systems in place to

help me to continue to develop in the role of appreciative inquirer. This included bi-monthly academic supervision meetings, and monthly action learning meetings. These helped me to reflect on the different dynamics and emergent tensions that were at play during the study.

I was working as one of four senior nurse researchers on the wider Leadership in Compassionate Care Programme (LCCP), thus I gleaned support from my colleagues on a regular basis. I also seized an opportunity to gain support from other experts in the field. I was invited to become part of another national group exploring dignity and compassionate care using AR, based at City University in London. I attended meetings with this group every three months and was able to present methodological issues for debate and discussion.

3.8.3 Ethical considerations

Ethical approval from the Faculty of Health, Life and Social Sciences Research Ethics and Governance Committee at Edinburgh Napier University was granted prior to commencement of the study (Appendix 1). The wider LCCP programme, of which this study formed part, pursued ethical approval from both the University and the National Research Ethics Committee (NREC).

Ethical issues that emerged that were not specifically addressed in the agreed ethical code of practice provided in the submission to the Ethics Committee are discussed below.

The ward had already volunteered to be part of the LCCP and had agreed to participate in the wider research programme. Thus access to the ward had already been agreed prior to commencement of my study.

Participatory approaches to research such as AI and AR are carried out in the context of practice, and involve close and open communication among the people involved. Because

of this, the researcher must pay close attention to ethical considerations in the conduct of their work (Hart & Bond 1995). Meyer (2006) argues that an important role of the researcher in AR is to ensure the well-being of those who participate, and it is essential that an ethical code of conduct is mutually agreed at the beginning of the study. Meyer recognises however that this has its challenges, because it is difficult for participants to understand fully the nature of the research at the start of a study, since it evolves and changes as it progresses. Winter and Munn-Giddings (2001) therefore argue for an ongoing ethical code as AR is constantly re-negotiated. Issues of consent and confidentiality are considered below.

3.8.3.1 Consent

Information about taking part in the study was given to all participants both verbally and in written form. The information sheets and consent forms for the wider LCCP programme were used to avoid duplication and participants were made aware that I was intending to use the data, with their agreement, for the purpose of my PhD (Appendix 2 and Appendix 3).

Consent needed to be constantly re-negotiated with participants throughout the study. Staff participants gave written and verbal consent at the start of the study. At each point of formal data collection I checked validity of consent by asking the participant whether they were content to progress with data generation and if they could give permission for data to be used in the wider programme. It was not realistic to obtain consent for inclusion of all data generated from informal discussions and observation. In practice, what happened was that I would check out interpretation and use of data when I had opportunities, and when this was not possible, I made sure that in any formal writings, where these data were used, I fed back sections to participants for confirmation that they could be used. This was only possible with staff who continued to work in the setting. For patients and families, written and verbal consent was confirmed prior to, during and after each data generation activity.

Where participants were from potentially vulnerable groups (e.g. those with a terminal illness) discussion took place with both the health care professionals involved in their care, and their family member, about the nature of the study and the extent to which they may be involved in data generation activities.

In relation to patients who had some cognitive difficulty, a principle of contextual and relational assessment was used (Dewing 2007). It was important to examine how the person presented themselves at any given moment and to adopt active listening strategies to gauge participation. This involved attending to how they presented during interviews and their responsiveness to questions. In total 3 of the patients who agreed to work with us in sharing their experience of caring had cognitive difficulties. As will be described later, the use of emotional touchpoints seemed to help these participants focus on the discussions as there were visual cues to assist the process.

Nicholson (2009) notes in her study that few older people found the consent forms and signing of them to be of any real importance. In fact, few seemed interested in the information leaflets about the study. She argued that consent was related to participants allowing her to come into their home and trusting her to hear and value their stories. She suggests that this is related to the process set down by Holloway and Jefferson (2000) of honesty, dignity and respect and relates this to the wider ethic of relatedness. In my study, similarly, patients and their families seemed disinterested in the paperwork and discussions that happened prior to data generation. It seemed that it was much more useful to have discussions after they had participated in the research activity. In this way they had an opportunity to get to know myself and the member of staff who was carrying out the work with me, and had a clearer understanding of what data we were in fact referring to.

The issue of agreeing to data being used in the wider programme can be unclear for participants. They might not be able to envisage their data and its different forms of interpretation presentation. Other authors advocate giving participants a copy of the study report, or articles (Forbat & Henderson 2005). Due to the transient nature of staff and the

likelihood that data may appear in presentations or journal articles long after the study has finished makes this difficult to achieve in practice.

Throughout the time I spent on the ward, I endeavoured to co-author with staff any articles and presentations that were produced. I shared publications with them and, where possible, with any patients or relatives whose data were used in the article and with whom we still had contact.

3.8.3.2 Confidentiality

Confidentiality and anonymity were discussed with all participants, at the start of the study, to give details about how this could realistically be managed, and at the end of the study or data generation activity, when participants could be asked how they would like their contribution to be identified.

I had assumed that people would want confidentiality and anonymity. However this was challenged by one of the participants. The charge nurse on the ward, was keen that his contribution was acknowledged in any presentation of the findings. Kaiser (2009) stresses the need to consider a wider range of confidentiality options in research. She warns against assuming that every person wants complete confidentiality. The research participant may want to be acknowledged for their contribution. She advocates the use of a post-interview confidentiality check. This approach was adopted in this study as it respects the individual and gives respondents greater control over the data.

Several authors have identified challenges of maintaining confidentiality and anonymity in AR, where small groups of people are involved and thick description of context and roles is given, making it hard to achieve ethical principles in practice (Bridges 2004; Lofman, Pelkonen & Pietila 2004; Meyer 2001). Data were checked out with participants as much as possible throughout the study so they could determine themselves whether they were happy to share this, even if they were made aware that others may be able to identify them.

3.8.4 Data generation

A range of methods was used in data generation, including stories, structured observation, photo-elicitation, exploration of beliefs and values through group discussions, informal observations and discussions captured as field notes. This multi-method approach ensured that different perspectives on the same issue were explored and served to minimise the limitations of any one method. These are described below. For ease of explanation the study is divided into different phases, although in reality there was overlap between them. The data generation methods used in each phase of the study are listed in Table 5.

Table 5 - Overview of Phases and Data Generation Activities

Phase	Activity/Data Generation
<p>Phase 1 -Setting the scene and establishing relationships</p>	<ul style="list-style-type: none"> • Field work including informal observation and informal discussions • Informal interviews with staff to explore their views about the study (n=35)
<p>Phase 2 – Discovery – what is working well?</p>	<ul style="list-style-type: none"> • Structured participant observations (n=10 events) • Staff (n=10) and student nurse stories (n=9) • Photo elicitation (staff n=16, patients n=2, families n=4) • Patient (n=10) and family stories (n=12) • Field work including informal observation and informal discussions
<p>Phase 3 – Dream/Ideal – What would be the ideal caring environment?</p>	<ul style="list-style-type: none"> • Feedback sessions to staff(n =14 sessions attended by 40 staff) • Beliefs and values group interviews with staff (n=25 members of staff attended 8 sessions) • Field work including informal observation and informal discussions

Phase	Activity/Data Generation
<p>Phase 4 – Design – What do we have to do to achieve our dream/ideal? Test this out and evaluate the activity?</p>	<ul style="list-style-type: none"> • Group discussions with staff to generate provocative statements • Field work using informal discussions to monitor impact of any development activity
<p>Phase 5 – Destiny – What has worked well and how can people be supported to develop further?</p>	<ul style="list-style-type: none"> • One to one exit interviews with staff (n=17) • Photo elicitation (carried out at time of exit interview n=17) • Analysis of charge nurse tape recordings submitted and discussed on monthly basis, containing reflections on process of change. Continued over 10 months.

The main data generation activities during each phase are discussed below.

3.8.5 Phase 1 – Setting the scene and establishing relationships

I worked on the ward for two or three days each week over the first month. The intention was to become orientated to the ward environment, to explain the study to staff, to develop relationships with the team, and to develop my confidence in participating in some aspects of care.

I was viewed as a new member of the ward team. Lofland and Lofland (1984) describe a number of stances that the researcher can play in research. They discuss the ‘martian’ role where the researcher attempts to view the situation with innocent and fresh eyes. Here the researcher considers their lack of knowledge to be an advantage as it will help them to notice taken for granted behaviours. They discuss how the participants can be seen to

‘look after’ the researcher as they are seen as ‘charmingly incompetent’. This was the role that most closely resembled the one I adopted on the ward, Although I did have knowledge of the context in which people worked and was a nurse, my lack of recent clinical experience enabled me to view the situation with ‘fresh eyes’ and ask curious questions. To help staff to accommodate me in the clinical environment I asked them to consider my expertise in direct care giving to be similar to the expertise they would expect from a clinical support worker.

My most recent nursing experience had been working alongside staff in older people care settings. I therefore shared a similar frame of reference to the staff on the ward and was able to form connections with them relatively quickly.

Some staff, however, seemed resistant to developing any relationship with me or to engaging in the research. They tended to be staff who had worked in the unit for a considerable number of years. A challenge I faced was how to avoid being overly concerned by situational emotions and opinions, but instead to try to see the actual situation in perspective and to maintain an awareness of the study’s long-term goals. A sensitive and flexible approach was needed to encourage participation in the study. I worked hard with more reluctant individuals throughout the course of the study and through time, the majority came on board and provided insightful reflections in the exit interviews (see Chapter 5) about their attitudes both to me as a researcher and to the process of the research itself. Developing relationships with individuals seemed key to progress in the study.

Key questions I used to begin discussions about the study included:

- How does it feel to be a Beacon ward?
- What are your hopes and fears about the study?
- What role do you want to play?
- What would help you to contribute to this study in a way that feels good and meaningful?

Staff generally felt proud to be nominated a Beacon ward but were anxious about whether I would think they were worthy of this award and whether they had to perform at their best all of the time when I was around.

The thing is we think we do our job well here but others might not. Maybe not everybody does everything well all of the time. If you go around spotting those moments – what is going to happen? It would be really embarrassing if the headline in Connections (the local hospital news paper) read ‘ward stripped of title’. So I think it was hard enough preparing the evidence to get the award but it will be even harder now to live up to it. (Staff Comment, recorded during field work, June 2008)

In relation to their hopes, they identified aspects such as improvement in attitudes, for all staff to see what compassionate care is and to be able to tell others, and for them to know what patients and families think about care.

A key outcome of the study that the charge nurse hoped for was a more united team. The team was split. Some individuals were explicit in their approaches to delivering compassionate care and were keen to learn as part of the study, whilst others seemed to be threatened by or uncertain about the study and appeared to work hard to battle against any innovation.

3.8.6 Phase 2 - Discovery Phase – looking for the best of what is happening

During this phase extensive data generation took place to discover aspects of care that worked well on the ward as perceived by staff, patients and families. This section describes in detail the data generation activities that took place.

3.8.6.1 Observation

Formal observation took the form of participant observation where my role was to work alongside participants observing what was happening, asking questions about issues as we progressed and carrying out some care duties if appropriate. This comprised observation of ten events in a 24 hour period and was designed to capture nuances in the delivery and receipt of care that might not be evident through other data generation methods. Due to the embedded and invisible nature of many nursing interventions and practice, staff might not be consciously aware of their compassionate caring actions and may therefore be unable to recount these in interviews (Leininger 1985).

A participatory approach to observation was adopted as advocated by McCormack *et al.* (2009), whereby a number of phases are worked through including, preparation and planning the observation, observing, consciousness raising, reflection and critique and participatory analysis and action planning.

Each structured observation lasted between 30 minutes to 1 hour. Five of the ten observations involved shadowing another member of staff (staff nurses and clinical support workers) at different points in the day, including night shift. The additional five observations were of a multidisciplinary meeting, handover meeting, visiting time, breakfast time, and a ward round. These events were observed where possible in collaboration with a member of the ward team. This was hard to fit into the busy routine of the day but was seen as essential to ease anxiety about being observed, to ensure appropriate contextual information was gathered, and to provide a development opportunity for staff. Staff rarely got opportunities to step back, look at and learn about practice in this way.

Staff, patients and families were informed of a period of observation at least 24 hours before the event. Patients and families were informed if the observation was to take place

specifically in one of the bays where they were being cared for. Observations and reflections at the time were recorded in a notebook and expanded on later that day.

I adopted the role of participant observer where I observed, engaged in the activity that was going on, and talked with staff and patients (Gold 1958 cited in Hammersley & Atkinson 2007). Observing in this way would therefore cause minimal disruption to the ward routine. At times during observation I stood back and watched what was going on (Observer as participant), and at other times I worked alongside staff and took opportunities to explore and clarify with the patient and/or family and the staff member any issues that arose during observations (Participant as observer) . Decisions about which role best suited the situation was dependent on a number of issues, including what I felt comfortable to take part in, whether I needed greater understanding from the perspectives of all those involved, picking up on cues from the staff, the patient and the family.

Gerrish (2003), in her account of participant observation with a group of district nurses, discusses the tensions and the blurring of boundaries that arise from having dual roles of nurse and researcher. Whilst she strived to remind people about her role as a researcher they often perceived her as a nurse and would ask questions and share with her issues that she found difficult not to respond to.

I had similar feelings of discomfort and uncertainty during the process of observation, as illustrated by the example below.

I was working alongside one of the staff nurses when she was trying to administer tablets to a patient who was new on the ward and had a degree of cognitive impairment. The lady was reluctant to take her medication. The nurse said it was important for her to take this and that she would tell the doctor and the lady's husband if she did not take them and that they would not be very pleased with her. The patient became quite angry and continued to refuse to take them. The nurse

left the tablets on the table and continued with medication for other patients.
(Researcher Comment, Field notes, June 2008).

Often in observation the researcher makes a decision not to intervene since this may result in masking or altering the outcome of the encounter (Bridges 2004). It felt uncomfortable to make a note of this observation and feed this back to the nurse later. I decided to take the opportunity to speak about what had happened immediately outside the patient's room. This meant that feedback and action were more inextricably linked, that there was an opportunity to learn in the moment and alter behaviour there and then and monitor its effect.

Understanding multiple realities was important, as well as the fact that intervention and inquiry need not be seen as separate entities. In addition, the focus of the research was more about what can be learned from observations in practice and how this can be used, rather than presenting an account of what happened. I focused on asking questions such as what she felt was going on?...how was she feeling?... how did she think the patient was feeling?...had she used any other strategies in the past that helped patients who had a cognitive impairment to understand what was going on?...what would she have wanted to happen in that situation?...what could she do to make that happen?...and what else did she think we could do? I shared with her experiences that I had, and planned together with her what we could do to make the situation better. We then implemented our new plan and discussed what worked well and why.

Thus research and development are more integrated in this approach. This fits closely with Angrosino and Mays de Perez's (2000) approach that advocates observation as 'context for interaction'. In other words the interaction between the researcher and the participants becomes the focus of the inquiry.

Consent from those being observed was explicitly sought prior to each formal structured observation. One nurse declined to take part saying that she would feel awkward. On the whole staff members were very apprehensive about this data generation method.

Feedback from staff after each observation event however was positive, particularly in relation to hearing about aspects of care they delivered well and of which they were unaware.

In addition to the structured observation I carried out extensive fieldwork using observation and informal discussions. I worked on the ward for two to three days per week over a period of nine months. Over 240 hours of informal observation were carried out and recorded as field notes.

It was not possible to gain specific consent from people prior to these more informal encounters. Staff had agreed in principle at the outset of the study to participate, however I was acutely aware of the fact that they might not have realised that these opportunistic natural conversations and observations contributed to the data. This dilemma has been reported in the literature (Goodwin *et al.* 2003). I made a conscious decision to check out inclusion of emergent data that I felt might make people feel uncomfortable.

Fieldwork was recorded as field notes. At the end of the study I had completed eight A5 notebooks. The notes described what I had seen and heard as well as reflections and preliminary analysis. Emerson, Fretz and Shaw (2001) note that field notes cannot represent a complete record as the researcher will make decisions about what to record and how this is framed. I made every effort to be reflexive in these recordings, taking note of my assumptions, beliefs and values and the way that these may influence interpretations.

Staff talk about how they like to share something about themselves with the patients. I feel this is a good thing – from personal experience I often use this as a strategy to get to know people better. I have noticed though that there seems to be a fine balance between what is appropriate and what is not. I heard one of the nurses telling a patient how tired she was and that she was desperate for a day off. I felt uncomfortable when she was saying this. But then this is me. The patient may have felt comfortable. All this is very complex – how do we judge when it is

okay and when it is not. Getting lost in this. It can be viewed very differently and therefore makes me think to be quite cautious how I share this more widely in the organisation. Personal sharing is a risk – must reflect this in analysis and ask staff about how they make decisions. (Researcher Comment, Field notes, Aug 2008)

Observation, both formal and informal, proved to be a powerful tool in identifying aspects of what worked well in relation to compassionate caring, that were more difficult to articulate. It required skills of noticing. The importance of the key skills of micro-noticing builds on other writers in the field of AR (for example Marshall 2001; Torbert 1999). These skills were crucial in feeding back positive tacit practices that go unnoticed by the practitioner.

Observation is rarely included as a core method in AI, the emphasis in data generation focusing primarily on interviews. The observation method was important in that it incorporated real time feedback and critical reflection in the moment which in turn supported the practitioner to work with this feedback in a live way in developing practice.

3.8.6.2 Individual interviews/story generation with staff

Individual interviews were carried out with staff (n=10) and student nurses (n=9) during the discovery phase of the study. The complex and nebulous nature of the concept of compassionate caring has already been discussed in Chapter 2. This meant that a method that helped staff to recount their experiences of caring was important. Stories were seen as an appropriate method to use since they are increasingly being recognised as a valid means of learning about experience (Benner, Tanner & Chessla 1996; Clarke 2000; McCance, McKenna & Boore 2001; Sandelowoski 1991) and a way of revealing the meaning and ambiguity of everyday situations. Furthermore, telling stories is said to be fundamental for human thinking and a way of creating increased understanding (Van Manen 1997). The purpose of telling stories is not only to describe a situation but also to motivate people to act in a way that is more consistent with their espoused values (Abma & Widdershoven 2005). According to Labonte and Feather (1996), story sharing with

colleagues is considered an important and valuable technique in critical reflection. The research and development aspects of this data generation method fitted well with the overall purpose of the research.

It was through stories that staff members were invited to take part in a conversation with me, to share their experience of a time when they felt they had delivered good care. Staff found this difficult as they wondered if I might judge whether indeed their story did demonstrate good care. Staff commented that care was not something they talked about with colleagues unless something had gone wrong. Staff clearly needed support to think about instances of good caring.

Therefore, rather than asking them to share an example of good care, I asked them to share a time when they felt really satisfied with care. This slight shift in the way people were invited to share their experiences made a difference to their willingness to contribute. The revised question was based on a subjective feeling that was less likely to be disputed.

Each interview was carried out in a private area on the ward to avoid disruption. The interviews lasted from between 40 minutes to 1 hour. Some were audio recorded and some were not, depending on participants' wishes. When they were not, detailed notes were taken at the time of interview. This meant that some of the detail in specific quotes was lost. However, the essence of the quote was fed back to participants and they were invited to add to or change this if they wished. Several changes were made by participants.

A broad open ended question was asked at the start of the interview that invited staff to talk about their experience. (Tell me about a time when you felt pleased or satisfied with the care that you gave to someone?) I encouraged the participant to engage in natural conversation and picked up on particular lines of inquiry as they emerged. The box below gives an example of an excerpt from the data gleaned during a story and the questions asked.

Excerpt from data from staff story	My questions
<p><i>Sometimes I feel I have done a good job and I can go with a clear conscience. The other day I cleaned somebody up at five to eight when I knew I was going off at eight. You can't leave somebody like that. The patient might not have known I was going off and I didn't say to the staff 'oh, by the way, I have just cleaned that man up' – so you have to feel happy with just knowing yourself that you have done a good job.</i>(Staff Story, SS3)</p>	<p>That must have felt good. What would stop you from telling staff that you had done this?</p> <p>You said you wanted to go off with a clear conscience – was this the motivation for doing this act or were there other things?</p>

My own beliefs and values include the importance of feedback and valuing each other. Thus my own knowledge and beliefs and values influenced the questions I might ask in these situations. During these interviews a process of reflexive questioning took place where the purpose was not just to glean information for the research from the respondent but to ask curious questions to help the storyteller and myself to better understand what was going on. In some instances this resulted in new learning for the participants, for me, and about each other.

A summary of what was said was fed back to the staff member within 24 hours. They were asked to read this and make any changes or additions they felt necessary. They were also asked to consider if they were happy for this account to be shared with others on the ward and outside the organisation for purposes of learning and development.

The issue of sharing transcripts with participants is advocated to enhance the rigor of the research and develop a level of ownership (Holloway & Wheeler 2002). However, Forbat & Henderson (2005, p.1118) suggest that participants may not always view reading the transcript as a positive experience and they may feel embarrassed. They ask us to

question the “*solidifying and reifying*” potential of transcripts as they stand in their written and concrete form. This sits uneasily with a relational constructionist perspective where one allows room to consider people’s accounts as fluid, and as only a representation of what they said at that given time. Some staff did comment about how embarrassed they were to read their account as this felt like they were ‘boasting’ about the care they had given.

Another member of staff, who initially had agreed that her transcript was accurate and was happy to include it in discussions about learning and development, asked at the end of the study if her data could be removed as her thinking had moved on since she told her story. After discussion we negotiated that she would write a postscript to her story highlighting her learning since telling the story and agreed that the two extracts would always be shown together. Thus negotiation took place between the member of staff and me as the inquirer, to achieve an outcome that we both felt comfortable with. The nurse felt able to challenge the methodological process.

Meyer (2001) discusses how, whilst participants may in theory be willing to sign up to sharing, they may not necessarily be able to envisage what sharing and debating stories with wider audiences looks like in reality. In this way she argues that, despite efforts to try to establish an open and transparent discussion, participants are in a “*potentially vulnerable position which places them at risk of exploitation and betrayal*” (Meyer 2001, p. 310).

I was acutely aware of this and tried to give examples to participants of how I might use the data. If I was using the data in a presentation I would ask them to look at the quotes I was presenting in the context of the presentation. Whilst this was possible to do while connected to the care setting, I envisaged that this would be unrealistic on future occasions when I left the ward or indeed when staff themselves had left the care setting.

Whenever we discussed stories with others on the ward I made sure that the staff member who had generated the story was present during the discussion so that they could hear others' interpretations of what happened and could defend or elaborate on their story.

Inviting staff to share their experiences of good work was useful for data generation but in addition it acted as a source of consciousness raising. This additional benefit has been supported by other authors (Christiansen 2008; Gardner, Csikszentmihalyi & Damon 2001), and further illustrates how inquiry and intervention are inextricably linked.

3.8.6.3 Photo Elicitation

Participants found it hard to articulate responses to some of the questions about compassionate caring. For example, in trying to define compassionate care, staff described this in very general terms such as humanity, being with another person, empathy, and individual care. They gave very little elaboration on these points and seemed to be detached from the words they were using. I made a decision to use photographs to prompt further discussion about the meaning of compassionate care.

The use of photos in research has a history in anthropology (Schwartz 1989). The method is called photo elicitation. Photographs have been used for example, to help people to communicate intangible aspects of culture and to bring out emotions associated with the phenomena under study, that may remain hidden with verbal interview (Lorenz & Kolb 2009). Other authors have advocated their use in research as a valuable tool in the development of knowledge (Banks 2001; Hansen-Ketchum & Myrick 2008). Harper (2002) suggests that photos can evoke deeper elements of human consciousness and stimulate greater cognitive response than words alone.

Each individual was asked to select an image from a range of 30 that I had selected from a web-based source (They depicted, for example, landscapes, people, and objects). Staff selected an image and explained why they had chosen it.

Two images and statements used to describe compassionate care are illustrated in the Table 6.

Table 6 - Images and Statements used to Describe Compassionate Care

Image selected	Words used by participants to describe compassionate care
	<p>‘It is about making a real effort to understand people and get along with them even if you don’t always agree with what they are saying’.</p>
	<p>‘I think compassionate care is about making sure you reflect on things so that you are continually wondering if what you did was caring enough’.</p>

Within these statements participants began to articulate not only the meaning of compassion to them but some of the challenges inherent in trying to deliver compassionate care.

This method resulted in more tangible and unique insights into understanding staff’s meaning of compassion. Staff enjoyed this exercise and were happy to have their image and quote about what the image meant to them in relation to the concept of compassionate care displayed on the wall.

3.8.6.4 Individual interviews/stories with patients and families

Patient (n=10) and family (n=12) stories, using the method of emotional touchpoints, were elicited to understand their experiences of receiving care.

Story method focuses on emotion by asking the patient and their families to think about key points in their experience (touchpoints) and to select from a range of emotional words those that best describe how they felt about the experience (Bate & Robert 2007). Examples of touchpoints are, coming into hospital, going for tests, talking to nurses, and mealtimes. The method helps the interviewer and interviewee to focus directly on the emotion related to the different points (touchpoints) in the patient/family experience.

A variety of methods have been used in research to learn about patients' experience in hospital (Bridges & Nicholson 2008; Clarke, Hanson & Ross 2003; Horvath 1999; Murphy *et al.* 2005). The development of methods has been in response to a move away from asking patients if something is 'good' or 'bad' (Schmidt 2003). Coyle and Williams (2001) believe that asking patients to report their experience without evaluating or blaming the service is more likely to pinpoint problems in healthcare. Whilst this recognises the importance of understanding, there continues to be emphasis on the negative in learning from the experience of others.

Similarly, researchers have recognised the limitations of asking patients what they need or want. People do not necessarily know what they need. It is through telling their story about their experience that these needs can become apparent (Guaspari 1999).

Indeed evidence is growing of the power of patient narratives (stories) in prompting practitioners to reflect on and improve the way they deliver care (Bate & Robert 2007; Hurwitz, Greenhalgh & Skultans 2004; Greenhalgh 2006; Newman 2003). Stories are especially appropriate in articulating the human side of the nurse-patient interaction because stories are said to be the juncture where facts and feelings meet (Van Manen 1997).

We know that it can be difficult for service users to feel free to express openly how they feel about a particular situation, particularly if this has been a negative experience. This can be due to a number of reasons, including low expectations about the service and fear of reprisal (Coyle & Williams 2001). This has raised some concern about the ‘truth’ value of patient accounts. Bate and Robert (2007) highlight that the purpose of seeking stories from service users is to get at the *experienced reality* rather than the *real reality*. By looking at the issue of ‘truth’ in this way, what someone has felt about a situation needs to be valued and respected and worked with in the context of the care.

The issue of truth or accurate representation is further debated by Bridges and Nicholson (2008) when they discuss what makes a good patient story for the purposes of service improvement. They ask the following questions:

- is a good story one that is an accurate representation of events?;
- is a good story one that best represents what happens to particular subgroups of patients?; or
- is a good story one that moves and motivates people to look again at what they do?

Although all three questions are important, it is the final question that is most closely aligned to the rationale behind using emotional touchpoint stories to explore and take action in relation to compassionate caring in this study.

The patient and/or family member, were invited to discuss their experiences of being in hospital. This was conducted in a private room on the ward and lasted from 20 minutes to an hour. The touchpoints were laid out on a table and the patient was invited to select those that they would like to talk about. They were also asked if there were other key moments that they would like to discuss. One relative, for example wanted to talk about her experiences of being on the ward at night, and this was therefore added as a touchpoint. It was important that the storyteller decided what was significant and

important to focus on. Taking each touchpoint in turn, the storyteller was then asked to select from the emotional words those that best summed up for them how that experience felt. There were blank cards that could be used if the patient used an emotional word that was not in the pre-prepared collection of words. They were then invited to say why they felt this way. If appropriate, they were also asked to discuss how practice could have been different, particularly if the emotion identified was a negative one. Talking with patients about what they see as potential solutions to issues they have raised, helps patients to co-design the service rather than being passive givers of information, what Bate and Robert (2007) call story 'donors'.

Notes taken from the interview and the story, in typed form, were fed back to the storytellers within 24 hours. Although some changes were made to the stories at the storyteller's request, all agreed their stories could be used for further learning and development both within and outwith the organisation.

From working with this method, key benefits identified by patients, families and staff included:

- participant has some control over the direction the discussion takes;
- can help the storyteller to go beyond bland statements of 'that was good';
- seeks feedback that is based on the person's emotional response to a situation and cannot be disputed;
- method does not directly focus on blaming the service;
- possible therapeutic benefit; and
- recognises and reinforces good practice (Dewar *et al.* 2010).

Observation, interviews, and photo elicitation were all undertaken during this phase in an attempt to capture practices that worked well on the ward as perceived by staff, patients and families. A process of grouping and initial analysis of the data took place in order to present this back to staff for reflection and debate. This enabled staff to then consider aspects they would like to happen on the ward in the future – their dream or ideal.

3.8.7 Phase 3 - Dream Phase – exploring the ideal for care-giving

Although, in the AI texts, this phase is called the dream, this is not the word I used to describe it to participants in the care setting. The charge nurse felt uncomfortable with this term feeling that it was ‘woolly’ and that a dream typified something that rarely came true. He also felt that if we were trying to make compassionate care have equal status alongside other approaches to care then we would struggle as the term ‘dream’ may not be acknowledged by, for example medical staff. We used the term ‘ideal’ instead. Two main activities took place through this phase: feedback of emergent data and using beliefs and values clarification exercises to explore ‘the ideal’ with staff. In reality, feedback had been carried out on a continuous basis throughout the discovery phase but it had not been presented as a whole. It was not possible to feed back to patients and families at this stage as the participants involved in data generation had already left the ward.

3.8.7.1 Feedback

During this phase, data from the discovery phase were fed back to the staff over a period of five weeks. Data had already been loosely themed by myself in collaboration with the other senior nurses in the wider programme (see data analysis section). There were five broad themes. Each week a new theme was presented for discussion with staff.

It was important to carry out feedback at this stage as much of the data captured described aspects of care-giving of which people may not be fully conscious. Looking at feedback at this point in AI could help participants to formulate a more specific ideal. Rather than describing a rather generalised notion of the ideal, for example ‘promote individualised care’, the data helped staff to articulate what they meant by this. Because the data reflected events that actually happened, the ideal could be seen as something that was achievable.

Opportunities were sought at different points throughout the day to feed back data. In addition a data display was made and placed in the ward meeting room which highlighted the main theme and sub-themes, with related examples.

Although patients and families were involved in identifying areas for development through sharing their stories, acting on this remained the responsibility of the staff. A limitation therefore is that there was not necessarily shared ownership of solutions or the way forward.

A distinct aspect of participative approaches to inquiry is the anticipation that staff will read written materials and discuss and debate them to further consolidate and refine their knowledge about practice (Hummelvoll & Severinsson 2005). In reality however, this was not the case. Staff rarely read information about the study or emerging data unless I or the charge nurse worked with staff to go through the data. Staff felt that they had too many other documents and papers to read. Wilcock *et al.* (2003) suggest a number of different strategies to feed back including reading stories at group meetings, or at end of ward reports and using visual or audio methods. However, integrating this type of work into everyday practice presents challenges without the involvement of a committed facilitator.

All of these methods were used together with one to one discussions at times in the day when staff members were able to take a few moments away from direct care-giving. Field notes were recorded of staff discussions. Some themes were altered in the light of staff comments and others were further developed and expanded on.

3.8.7.2 Beliefs and values exploration to create the ideal

Staff (n=25) were invited to join small group discussions to explore beliefs and values about caring. Following feedback about real, current practices, this enabled staff to share beliefs and values about specific aspects of care they valued. For example, when talking about the desire to provide individualised care, they were reminded of a quote from a staff story that talked about how difficult this was and how we have to negotiate care with

patients, to have a common goal. Dutton *et al.* (2006, pp. 74) emphasise the importance of values exploration work when they state:

shared values define what is important in an organisation and create expectations about how to act in different situations, as well as supply an impetus to act and help people to make meaning from actions.

In the beliefs and values discussion staff were encouraged to think about what they valued in their work, what helped them to care in a way that they wanted to, and to imagine what they would want from caring if they were a patient or a relative. By understanding their beliefs and values, a vision for their ideal caring practice was developed. I was then able to work with staff to identify whether their ideal matched reality and if not what changes they would like to make to the service they provide.

Through the process of feedback and exploring beliefs and values an ideal vision for the ward that was owned by staff began to develop. The next phase of design refined this vision by supporting staff to articulate the activities that needed to be put in place to enable all staff to make the ideal happen most of the time.

3.8.8 Phase 4 - Design Phase – developing activities that would help to achieve the ideal

The focus of this phase was to work with staff to refine the ideal by producing statements about positive caring practices and then design, implement and evaluate activities that would support staff to achieve these practices most of the time.

3.8.8.1 Developing positive caring statements

I worked with groups of staff to review data from the previous phases and used this to generate statements about care practices that worked well and that people were willing to defend. These were care practices staff had either been observed in the course of the

study, or had been highlighted as something staff aspired to. These were specific statements about practice that would help staff to design activities to enable the caring practices and to monitor whether they were carrying them out. In AI these statements are called provocative propositions (Cooperrider, Whitney & Stavros 2003).

The literature argues that a provocative proposition or statement should meet the following criteria:

- is it provocative? Does it stretch, challenge or innovate?;
- is it developed from real-life examples?;
- do people feel passionate enough about it to defend it?; and
- is it stated in bold, positive terms and in the present tense? (Cooperrider, Whitney & Stavros 2003).

These criteria were useful in developing the statements. So, for example, in relation to the observed positive care practice, shaking a new relative's hand when you first meet them, we developed a statement:

*We believe a deliberate welcome is important when we meet new patients and families. It costs nothing (**provocative element**). We go out of our way to welcome them (**bold positive terms**), for example by shaking their hand when we first meet them and introducing ourselves by our first name (**developed from real life examples**). When we do this it helps us to make a connection with them and develop relationships more quickly (**impact of the action**).*

I would add the criterion that it also states what the impact of the action could be.

Staff found it hard, however, to generate statements. To develop one statement from the wealth of data took around one hour of discussion. It was clear that developing a range of statements to prompt action would be time consuming and difficult. I was cautious about developing the statements alone, as this could have altered the caring practice that was

observed or talked about so that staff felt less ownership of it. Therefore I worked with all of the data and generated 72 positive caring statements that could then be debated on the ward and redrafted to arrive at care practices that people felt they could defend, and that generated specific actions in response to the statement's intent. So, although I took a lead on this work, staff owned the content of the positive care practices as they had already carried them out in practice. They actively debated and redrafted them. Examples of statements can be found on page 238 in Chapter 6.

Following development of statements the following process took place to enable all staff to engage with the messages, to debate them and decide on future actions if appropriate:

- developed statements from data and chose images to depict the essence of the message;
- displayed these using a digital photo-frame at nurses' station in centre of ward; and
- created daily opportunity to discuss and debate each statement using the framework of questions:
 - How does it make you feel?
 - Does it happen most of the time?
 - What helps it to happen?
 - How can it happen more of the time?
 - What action do we need to take?

This structure of questions was crucial to help staff focus, in what was often a very short period of time, on having meaningful dialogue that helped them to express respect and humility as well as open up conversations for discussing possibilities.

Examples of statements and images that were displayed using the digital photo-frame are shown in Table 7:

Table 7 - Positive Care Statements and Images

 <p>Telling other fellow patients that someone has died on the ward, if appropriate</p>	 <p>Remembering that what the professional thinks is most important is not always what the patient thinks is most important - there is a need to check things out</p>
 <p>Making sure we tell people specifically why they have done a good job or made a difference to our day</p>	 <p>Saying to patients when you are busy - I'll be back as soon as I can rather than I'll be back in a minute</p>
 <p>Always offering the patient handwashing facilities after a person has done the toilet whether they have wiped themselves or not</p>	<p>Image based on original image called Sunset in Acapulco by Esparta distributed under control of creative commons attribution license http://www.flickr.com/photos/esparta/1443263202/sizes/l/in/photostream/ Image based on original image called A pair of African penguins by paul mannix distributed under control of creative commons attribution license http://www.flickr.com/photos/paulmannix/552264573/sizes/o/in/photostream/ Image based on original image called Dandelion by Nerdegutt distributed under control of creative commons attribution license http://www.flickr.com/photos/nerdegutt/3584415033/ Image based on original image called Bumble bee by Ahisgett distributed under control of creative commons attribution license http://www.flickr.com/photos/hisgett/4849358448/ Image based on original called Toilet by dominiccampbell distributed under control of creative commons attribution license http://www.flickr.com/photos/dominiccampbell/2398857758/sizes/z/in/photostream/</p>

3.8.8.2 Designing and implementing the activity

Specific projects were identified by staff as care practices they wanted to take forward to try to reach their ideal. Decisions had to be made however about what would be left behind and what would be taken forward as there were potentially 72 actions available. Decision making was pragmatic and was guided by a range of factors, including the emotional impact the data extract had on the participants. Thus a level of consensus had to be negotiated.

3.8.8.3 Field notes to evaluate impact of activities

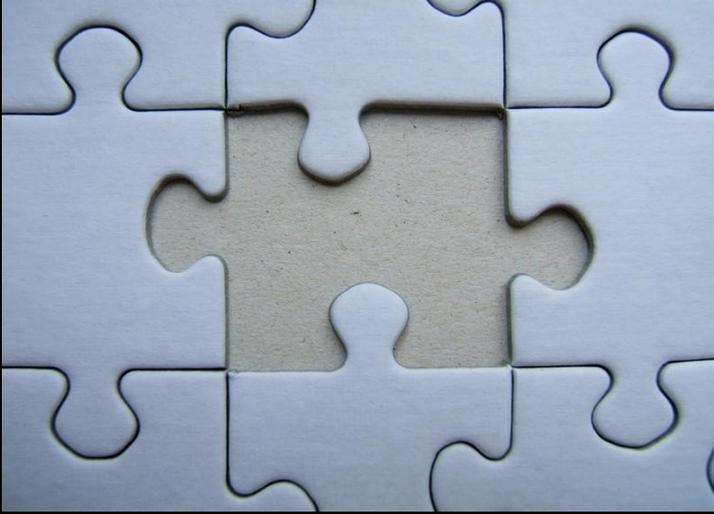
A number of action cycles were taken forward and I continued to work on the ward for two or three days per week carrying out informal observations and discussions to monitor the impact of the action cycles. These data were recorded as field notes. So, for example, in an effort to establish the impact for staff, patients and families of learning more about them as people, key stakeholders were asked a series of informal questions about how it felt to be asked questions that helped staff to find out more about them as people, and what impact this had on development of relationships and caring activity.

3.8.9 Phase 5 - Destiny Phase – implementing, evaluating and sustaining actions

In this phase of the study data generation focused on asking staff questions about the process and outcomes of the work so far, and discussing with them future development and sustainability. All staff members were invited to take part in a one to one interview (exit interviews) with myself; 17 interviews were carried out. A one to one interview was chosen at this point to allow individuals to reflect on their own experiences of involvement in the study and to learn about how they as individuals could be encouraged to progress.

In these interviews with staff the photo-elicitation method was also used to identify their learning. Some of the images and statements used to describe their learning from the study are illustrated in Table 8.

Table 8 - Learning from the study using images

Image	Quote
	<p>The missing part of the jigsaw for me was the patient and family experience. I thought I knew what they needed and wanted by imagining what I would want myself – this was wrong. I know now that checking out with them is part of compassionate care. They may want something quite different to what you think they want. (SE5)</p>
	<p>For me it's about going on a journey with the patient – taking the ride with them and trying to find out every part of the way about the journey so that you can tell others. (SE14)</p>

Having adopted an AI approach to the study, it was important that any evaluation fitted with participatory research principles. Bradbury and Reason (2001) stress the importance of evaluation in order to find out if 'we are doing good work'. Good work would refer to the extent to which the study met its aims and enabled all stakeholders to access knowledge, as well as playing a legitimate role in its production, use, evaluation and dissemination. Authenticity criteria originally developed by Lincoln and Guba (1985) specifically address these aspects. These criteria have been adapted and further developed by Nolan *et al.* (2003) so that they are more accessible to all stakeholders involved in the research process. The criteria are:

- equal access – are views of all stakeholders solicited and represented in a balanced way?;
- enhanced awareness – do individuals better understand their own situation and that of others?;
- encourage action – is action stimulated and facilitated?;
- enable action – to what extent have people been given the tools to change things?

These criteria were used both as a basis of reflection throughout the study and to construct the evaluation questions for use in the one to one interviews (Appendix 4). I found these criteria useful as they give equal emphasis to the importance of thinking and actions as outcomes of the research process. In addition, the framework enabled me to provide evidence about the quality of the research process.

The interviews were conducted in a private room and lasted from 20 minutes to 1 hour. They were audio-recorded and typed transcripts were given to the participants to check for accuracy, ask for additions or deletions and to check if they agreed that quotes could be included in a short report that would be disseminated to all staff, the consultants on the ward and the ward manager. Only one participant asked that details be changed. She had made reference to the fact that she now felt part of the team and had felt bullied in the past by some colleagues. She asked if this could be removed as she felt that people would be able to identify her.

The report was disseminated and staff identified which actions they wanted to take lead responsibility for and the support they would need from me to enable them to develop practice.

I reduced the amount of time I spent on the ward in April 2009 from 2/3 days per week to two afternoons per month. This reduced contact continued for nine months from April 2009 – December 2009. The purpose of these visits was to:

- support staff in continuing to develop and evaluate their action projects;
- gather more evidence about changes to practice through informal discussions and observations and;
- have meetings with the charge nurse to discuss his reflections on changes and impact on a day to day process.

In addition the charge nurse continued to take part in action learning sets and data from his discussions in the set continued to be collected and analysed. This meant that I could capture challenges he presented to the process of sustaining change on the ward.

3.8.10 Other processes

3.8.10.1 Reflexivity

Reflexivity encourages researchers to acknowledge the integral part they play in the social world that is being studied (Gerrish & Lacy 2006; Kingdon 2005). Parahoo (2006) emphasises, that it is not just the researcher's reflections on their values, perceptions and behaviours that need to be taken into account during the research process but the participants' also. Much writing in relation to the concept of reflexivity has focused on the importance of this process to provide validity to findings. However McCabe and Holmes (2009) suggest that reflexivity is also a

useful tool for informing the research process, more specifically in relation to using this process as a tool for encouraging emancipation in the research whereby participants and the researcher together come to a new understanding about situations during data collection and analysis. This extended version of reflexivity more accurately describes the process in this study. This can be evidenced in the data extracts presented on pages 99 and 126 that illustrate the ‘curious’ questions asked within data generation processes and the identification and sharing during data generation about the learning for both the participant and myself.

A number of strategies have been advocated to enhance reflexivity (Lax & Galvin 2002; Marincowitz 2003; McGhee, Marland & Atkinson 2007). Those used in this study included, for example, reflective diary recordings, which detailed reflections about processes and outcome of change and about the nature of self on the inquiry. These reflections helped me to reconsider the way I was acting in the study in my role as an appreciative inquirer, for example, in my struggle to be appreciative and combine this with being transactional. In addition, they provided a useful backdrop to the analysis whereby I was able to look at reflections in relation to emergent analysis.

As described in Chapter 1, I had a background as a researcher and as a nurse and thus it was important that I looked at how my personal and situational influences could affect the process of change. For example, an extract from early field notes showed how my history of having worked with a range of research approaches that adopted a critical stance to developing practice created a tension in an approach that worked primarily with celebrating success:

I find it really hard to adopt this appreciative approach all the time. I am uncertain what to do if I see practice that I think is not good. There is tension for me in my role as a nurse and working in a professional role with the NMC Code of Conduct as guidance and my role as a appreciative researcher where I am encouraged in theory to suspend judgment about a situation and be curious about what has happened. It seems much quicker and clearer to identify what is going wrong and work with the person to find a resolution. This is the way I am used to

working. It takes time and a lot of thought about how I question to work in this appreciative way. I wonder sometimes if I am being a bit deceptive – in not sharing how I initially feel about a situation. (Researcher Comment, Field notes, May 2008).

I was diligent in recording reflective notes on a regular basis throughout the course of the study. I was aware however that the notes were only as good as my level of self awareness about what was happening. The bi-monthly discussions with university supervisors were therefore helpful in challenging my perceptions and acknowledging the possible impact of my history and personal perspective on the direction of the research.

In addition, findings were fed back to participants and members of the wider organisation in an ongoing process. As I got to know participants better, I was able to share with them feelings I had about situations, as well as asking questions that were curious in nature to try to understand what was going on. Finlay and Gough (2003) calls this *reflexivity as mutual collaboration*, whereby, at a minimum, participants are involved in dialogue during analysis and evaluation of data and this was integral to the overall reflexive approach of the work.

3.8.10.2 Action learning

Action learning was offered to the charge nurse as a leader of change. This happened on a monthly basis throughout the study. Action learning is “*a continuous process of learning and reflection that happens with the support of a group or ‘set’ of colleagues, working on real issues, with the intention of getting things done*” (McGill & Brockbank 2004, p. 11). This process was to enable the charge nurse to identify issues that acted as a barrier, or aspects that enhanced delivery of compassionate care, and evaluate the impact of strategies to promote the concept in practice. Issues presented and resultant learning were recorded as data.

Action learning, a process that supports people to reflect on experience and take action, has been advocated as an important way to support staff in complex change studies. In

particular, the process helps develop the confidence of participants as co-researchers and facilitators which can support the ability to continue with the work once the study has finished (Dewar & Sharp 2006).

Action learning made learning much more deliberate. The charge nurse regularly presented issues that he found challenging in the change process. Through careful questioning he was supported to consider other perspectives, examine the challenge in more depth and develop action. An example is shown below:

The charge nurse presented an issue that was troubling him on the ward. Staff morale was low and he was becoming increasingly frustrated with the fact that there was continual moaning at the start of the shift and people found it hard to work as a team on days when there were staff shortages or excessive workload. He felt hopeless as a leader and saw no clear way of addressing this. He was asked to talk about what he did in these situations. From his account he was able to develop six key principles that he works with to help staff to get through a difficult day in a positive way. He talked about the difficulty he has in communicating ideas such as these to the staff team and getting them to try to work collectively with the same principles. In looking at when ideas had been taken on board in the past he remembered important principles such as developing ownership of ideas. He developed an action project from this action learning session that included the team in its development. The action project was about different ways of motivating the team on 'difficult days'. (Researcher Comment, Field notes, November 2008).

3.8.11 Data analysis

The data analysis process was not driven by a predetermined schedule as used

in quantitative and some qualitative research designs. Rather a more fluid, intuitive and inductive approach was adopted that increased the opportunity for naturally occurring data to emerge from the field (Kilbride 2007).

The overall data analysis strategy was that of Immersion/Crystallization described by Borkan (1999). This is a style of data reduction that is suited to exploratory research where knowledge in the area is limited and research is participatory (Kilbride 2007). This particular approach seemed appropriate since it is described as an intuitive process that asks the researcher to engage cognitively and emotionally with the data. Furthermore, the approach recognises that attempts to measure and describe the world are influenced by a complex range of social and cultural factors. Thus it was important to recognise that one's account can only be a partial understanding of the topic and that analysis should strive to reflect multiple perspectives. This seemed to fit well with the relational constructivist view of knowledge generation.

Before discussing explicitly how this approach was used, it is important to outline the relationship of my analysis in this study to that of the wider LCCP.

3.8.11.1 Relationship of analysis to wider LCCP

The collaborative nature of data generation and analysis in this study raised challenges which included the blurring of boundaries between the researcher and the participants, and what knowledge sat firmly with this study, and what sat in the wider LCCP.

These challenges were addressed by the following:

- a careful audit trail was kept throughout the study to document processes, changes made to analysis, and who led different parts of this analysis. In addition an

explicit account of my own values and intentions was recorded and detailed alongside the analysis;

- regular meetings and discussions were held with academic supervisors and the Lead for the programme to debate issues of intellectual lead, ownership, publication and overlap; and
- peer review of the analysis section of this report with members of the LCCP team to confirm accuracy of my interpretation of the process.

As part of the wider LCCP myself, three other senior nurses and the Lead nurse for the programme developed six broad themes derived from:

- early work in the field;
- team members in depth knowledge of both practice development and compassionate caring; and
- literature.

Facilitation of this initial identification of overarching themes was led by the Lead Nurse. Themes formed the initial framework for both the LCCP and my study from which data were further analysed and categorised. These themes were:

- caring conversations;
- feedback;
- knowing me, knowing you;
- flexible person-centred risk taking;
- involving, valuing and transparency; and
- positive caring practices.

From this initial theming process I worked independently and continuously with the data from my site to analyse data generated from observation, stories, exit interviews, photo elicitation, beliefs and values discussions and informal observations, discussions and field notes. This analysis, which comprised the themes identified above and 52 sub-themes,

was presented to the wider LCCP team where I led discussions that supported them in mapping their data to the themes and sub-themes developed by myself from data in my Beacon ward.

Following this, I carried out, independently, a process of secondary analysis to make the overall framework a more manageable size and to group themes where overlap occurred. During this summarisation process constant checks were made with the original data to ensure meaning was not lost. The secondary analysis was shared with the research team and the charge nurse on the ward. The research team decided to continue to work with the original framework. Following this decision I continued to develop my analysis independent of the LCCP and did not feedback developments.

3.8.11.2 Data analysis using Immersion/Crystallisation

The process of immersion/crystallisation was central to the data analysis process across all data collected as part of my study. The process emphasises an open approach that progresses through a number of stages: initial description of the data, crystallising the core messages in data extracts, considering these in relation to all other data, reflecting these back to participants, and creative synthesis and corroboration of the themes.

Details of how this process was used in my study are provided in Table 9. The Table also specifies where the analysis process was shared with, and independent of the wider LCCP. It should be noted that in accounts of the process of analysis described by the LCCP, thematic analysis is reported rather than immersion/crystallisation.

Table 9 - The Process of Immersion/Crystallisation as applied in this study

Elements of immersion/crystallisation process	How elements were carried out in my study
Initial engagement with the topic/reflexivity (Collaborative activity with wider LCCP)	Recognising and reflecting on hunches and prior knowledge and experience debated with other senior nurses and documented in reflective diary (also see my beliefs and values articulated in Chapter 1).
Describing (Collaborative activity with wider LCCP)	Initial introduction to the field and beginning data generation. Reflections with the team on 6 broad key themes to form framework for initial data analysis (this was eventually reduced to 5). These derived from all team members' initial orientation and early data (mainly informal observation), and previous knowledge and experience of practice development, action research and caring.
Crystallisation during data generation (Specific analysis as part of my study)	<p>This began as soon as first questions were asked in the research. I considered consciously what struck me about the data, are there 'aha' moments, what stands out, what is at the heart of what people are saying, are there any surprises? What elicited an emotion in me and why this was the case? Noticing the mundane, noticing the exceptions.</p> <p>Generated questions for further inquiry and analysis.</p> <p>Summarised these points and reflected back in transcript summary or in discussion for</p>

Elements of immersion/crystallisation process	How elements were carried out in my study
	<p>consideration by participants.</p> <p>Made changes in data generation activities in the light of new insights.</p>
<p>Immersion and illumination of emergent insights from collected data and texts</p> <p>(Presentation of sub-themes back to core research team-Collaborative activity with wider LCCP)</p>	<p>Systematic review of all data. Read through again each piece of data and began to develop sub-themes from the key messages within each piece of data. Organise sub-themes around main themes.</p> <p>Present these sub-themes back to core research team. Read through all data with core research team and collectively debate sub-themes, patterns, connections.</p> <p>Concentrated on vertical look at the data – where each sub-theme was scrutinised to check for occurrence across other data extracts and representations from key stakeholders – patient, staff and family. In particular, if a sub-theme had been developed from data from a member of staff, all data were reviewed, particularly, the relative and patient data, to see if there were data that could be themed in this sub-theme. If there was no evidence of this, I integrated the sub-theme into questions that I asked in the field during subsequent visits to the ward.</p>

Elements of immersion/crystallisation process	How elements were carried out in my study
<p>Explication and creative synthesis (Specific analysis as part of my study)</p>	<p>Re-examine initial data analysis and refine themes and sub-themes paying particular attention to overlap, patterns and relationships.</p> <p>Once all data were assigned sub-themes and situated under different key themes these were reread to check that each data entry continued to reflect the overall sub-theme and theme.</p> <p>Where metaphor or quote is used as heading of sub-theme check out clarity of this meaning with other groups.</p>
<p>Corroboration/legitimation and consideration of alternative interpretations (Specific analysis as part of my study)</p>	<p>Pose alternative questions on the themes and sub-themes to force consideration of alternative responses.</p> <p>Search for alternative responses in literature and with colleagues and participants.</p> <p>Review reflective diary to enable more thorough understanding of my interpretations.</p>
<p>Representing the account/reporting (Specific analysis as part of my study)</p>	<p>Organise textual accounts for dissemination.</p> <p>Provide detailed description of both process and outcome of analysis.</p>

Table 9 shows the different stages that I progressed through to analyse the data. In reality the analysis process was less linear than the table implies. Rather an iterative process took place where there was movement backward and forward between data, initial analyses and further data. Analysis was therefore a continuous and inductive joint activity between participants (primarily staff) and myself as the researcher.

To illustrate the iterative and continual process, I made notes of initial themes, thoughts and questions and presented these alongside their words. I had a conversation with the participant after they had read the transcript to ask if they had any further reflections or points for discussion. We also discussed the learning that we had both gleaned from the process. They often had further comments, and these were then added to the story. Thus the conversations included reflections and learning about the story for both myself and the participant. This made the interview a more democratic process where there was a more equal relationship between myself and the participant. An example of a story excerpt, analysis and discussion is shown in Table 10.

Table 10 - Example of Discussion and Emergent Analysis of Story

Excerpt from staff story	Researcher notes/early themes	Points from discussion
<p>While he was in hospital he was in one of the 4 bedded bays and he smelt really bad. It was hard for the other patients. The smell lingered all day. It was becoming more of a problem as the smell was really bad and nobody wanted to go near him. I often felt sick when I went up to him and had to try hard to cover up what I was feeling (Staff Story, SS1).</p>	<p><i>Being compassionate when other factors go against it.</i></p> <p><i>What does compassion mean in situations like this – covering up how you feel, ignoring the issue, confronting the issue – who says what is right? Depends on the situation – the relationship etc.</i></p> <p><i>Not sure how I would act in this situation.</i></p> <p><i>How do you get support for the way you are feeling?</i></p> <p><i>Real skill of making appropriate judgment on how to act depending on the person.</i></p>	<p>Compassion is hard in these situations – I did not feel able to tell the man. It did not feel right. It might have felt right if I had known him better. Talking with other staff on the ward who had similar feelings and acted in similar ways helped me.</p> <p>Can we give compassion best when we know people better?</p> <p>How do we get to know people better?</p>

Emergent findings were analysed and shared with participants on the ward for their interpretation. I was aware of the limits of an approach to co-analysis that focused purely on textual interpretation of the data and made attempts to work with staff to present analysis using both visual imagery, metaphor and poetry. This is said to engage people on both a cognitive and emotional level (Rosenbaum , Ferguson & Herwaldt 2005). In addition, I included clear examples from data that demonstrated the context of themes. Also, within the process inherent in immersion/crystallization questions such as: *What struck you? What was at the heart of what was said? How did you feel about what you read?* were helpful prompts in inviting participants to co-analyse data in a meaningful way in the context of their every day practice.

The creative strategies used helped people to engage with a large number of themes. Participants did offer useful commentary on the wording of particular themes and suggested ways in which they could have more meaning for staff. For example, staff felt that the term ‘flexible person-centred risk taking’ (a key theme developed by the core research team) was difficult to grasp and that this was more about negotiating care, and balancing out choice for one patient versus the needs of all those involved in the care context. These comments were taken on board. What resulted were two sub-themes entitled *‘knowing when you can and can’t do person-centred care’* and *‘taking the time to work with processes to get the best experience for all’*. Similarly, with the theme of ‘knowing me knowing you’ staff felt strongly that this should be changed to emphasise the importance of finding out what matters to people. They questioned what right we have to really know patients or each other, and wanted the theme to reflect more that the person themselves had a choice to share aspects about themselves that they felt important. Thus the theme was revised to *‘knowing who I am and what matters to me’*.

In addition during the process of analysis several sub-themes were grouped together where there was similar meaning. Examples follow in Table 11.

Table 11 - Secondary Analysis showing regrouping of sub-themes

Original themes	Grouping and new subtheme
I'm glad you are here today because	Going beyond they've had a good night or we've had a good day
Knowing you have made a difference	
Power of the voice of the person who has had the experience	

In my secondary analysis the framework was reduced to two knowledge domains of *knowing who I am and what matters to me*, and *understand how I feel*, and two processes of *work with me to shape the way things are done* and *engage in appreciative caring conversations*. Details of these are shown in Table 12.

Table 12 - Secondary Analysis

Knowledge Domain	Theme	Sub-themes
Knowing who I am and what matters to me	Knowing how to make a connection and click with the person	<ul style="list-style-type: none"> -a deliberate welcome and a smile costs nothing -personal sharing -knowing when to use banter, humour and play - use of language to reflect personhood and a shared understanding
	Knowing what is important to the person and using that to influence the way care is given and received	<ul style="list-style-type: none"> -knowing the little things that matter - not assuming how people want to be cared for
Knowledge Domain	Theme	Sub themes
Understanding how I feel about my experience	Feeling safe and taking the time to ask and tell	<ul style="list-style-type: none"> - recognising and sharing your emotion -proactively seeking out feedback from others – I know you are busy but.... -going beyond ‘they’ve had a good night’ or ‘we’ve had a good day’ -supporting people to hear and respond to learning how others feel

Key Process	Theme	Sub-theme
<p>Work with me so we can shape the way things are done</p>	<p>Knowing when you can and can't do compassionate relationship-centred care</p>	<p>-working with what is in your control and what is not -taking the time to work with processes to get the best experience for all - confidence to challenge the way things are done -being open and real about expectations</p>
	<p>Developing ways of working that help to shape the way things are to be done</p>	<p>-thinking and talking about how we do things and how we can do them even better - spotting opportunities and knowing the possibilities -being proud and sticking to principles of person-centredness</p>

Key process	Themes
<p>Engage in appreciative caring conversations</p>	<p>Being Curious Connecting emotionally Collaborating Considering other perspectives Being Courageous Compromising Celebrating</p>

3.8.12 Assessment of the quality of the research

In this AI study I wanted to help readers to ascertain if the study met its aims and enabled all stakeholders to be involved and develop practice. It is well recognised that criteria for judging traditional research are not necessarily useful in participatory research approaches (Morse, Swanson & Kuzel 2001). Assessment of quality in AR has been assessed according to the criterion of trustworthiness, which includes techniques such as triangulation, reflexivity and member checks (Waterman *et al.* 2001). Guba and Lincoln (1989) question whether trustworthiness is entirely consistent with constructivist research, which emphasises the social construction of meaning, which in itself changes over time and in different situations.

Kvale (2002) highlights the importance of pragmatic validity which relates to the relevance of the knowledge for generating action and change. Nolan *et al.*'s (2003) authenticity criteria already discussed in this Chapter provide a useful framework for assessment of pragmatic validity. This framework was used to evaluate the extent to which this was 'good participatory research' or not.

Also considered were criteria developed by Bushe and Kassam (2005) that are specific to evaluation of AI projects. These were useful in relation to the extent to which a project is transactional or transformational, the argument being, that transformational projects are more sustainable. This criterion could be a useful addition to the authenticity criteria as it asks more specifically about the actions that were taken forward. It asks about the project's generative capacity. Gergen (1994a, pp. 1346) refers to this as '*capacity to challenge the guiding assumptions of the culture, to raise fundamental questions regarding contemporary social life, to foster reconsideration of that which is 'taken for granted' and thereby furnish new alternatives for social actions*'.

Building on this notion of generative capacity, Bushe and Kassam (2005) describe transformational change where there is a qualitative shift in the state of being or identity of the system (case is not transformational when the changes described new processes,

procedures, resources or plans that were applied without changing the basic nature of the system).

Key questions derived from Bushe and Kassam's (2005) criteria that I have incorporated into the authenticity framework under the heading of 'enhanced awareness' are:

To what extent has the study:

- resulted in new knowledge rather than just new processes?;
- changed background assumptions on which all actions are based?; and
- stimulated numerous diverse ideas for change pursued by a range of people?

Inclusion of these questions in the authenticity criteria would be of value in addressing the important concept of generative capacity in research.

3.8.13 Transferability of data

It is important to note that the primary value of findings in AR and AI is their use within the context in which they were generated. In qualitative research and AR, generalisation is referred to as transferability (Sharp 1998). Transferability is the extent to which findings can be generalised beyond the field of origin (Seale 1999). Winter (2003) claims that this should focus on an underlying pattern of events and meanings from a specific situation that others can translate into their own situations and thereby learn from.

AR is often written up as a case study and findings reported in rich contextual detail, with the aim of giving sufficient detail and depth of description for readers to be able to judge the relevance of findings to their own area of practice (Lewis & Ritchie 2003). This study provides a rich description of the context and processes to enable transferability to be judged.

3.8.14 Sustainability of developments

Several ways of working were embraced in an attempt to enhance the sustainability of developments (see Table 13).

Table 13 – Example of methods to enhance the sustainability of developments

Example of methods to enhance the sustainability of developments
<ol style="list-style-type: none">1. Embedding processes of inquiry, such as emotional touchpoints, into the day to day activities of practitioners.2. Invitations sent out to other practitioners in different sites across the organisation to visit the ward to learn about compassionate caring practice. There was thus some pressure to ‘keep up the good work’.3. Embedding compassionate caring processes within wider organisational structures e.g. use of emotional touchpoints in the complaints process.4. Seeking feedback and embracing change identified as specific aspects to be developed within staff’s Professional Development Plans.

A key issue in sustaining any change is that it is not dependant on any one individual (Garbett & McCormack 2004). I was acutely aware of this and tried throughout the course of the study to adopt strategies to the work that encouraged ownership among staff.

3.9 Chapter Summary

This chapter began by introducing the paradigm of relational constructionism as the underpinning philosophy for AI. This paradigm emphasises that research is done **with** and **for** people, the researcher is a part of the process and that knowledge is generated

through practices, interactions, and experiences. This chapter makes the case that AI can be strengthened by including elements of AR namely reflection, feedback and evaluation and that this provides a valuable framework to underpin this study. AI was proposed as most appropriate research approach to explore and develop compassionate care in the unique context of the Beacon ward, in that it involves participants in both the change and research process and privileges the generation of practical and theoretical knowledge. Arguably it is therefore well placed to address the identified gap in knowledge of how to support the development and implementation of compassionate relationship-centred care.

The chapter describes the data generation activities during different phases of the AI (discover, dream, design and destiny) and the process of data analysis. It reflects on the importance of these methodological details to both the study aims and their consistency within the paradigm of relational constructionism. Finally, details are given of methods to enhance the quality, transferability and sustainability of the research to help the reader judge the quality of the findings described in the following chapters.

Chapter 4 – Findings: Developing Knowledge for Compassionate Relationship-Centred Care

4.1 Introduction

The next three chapters present the findings from this study, each describing different dimensions of compassionate relationship-centred care. The first two chapters relate to a) the types of knowledge needed to deliver compassionate relationship centred care, and b) the processes that enable this knowledge to be developed and used in practice. The third chapter presents a model for compassionate relationship-centred care and discusses how the model was implemented in practice.

The data and analysis support the premise that the knowledge and processes that enhance compassionate care are relevant for staff, patients and families and therefore whenever possible, evidence supporting themes is provided from each of these perspectives. An explicitly relational stance is adopted that explores knowledge and processes that are shared between and amongst patients, relatives and staff.

This chapter presents the findings primarily related to the discovery phase of AI and addresses the first two objectives of the study:

- to explore the experiences of staff, patients and their families in giving and receiving care; and

- to develop an understanding of the concept of compassionate relationship-centred care within the practice setting.

This chapter describes person knowledge that was developed by staff, patients and families and which informed and directed compassionate relationship-centred care. This knowledge had two dimensions: *'knowing who I am and what matters to me'* and *'understand how I feel about my experience'*. The focus here is on the relational dimensions of this knowledge, how such knowledge was used to inform compassionate relationship-centred care and the specific strategies that staff used to promote such care. Attention is also given to the challenges and risks associated with this activity.

In presenting the findings there are two caveats. The first relates to the rather linear way in which findings are presented, which does not fully capture the complexities and nuances of 'real life' interactions. The second is the fact that my presence on the ward and the nature of AI itself cannot be separated from the data that emerged. Through an analysis of reflections recorded as field notes I make reference throughout the findings chapters to the possible impact of the research process on the account that is presented.

4.2 Knowing who I am and what matters to me

'Knowing who I am and what matters to me', be it for staff, patient or family member, was a key dimension of the knowledge necessary to building the relationships that underpin compassionate relationship centred care. This dimension was about building up knowledge through engaging with people to ascertain who they were as a person, for example, their likes and dislikes, values, social situation and crucially what mattered to them in the care experience. Whilst the importance of such 'person' knowledge was identified in Chapter 2, it was less clear what constitutes such knowledge, how it is developed and the influence it has on care. Addressing such questions is a major goal of this chapter, beginning with *'knowing who I am and what matters to me'* the main dimensions of which are captured in Table 14.

Table 14 - Knowledge Domain: Knowing who I am and what matters to me

Knowledge Domain	Theme	Sub-themes
<p>Knowing who I am and what matters to me</p>	<p>Knowing how to make a connection and ‘click’ with the person</p>	<ul style="list-style-type: none"> -a deliberate welcome and a smile costs nothing -personal sharing -knowing when to use banter, humour and play - use of language to reflect personhood and a shared understanding
	<p>Knowing what is important to the person and using that to influence the way care is given and received</p>	<ul style="list-style-type: none"> -knowing the little things that matter - not assuming how people want to be cared for

4.2.1 Knowing how to make a connection and ‘click’ with a person

Knowing how to make a connection and ‘click’ with the person helped people to begin to develop relationships in the busy world of practice. This section presents accounts and observations that were related to the skill of making connections with people, which can be considered as a pre-requisite to asking questions to know what is important to the person (see next section). Being ill in hospital can be a stressful experience for patients and families. Getting to know the person could be way down the list of priorities, in favour of attending to emergency physical treatment. Indeed, getting to know people was

seen to take time, but there was a range of skills that staff, patients and families believed helped this process to happen naturally and alongside other care activities. These are described below.

4.2.1.1 A deliberate welcome and a smile costs nothing

The first encounter with the care context was seen to be important to staff, patients and families, particularly in building relationships more quickly. It seemed to set the tone of what was to come.

I remember arriving in this ward, the ward clerkess welcomed me, and she knew my name and told the porters what bed I was going into. The nurses helped to slide me into my new bed; I was attached to drips and infusion pumps and oxygen. I was made very comfortable and offered a cup of tea and a sandwich. The nurse sorted out all my belongings and phoned my nephew to let him know I had moved wards. I was given an information booklet about the ward. It was very helpful. My nephew got the phone number of the ward and information on visiting time and a whole host of other information. (Patient Story, PS9).

When I first came to the ward I wasn't expected, and in other wards if this happened it can feel uncomfortable – but here people apologised for not knowing that I was coming and the charge nurse took me under his wing for the day until he sorted out a mentor. I was shown round the ward and introduced to everybody. It was a busy day so we just had to get on with things, but it doesn't matter how busy you are, taking the time to say you are sorry and say 'come along with me' works. (Student nurse story, STS 2).

Humility in this situation and having the courage to feel comfortable to acknowledge when things had not gone to plan was important for the student in helping to create a sense of belonging and to make the connection.

Staff talked about the importance of welcome on a day to day basis:

Even when you come on duty in the morning it is nice if people say 'hello, how are you?' The patients often say this to me when I come in. I always try to ask the night staff what kind of night they have had and thank them when they go home. I think these sort of things set the tone for the rest of the day. (Staff Comment, recorded during field work, May 2008).

The deliberate welcome was not just seen as something that staff carried out with each other, but there was evidence that patients took an active part in this process, which was valued. Reaching out to people to connect with them, albeit in a brief encounter, was important.

Observation data also illustrated aspects of a deliberate welcome:

I observed one staff nurse entering a side room and greeting a relative that she had not met before with a handshake. She shook the person's hand and introduced herself. She asked what she should call them and how they were. She also told them if they had any worries just to ask. (Observation 4)

When feeding this observation back to the staff nurse, she felt embarrassed that I was highlighting such a simple, seemingly inconsequential interaction, but agreed that this did enhance relationships. The processes inherent in AI highlighted these seemingly inconsequential happenings to validate them as representing good caring practice.

A deliberate welcome was appreciated by all participants. It was valued, not just when arriving on the ward but at regular intervals throughout the care experience. It seemed that this intervention also helped to build relationships and create openings for other conversations, that would support the development of personal knowledge.

4.2.1.2 *Personal sharing*

Evidence from the data showed that staff, patients and families shared personal information and that this seemed to enhance developing relationships which in turn enhanced care-giving. One staff member talked about a time when he shared personal information with the patient and the patient helped him to come to a new understanding about something based on their own experiences:

“She (the patient) had quite a high demanding job in the Forestry Commission – she was really proud of this. She talked about the relationship with her team at work and how she was with her boss and she used to give me advice on how to work with my staff which I valued as well.” (Staff Story, SS7).

This quote provides evidence about the reciprocity that can occur during interactions in the care environment. Indeed patients and families had the potential to provide a source of support for staff.

Some patients valued hearing about staffs’ lives:

I felt safe and confident with the doctors and nurses. .. I have got to know a few of the nurses really well; they talk about their children and husbands, nights out I love to hear about their lives and how they cope with this busy ward and demanding patients. (Patient Story, PS9).

Some staff shared information both about themselves and about what it felt like to work on the ward. Staff felt these conversations were important to people in that they normalised the experience and to some extent provided a welcome respite from conversations about illness.

This idea of conversations that normalise the experience was commented on by one patient:

I like talking to the nurses. We talk about everything and anything. I know a little about them too. I ask them what they are doing tonight – we talk normally. We don't talk much about what is wrong with me. I know what is wrong with me but I don't want to talk about that. (Patient Story, PS6).

What this quote also illustrates is that not everyone wants to share information about how they are feeling about their illness. Knowing that a person does not want to talk about how they are feeling, and responding to this, seemed as important as learning about how they were feeling.

In discussions with staff about the theme of personal sharing, one staff member commented:

In the past, I would not have said that I do this (personal sharing) with others as they may have thought it was unprofessional, but seeing it up there as something that is important – it's like we have agreed it is okay to do this – it is recognised as important. (Staff Exit Interview, SE12).

So although staff valued sharing something about themselves with the patient, many staff did not think was a legitimate part of their practice – something they did but did not necessarily talk about and celebrate. The absence of validation resulted in staff feeling that they were taking a risk when acting in this way.

Staff seemed to have an intuitive knowledge about who they felt comfortable to share information with and who they did not:

You can just tell that some people really enjoy hearing a bit about your life and they tell you a bit about theirs' but others are more stand offish. You need to be able to pick this up. Everybody is different. (Staff Comment, recorded during field work, May 2008).

So, whilst personal sharing was seen as important in building relationships, thoughtfulness and sensitivity were also important in making judgments about what to share, and with whom to share information. Staff seemed to consider the perspectives of others when acting in this way. The process of the research helped to legitimize this aspect of knowledge for compassionate caring.

4.2.1.3 Knowing when to use banter, humour and play

Staff, patients and families often referred, in their accounts of their experience, to the value of banter or humour in their interactions. Observations also reflected their use in interactions.

From one of the observation records I observed staff joking with two ladies in a 4-bedded area whom they said they knew quite well. They did not feel it was appropriate to use humour with the other two ladies in the bay as one was very quiet and liked to keep ‘herself to herself’ and the other was quite unwell. Thus staff were discerning when using the strategy of humour in interactions.

Relatives made comments in their stories about the use of humour and banter in interactions and these were, on the whole, positive:

There is a lot of banter here and I get dragged into it. You have to take part in all that – because that’s the way it happens. Basically staff are often looking after people who are dying – it is not easy for them and the banter can be a bit of a release. I like the banter. It’s part of feeling they trust me. I feel privileged and accepted that they include me in the banter. You have to be careful though – I don’t think I would start it but I can join in. (Relative Story, RS10).

So although this relative saw the banter and humour as a marker of a positive relationship he had with staff, he highlighted that the process was risky and not necessarily reciprocal.

Making decisions about when to use this strategy and when not to, seemed to rest on knowing something about the person.

Other observations illustrate the use of banter, humour and play:

A clinical support worker said to the patient, when she pulled the covers back, that she was 'in a puddle right up to her middle'. She then went on to recite the Dr Foster rhyme – the patient knew this and started to join in – staff take a risk here and talk about having to know the patient well before doing this. They said they would pick up cues from the patient if they were not happy about this.

(Observation 4).

It seemed, that in taking the risk, staff needed to know something about the patient as a person and possible ways in which they might react to such interactions. It raises questions about how much time is needed to get to know patients in this way, and strategies we can use to support the development of this knowledge.

Staff felt that use of humour could help to make an instant connection with someone and could also diffuse emotional situations. There is a risk however in using this process inappropriately. Staff also used banter, humour, and play with each other as the following quote illustrates:

We like to have a laugh around here- it keeps us sane. One of the staff nurses had a needle stick injury. I had to take bloods from her. When I came in the next day she had a bandage and a sling – she said she had developed phlebitis from me taking blood the day before – I believed what she was saying – I was panicking. She was having a joke on me and there was no phlebitis. (Staff Comment, recorded during field work, Aug 2008).

Use of banter, humour and play proved to be a useful strategy to develop connections with people. The reference to '*keeping us sane*' and '*banter can be a bit of a release*'

relate to the emotional context of health care which will be discussed in more detail later in this chapter.

4.2.1.4 Use of language to reflect personhood and a shared understanding

There was evidence from stories and observation that the language people used had an impact on engagement. Healthcare workers often use jargon. This can be confusing and can act as a barrier to communication and developing relationships. Evidence from the data suggests that people appreciated the use of language that they could understand and that reflected acknowledging them as a person.

One relative shared her appreciation of jargon-free language:

It was important to us that any decisions about my father's care or simple changes to his treatment were communicated to us and the staff did keep us fully updated. ... the IV machine would suddenly beep repeatedly and no-one would come rushing to attend to it. We were at first quite alarmed by this until a nurse explained that it was just a warning that the bag was running low and would need changed. (Relative Story, RS1).

Thus use of language that promoted shared understanding seemed important in communicating what was going on and helping people to feel connected. Staff were, however, not always aware of this in their day to day practice:

At this time, Dr X told us that he felt this was their Dad's 'final illness'. I felt this was a nice way of putting things. I understood by this that we should not really expect recovery and this was clear and helpful. I also understood that the Dr. had not put any timescales on things, which also felt appropriate at this stage. (Relative Story, RS1).

When this quote was fed back to the consultant as part of the research process he commented that he was unaware of the language he had used, and that it felt good to get

this feedback. He felt he would be more aware of this in the future. It seemed that the language we use often remains at the subconscious level yet can be a powerful vehicle in relation to engagement. Routine practice has very few systems in place that enable us to examine and challenge the language we use. Understanding how others feel about your actions emerged as an essential process for compassionate care giving and is the focus of the latter part of this chapter.

How people referred to each other was also seen as important:

I feel really respected for who I am as a person, not just as a student. I feel accepted that I am black and I like the fact that people call me by my name and not 'the student'. (Student Story, STS1).

During periods of observation it was evident that some staff referred to patients by terms such as 'love', 'honey' or 'poppet'. Staff felt these were terms of endearment and that they would be able to pick up if a patient did not like their use. However, staff rarely checked out with patients if it was appropriate to use these terms.

4.2.1.5 Summary of theme

What people were called was important in helping people feel that their identity was maintained. How people made decisions about the language they used when referring to people was the focus of debate among staff. They did seem to use some discernment about how they addressed people, but it seemed they rarely checked this out with the person. So this process of 'checking out' seemed crucial to develop interactions that strengthened relationships and were appropriate to all parties. The language staff used to communicate with patients and families was important and made an impact on how connected people felt.

Staff used a number of strategies to facilitate making connections with people that in turn helped build relationships. Again, some discernment was evident reflecting the

individuality of each person staff were communicating with, but they rarely checked out if the way they were communicating was appropriate.

The skills of making connections were integrated into normal conversations. When connections worked well they seemed to depend on the extent to which staff considered the perspective of another, had the courage to initiate the connection e.g. using banter and humour or sharing personal information, and checking out the appropriateness of the interaction. People were not necessarily aware that they used these skills or of their impact. The process inherent in the research of micro-noticing fine details that worked well, and feeding this back, raised the profile of these skills, celebrated them and made them more evident. The skills of making a connection opened up space for conversations that helped staff find out what mattered to people and to begin to use this information in shaping the way care was given and received. This theme is described in the section below.

4.2.2 Knowing what is important to the person and using that to influence care

There were many examples across the data of knowing something about the person as an individual and using this to influence care-giving. Knowing something about the patient as a person is highlighted in this quote from a relative who wanted to share her appreciation for the care of her mother in the last few days of her life:

One thing that I will never forget was one of the nurses, at the end, when Mum had died. ... I was kneeling at the bed and the nurse came round and said ' would you like me to say a prayer' – it was beautiful. Where it came from I don't know. She did it so nicely – she had her hand on my Mum and said these words – it was amazing and something that I will never forget. I know it's not something that everybody would want but the nurse knew her – she knew how strong her faith was. (Relative Story, RS8).

The relative recognised the risk that was potentially there for the nurse and the patient in deciding to offer to say the prayer. Balancing this risk and taking the courage to act in this way was a skill that was helped by knowing the patient. What was interesting was that when I fed back this quote to the staff nurse who had cared for this lady, she was embarrassed and said:

It was like when I was saying the prayer with the family – I didn't think this was anything special, it's just doing your job right. It feels a bit embarrassing that you have made a fuss of this.... (Staff Comment, recorded during field work, July 2008).

As noted earlier this reinforces the important point about being able to recognise and value the special acts that are carried out and that often go unnoticed. Most of the time, staff were unaware of the impact their interventions had on patients, families and other staff. It was not common for staff to celebrate these acts during conversations.

4.2.2.1 Knowing the little things that matter

Knowing something about the person, who they are, their likes and dislikes, and what is individual to them was something that all participants valued. It seemed to move the care experience from ordinary to excellent.

One staff member talked about the *little things that mattered* to her when she worked with others, which in turn facilitated teamwork:

I like working with X, we care about the same things. We like things to be organised and for everybody to know what they are doing. Little things, like making sure you go round and clear all the patients' tables before lunch so that when you put the tray down you have a clear space. These things are important. It's good if you are working with somebody who cares in the same way as you do. (Staff Comment, Observation 8).

Knowing the *little things that matter* to each other as staff was seen as important but again this was rarely discussed, shared and celebrated.

Reciprocity was evident in data extracts where staff found out something about the patient and used this to enhance the care experience for the patient and themselves:

She (the patient Beth) sometimes becomes agitated and would be searching for keys or a door to get out and go home. One staff member, when finding out about her work in the beauty section of a department store asked her for a hand massage. Beth was given the hand cream and proceeded to do the hand massage to the staff member. Beth said to the staff nurse that she 'had let her hands go' and they needed quite a bit of attention. The staff nurse laughed and thanked her for this and asked if she would like her to massage her hands. They both had a thing going – with hand massaging. This really helped Beth to become more relaxed and the staff enjoyed this too. (Staff Story, SS3).

I was able to observe an instance of the hand massaging between staff and this patient during a ward round. Staff made a decision to balance the needs of the patient, who was particularly anxious at this time, the need for the care team to discuss patients, and the risk of this in relation to confidentiality issues where this patient was present at discussions about other patients. This was a courageous act, as staff might have been questioned about this practice and they needed to feel comfortable to defend their actions. In addition, staff had to make compromises to try to achieve the best experience for all. It was evident that people working in the care environment cared for and about each other. Knowing the *little things that mattered* seemed to help staff to spot opportunities to adapt their care-giving practice so that it met the needs of patients and families.

A staff nurse talked about how important it was to find out the individual or special aspects that make up the person:

It was a lady we had on the ward she had been in for a couple of weeks and she began to deteriorate. She was quite a proud woman and she took care of her appearance. She would always brush her hair and on the days when she felt well, she would put her makeup on – blusher and lipstick. She got quite poorly ... and eventually she lost consciousness. Her husband was coming in every day – they had been married for over 50 years. One day, when I was giving her a bed bath, I was looking in her toilet bag and I found her makeup. I thought she used to put it on herself so I thought I would put it on. I don't know if she was aware that I was doing this for her because she was unconscious. ... A few members of staff went in afterwards and kind of laughed and said, what is the point, or that was a bit silly. I think they thought I was a bit daft and slightly time wasting... When her husband came in, he came out of the room and said 'who put her makeup on?, she looks lovely, she looks like herself'. (Staff Story, SS9).

The nurse in this instance was actively considering the perspective of another. There is also evidence of the important contribution that the relative made in validating the decisions she made. This quote highlights the challenge of valuing person knowledge and the courage to act on it even if others do not share the same philosophy.

In addition, this quote highlighted the challenges of finding out about 'the person' when they themselves were unable to give this information. Additional skills of looking around, picking up cues, and asking relatives were important, in these instances. If this process is key to compassionate caring it raises issues about potential inequity if, for example, it takes longer to find the *little things that matter* for a person who is unable to communicate verbally.

Following a discussion with the staff about their reaction to this story, some commented that they did not know if the lady would continue to like her makeup on while she was ill. They felt that the staff nurse who put her makeup on was making decisions for her that may not be correct. The husband did appreciate that his wife had makeup on, and we discussed whether this was 'good enough' evidence for staff to continue to do this. What

this situation highlights is how complex the process of ‘*knowing who I am and what matters to me*’ is. What is it we need to know about the person to help us to care for them? Is what we learn fixed in time or does it change depending on the circumstances? And, how do we learn what is important to the person if they cannot communicate this information? Having discussions together about these issues, where people had the courage to ask curious questions of each other, and consider different perspectives, seemed to be important to value and celebrate any decisions made.

One staff nurse shared how the staff had learned details about a patient’s normal routine and likes and dislikes and tried hard to integrate these into care:

We went to the canteen to get her bacon rolls. These were small things that she missed about home. I suppose it was tapping into things that she would have at home.. ... We tried to make it as homely as we possibly could. She liked The Scotsman – we got her a newspaper everyday. We also gave her jobs to do – she folded up the bags for us. She knew at times we were busy and she wanted to help us. She enjoyed this... (Staff Story, SS7).

Considering other perspectives in relation to what would make a difference to the person’s experience was evident in this extract. The example does raise questions about the reality of the process of *knowing who I am and what matters* for all patients. Would it be possible to do these ‘little things’ for all patients? How do people decide who gets what? These questions are developed further in Chapter 5 where key skills of negotiation and compromise are important in a dialogue where people feel safe to be open and real about expectations.

Staff felt that they found that they gleaned information about what mattered to patients informally through conversations. This was supported by evidence from observations:

Discussion took place at a multidisciplinary team meeting about a lady who was hoping to get home in the near future and a home visit had been planned. There

was a lot of discussion from the occupational therapist, physiotherapist and consultant about this lady, including details about her mobility, and her wound. The consultant then said – ‘the thing the patient is most worried about is will the chair get through the door – have we checked this out?’. (Observation 5).

The consultant who led team meetings often made referred to aspects that were important to the patient and raised questions that challenged people’s thinking. He therefore role modeled a way of interacting that was mirrored by others. There was evidence at team meetings that others volunteered information about the *little things that mattered* to the patient. This style of leadership from the consultant seemed to be a key aspect in ‘setting the tone’ of the way care could be delivered. This raises questions about who we consider to be key leaders in the multi-disciplinary team and the impact different leaders can make to the progress of change initiatives and the culture of the caring environment.

Staff tried to incorporate *little things that mattered* to patients into their routine even if it was not necessarily seen by others, e.g. managers/medical staff, as a legitimate part of their job:

One nurse really stood out for me. She took me downstairs for a cigarette. The Doctors might not think this is a good thing but it is good for me – it is all I have left to enjoy now. (Patient Story, PS6).

This highlights risks that staff, and in this instance the patient, felt safe to take in order to enhance the care experience. It seemed, in this example, that the patient and staff member were taking joint responsibility for the action. It was evident however that the intention behind such actions was not just to meet the specific needs of the patient. Staff also got something out of knowing the *little things that mattered* to people and acting on them.

Thus there was reference not only to the pleasure and appreciation of receiving care that incorporated the *little things that mattered*, but also to the difference this made to the person providing this care:

I know just how much talc she likes and that she doesn't like spray on her body – that she likes me just to spray her clothes. It makes you feel good when you know about these things because you feel you are really giving the care that they want. (Staff Story, SS8).

Staff did gain a sense of achievement when carrying out these acts, however the *little things that mattered* were not necessarily communicated to the rest of the team. Acting on these *little things that mattered* to the person was done by some nurses, but not all, thus making care fragmented.

One patient talked about what mattered to her, but felt that this was not known by all staff:

One thing that is important to me is making sure my hands are washed after I use the bedpan. This is very rarely done. Sometimes it is. I ask – ‘can I wash my hands?’ and people would say ‘well you don’t need to because you’ve not cleaned yourself – we’ve done it for you’. But I like to feel clean – I like my clothes to be clean, I like my hair to be nice. (Patient Story, PS 10).

This quote surprised staff. Many talked openly about how they did not always do this act for patients. They appeared keen to learn about this rather than be defensive about the criticism, thus demonstrating openness to change. I felt they showed a degree of humility in this situation where they recognised that the ‘expert’ does not necessarily know what is best, and that there is a genuine desire to hear and consider other perspectives. This seems to be an important element of the culture, where people were supported to have the courage to own up to mistakes and be interested in learning from them rather than becoming defensive. It may be that AI, with the emphasis on being curious and asking unconditional questions, may have role modeled and thus encouraged this type of open response.

4.2.2.2 Not assuming how people want to be cared for

Much of the evidence for this theme came from staff accounts of giving care to patients. There was little evidence from staff about making assumptions about how they care for each other. This may reflect the fact that although staff were pleased, and in some ways surprised, that the focus in this study was on compassionate care for everyone, they primarily discussed caring in relation to patients.

The sub-theme of *not assuming how people wanted to be cared for* emerged throughout the study. At its start, staff views about what influenced caring were based on how they would want to be cared for themselves or how they would like their family to be cared for:

Compassionate care is about caring. It's about loving, treating others like you would want to be treated yourself, going the extra mile. (Staff Comment, Beliefs and values 15).

This personal philosophy of caring for others like you would want to be cared for yourself did seem to influence care. Staff felt deeply about the vulnerability of others, and used their own beliefs and values to influence care-giving. Whilst this is a good starting point, staff seemed less likely, on a regular basis, to check this personal philosophy out with others to ascertain if this resonated with the individual receiving care.

However, as the study developed and staff were able to hear stories about experiences of caring, their thinking changed:

I've really learnt that what I think is important and right might not be what the patient thinks. This has been hard because sometimes something that they think is important – I don't necessarily agree with, and I have to take a step back and think- well that is not what I think but let's go with it. I feel more confident with

this and that others will support me. (Staff Comment, recorded during field work, Nov 2008).

The importance of compromising through checking out with people how they felt about practices, and not making assumptions about caring was something that was highlighted particularly by staff in the study. Comments by patients that challenged staff assumptions and made staff think about the way they care were evident in the data and follow up discussions. For example, some staff felt that visiting was an enjoyable time for all patients and that they would not like to be disturbed during this time. Staff also felt that most patients would not like to be beside a person with a dementia for long periods of time. These two assumptions were brought into question:

I enjoy visiting time, I chase my family out after half an hour, we all run out of things to talk about and it can be tiring. I don't expect them to visit twice a day, in fact once a week would be fine. (Patient Story, PS8).

I enjoy the company from the patients; I help Janet who is in the bed next to me. She is confused. Janet wanders about the room and the ward. She goes into other people's lockers and takes things.... The nurses are very good with Janet, they remind her where she is and that her husband will be in at visiting time, they give her magazines to read and put some music on to try and pass the time for her. The nurses had to move Mary (another patient) into a side room because Janet was driving her mad. The nurses kept asking me if I was okay with Janet, I always say 'of course I am okay, Janet and I, we get on well together'. (Patient Story, PS9).

Considering other perspectives with curious questions was however associated with a risk, as identified by one of the nurses:

We make a lot of assumptions about what people want – it's hard to check this out because sometimes you are worried that they will ask to be cared for in a way that you can't. (Staff Comment, recorded during field work, Nov 2008).

Thus this process was complex, as the response might challenge both the personal philosophy of the member of staff and the ability of the person to have the courage to challenge the organisation to respond to this need. Staff may feel a sense of failure, as a consequence, rather than achievement.

Staff recognised that it was sometimes necessary to make assumptions when patients were unable to tell you how they wanted to be cared for. This links back to the challenge identified in the previous section about care-giving, in the absence of dialogue, that helps you to ascertain what is important to people.

In summary, the data illustrate that people valued *knowing the little things that mattered* and that acting on this knowledge to inform care giving could enhance the experience for staff, patients and families. Leadership and role modelling this way of working was important in helping it to happen more often. People needed to feel safe to have the courage to ask about *the little things that mattered* and to feel confident to negotiate and compromise with people when integrating those things that mattered into the caring activity as far as possible. Considering the perspective of others and not assuming that people's perceptions and perspectives are the same as your own was a key consideration in initiating interactions that sought to develop person knowledge. Although the discovery phase has highlighted where the development of this knowledge worked well, it also highlighted that knowledge is often not celebrated and shared with others and therefore not used systematically to influence care giving. Staff raised some concerns about whether or not development of this knowledge was always feasible, particularly in the context where people were unable to say what mattered to them and where meeting everybody's individual needs would be unrealistic in the busy world of practice. This is explored further in Chapter 5 where the key process of negotiating caring is discussed. Staff did use interpersonal strategies in their day to day practice that enhanced the

development of this knowledge, however these strategies were not necessarily conscious, shared, validated, celebrated and checked out with others.

4.3 Understanding how I feel about my experience

Finding out how somebody feels about their experience was the second key dimension of person knowledge that emerged from the data. This way of knowing is about giving and receiving feedback. Feedback was the original term used to describe this theme, however staff felt that this terminology did not adequately reflect the ‘feeling’ component of this process. Staff commented that feedback was a term used to learn how you had performed, but that understanding how people felt about their experience was not just about rating performance but about helping to understand where people were coming from and developing relationships.

Many participants talked about the importance of understanding how others feel, in that it provided another perspective, formed a stronger connection between people and helped people to understand practices that worked, as well as those that needed to be improved. This was not always seen as a straightforward process from the staff’s perspective. It seemed uncomfortable to hear negative emotions. In addition, feeding back to others specific feelings about an experience seemed to require a level of confidence and courage and language that would help to ‘get at’ the specific elements of this experience. When people talked about how they felt and when this was expressed directly it was valued by participants. Patients and families liked to be given the opportunity to say how they felt about their experience but tended to give this if they were asked, rather than taking a proactive position. The dimensions of this knowledge domain are presented in Table 15.

Table 15 - Knowledge Domain - Understand how I feel about my experience

Knowledge Domain	Theme	Sub-themes
<p>Understanding how I feel about my experience</p>	<p>Feeling safe and taking the time to ask and tell</p>	<ul style="list-style-type: none"> - recognising and sharing your emotion -pro-actively seeking out feedback from others – I know you are busy but.... -going beyond ‘they’ve had a good night’ or ‘we’ve had a good day’ -supporting people to hear and respond to learning how others feel

4.3.1 Feeling safe and taking the time to ask and tell

Feeling safe and taking the time to ask and tell seemed to be a key factor in determining whether people shared how they felt about experiences. The feeling of safety relates to the culture of the ward and the accepted ways of communicating with each other. The experience of feeling safe seemed to relate to whether people were specifically invited to share aspects about their experience or not. Specifically asking someone how they felt about their experience stems from an inherent curiosity and indicates a readiness to be open to hear responses. Being able to say how you are feeling also depends on whether or not people are able to recognise these feelings. Recognition of feelings, related to an experience, requires that a person undertakes a level of reflection which is not always easy to do on your own.

4.3.1.1 Recognising and sharing your emotion

Data presented in this subtheme related to participants sharing their own emotion about caring and learning about others' emotion. Ability to do this often resulted in a better connection with the person, and an understanding of where they were coming from, which in turn could shape new understandings and development of caring that met people's needs. Although there were many examples across the data set where participants shared their emotion, feeling safe to share with others how you were feeling was potentially quite difficult. This difficulty often related to sharing negative emotions.

Some patients and families recognised their own emotions and the impact these might have on the way in which they responded to situations:

We did not feel like saying anything about things that had upset us, as we felt we were on an emotional rollercoaster and may not have reacted in the best way, so decided to say nothing at the time. Also, because it was such an emotionally draining time and we were so tired, we wondered if our perceptions were accurate. (Relative Story, RS1).

The recognition of emotion in this quote influenced decisions this relative made about giving feedback about care. This relative was invited at a later date to share these emotions, and was happy and able to do this. It raises the issue about the timing of emotionally engaging interactions.

One patient talked about recognising the emotion of staff. She shared with us how she felt when talking to the nurses and gave us her interpretation of what she thought was happening in her interactions with them:

You get to know the staff – they are all different and you react to them in different ways.... I don't know how staff keep their patience – they seem to be here all the time. That smile that comes across staff's face – I am sure they have to work on

that. I like to be independent and I want help to become independent. Sometimes if I think staff are being unkind, I have to think why are they being unkind and when I think it through I think they are trying to help me. I get a bit annoyed when they are unkind or make me do things for myself but I understand. I get so frustrated with myself. (Patient Story, PS7).

Staff were surprised when hearing this account. They had found caring for this lady ‘difficult’ in that they had found her to be demanding and ungrateful. Hearing this account helped them to understand the complex feelings that were underpinning the way in which she was acting and responding. The staff member who took part in this conversation was able to talk to the patient about how pleased she was to learn about how the patient felt. She said that she felt that it would help her to ‘be less bossy’. Thus, staff and patient were sharing their emotions during the dialogue which seemed to result in a more responsive interaction, where they connected with each other and formed a stronger relationship.

The way people felt seemed to influence the way care was given. Sometimes staff felt uncomfortable and responsible if their emotions altered the way they gave care, in that it was below the standard they normally set themselves:

We say we don't have favourites but we do. There are some people you get on with better than others. Some of the patients shout out at you and that can be hard – you put up your guard. It's not their fault – you just have to care for them in the best way you can. (Staff Story, SS4).

This quote raises questions about the level of caring and empathy that is acceptable when staff find it hard to engage emotionally. When staff did share emotions about their feelings about caring it seemed to help them to question and understand why they gave care in a particular way. There was evidence that staff felt more positive about relationships if they could be open and honest about expressing their feelings.

Staff also talked about how recognising emotions of others helped them to understand why people were behaving in different ways. Providing opportunities for patients to recognise and share their emotions openly was seen as important as it opened up dialogue, helped people to appreciate where others were ‘coming from’, and enabled connections to be made that were not present before.

Sharing positive emotions was encouraged by the process of AI. Examples of positive feelings staff expressed about care-giving are detailed below:

I felt excited by the fact we were taking a risk and trying something new. (Staff Comment, recorded during field work, March 2008).

Similarly:

When I had to challenge the family’s request to move the lady to a side room because I knew that the lady herself did not want this I felt proud that I was sticking up for something I knew she wanted. (Staff Comment, Recorded during field work, March 2008).

Confidence was also highlighted as a positive feeling:

I felt confident and in control when I was able to say to the audit team not to visit during meal times. (Staff Comment, Recorded during field work, Jan 2009).

There seemed to be real value in supporting people to share their positive emotions about caring. It affirmed the value of what they were doing and helped them to articulate the satisfaction they felt about their work, thus helping them to affirm a sense of purpose and achievement.

Recognising emotion and the potential influence this might have on the way care is given and received was evident in a number of stories from all participants. Sharing how you

are feeling and how this may influence the way you are acting and responding seems important in helping people to connect, but it was evident that this was sometimes difficult and that support to have the courage to interact in this way was valued.

4.3.1.2 Pro-actively seeking out feedback from others – I know you are busy but...

Taking a proactive stance to ask people how they were feeling about their experience was evident in some of the stories and observation data. Some staff, for example, developed specific strategies to seek feedback from patients, incorporating them into normal conversation:

I try to find out if I have done okay – I put it across in a jokey way so just like if I have given them a shower I try to ask them was it okay, did you enjoy that – if they stay quiet I might think I might have done something wrong or that – I will ask them was there anything wrong with the shower. (Staff Story, SS2).

Although this member of staff was trying hard to learn about how the patient felt, there seemed to be hesitation about asking this in a direct way. We see again the use of humour to perhaps mask feelings of hesitation in trying to find out this information. Thus, being curious and taking the time to ask about people's experiences could be integrated into the day to day routine of the ward, but it seemed to depend on the confidence and courage of the person seeking feedback.

Being direct in questions that seek to understand how others feel was valued by patients and families:

The doctors ask me how I think Mum is and this is nice and I value that they want to know my opinion. I would feel comfortable to ask if I didn't understand anything they said. (Relative Story, RS6).

In order to proactively seek feedback, courage was needed to feel open to hear a range of responses some of which may be uncomfortable:

I have not really taken the time to ask the staff why they feel uncomfortable with observation – sometimes I don't ask why because I am not sure if I want to hear the response. (Staff Comment, Action learning set5).

Thus, several factors influenced ability to pro-actively ask or tell someone about how you were feeling. One of the biggest barriers staff, patients and families talked about in relation to feeling comfortable to say how they felt about care was the fact that they felt people were 'too busy':

I hate having to bother staff when I need to get up in the night. I lie and twist and turn rather than pressing the buzzer. Then I press the buzzer. (Patient Story, PS7).

The phrase *I know you are busy but* was possibly a 'catch all' phrase that encompassed a number of other reasons why it was difficult or easy to say how people felt.

People seemed to feel able to say 'I know you are busy but...' if there was a relationship with the person and a belief that the response will be one of genuine interest. An excerpt from a student story illustrates these points:

I felt a bit powerless. I was counted in the numbers and we are not supposed to be. I didn't know how to say this to someone. I would be trying to catch up with my paperwork in the afternoon and would get caught. If my mentor had been there I could possibly have said something to her. I am not saying she would sort it all but she would understand. (Student Nurse Story, STS 4).

Expectations of the service might enable or act as a barrier to saying how people felt:

Thinking about her going home wherever that new home is – I feel optimistic, hopeful and encouraged that we are going on a new journey. I also feel in control

and that if a home is not suitable I will say because people ask me what I think and I think it is expected that I will have a view on this. (Relative Story, RS2).

Thus the perceived busyness of the ward, the extent to which people had developed relationships with others, believing that the response to your feedback would be one of understanding and expectations of the service seemed to influence whether people felt able to pro-actively ask or tell others about their experience. These issues are complex and require a culture that supports this type of dialogue. Culture is manifested in everyday patterns of communication. People need to be supported to engage in patterns of communication that are curious in nature that openly ask questions to learn about experiences. This issue of support is discussed later in this chapter. It may be that it is health care professionals who have to take the lead at role modeling these ways of relating, as patients and families may not expect them or regard them as appropriate.

4.3.1.3 Going beyond ‘they’ve had a good night’ or ‘we’ve had a good day’

There were examples across the data set where people had taken the time to tell others specifically how they felt. This sub-theme relates to the strong desire for people to know how and why they had made a difference. This is illustrated in a quote from a staff member in a beliefs and values session:

What’s important - for people to value my contribution, to get good feedback on how you are doing, not feeling under pressure to get things done – sometimes it’s beat the clock around here. For people to say I am glad you were on today because.... (Staff Comment, Beliefs and values, 6).

This quote emphasises the value of specific feedback. Staff gave examples of when they had received this:

One of the patients said to me she liked when I was on because there was no patter with me – she could tell me anything. (Staff Story, SS11).

One of the students said to me recently that she liked being on with me because she felt safe – this meant a lot to me. (Staff Story, SS9).

Relatives and patients also expressed pleasure at people recognising their strengths:

When we are in visiting we give him a drink ...Staff said he maybe takes it a bit better from me as he knows my voice. (Relative Story, RS4).

Staff sometimes say thanks to me because I have been looking out for Janet (another patient) when they have been busy. They know I will come and tell them if she wanders off. (Patient Story, PS9).

At multidisciplinary team meetings the consultant role modeled giving people specific feedback on a regular basis:

The nurse in the meeting said that the lady's wound was healing well. The consultant said 'I'm glad – you have worked really well on that one. I don't think any of us thought it was going to heal – well done'. The physiotherapist gave a very detailed description of how a patient was walking and when he became breathless. The consultant responded by saying 'thank you – that is exactly the type of detailed information we need. (Observation 5).

We see again the important contribution that the consultant made in creating a culture that valued giving feedback as part of day to day practice. Valuing people and sharing the specific qualities was appreciated by participants. Ability to be specific depended on taking the time to really notice different practices that were happening. AI facilitated this process of 'micro-noticing'.

In order to give specific feedback to people it was clear that knowing a bit about them as individuals was important. These instances of feedback did not necessarily take up a lot

of time, but were valuable in helping people to feel that they were being cared for as an individual.

Thus taking the time to ask and tell was something that staff could integrate into their normal day to day work and when this happened it was valued by staff, patients and relatives. Being able to do this depended on ability to notice what was happening and know something about the person.

On this ward, complaints often gave very detailed descriptions of what did not work well, which was in contrast to thank you cards which often gave generalised statements about good care. There did not seem to be systems in place within the organisation that encourage sharing and celebrating specific details about good practice. AI proved to be a useful approach to encourage people to be active in ‘noticing’ and therefore better able to express details about good practice.

4.3.1.4 Supporting people to hear and respond to how others feel

The sub-themes in this section so far have focused on recognizing emotion in order to be able to articulate feelings, pro-actively connecting with others by asking how they are feeling, trying to integrate this into day to day conversations in practice, and ‘noticing’ what is happening so that you can be specific about how you are feeling about experiences. The evidence above illustrates that when it works well it is valued, but it is not always easy to do, if feeling that everyone is too busy, and concerned about possible responses to being asked how you feel. Staff could feel powerless to do anything with or about the learning gleaned from hearing about others’ experiences:

It’s hard because you can hear about what somebody is saying but it can be difficult to do anything about it – sometimes there isn’t anything you can do. This just makes you feel bad. If there is too much of this you just stop asking. (Staff Comment, Beliefs and values, 5).

Thus, seeking feedback could feel like taking a risk in that you have little control over what might emerge and might be uncertain about ability to respond. This uncertainty was highlighted in the previous section in this chapter where staff felt they had little control over responses to their questions that sought to know what mattered to the person. Getting support to respond to feedback was not talked about by participants in the study.

People tended to focus on discussing negative feedback and often did not refer to positive comments. Throughout the course of the study I gave positive feedback to many of the staff. However, they tended not to feel comfortable about noticing and reflecting on the practices that had gone well:

I know you have come up to me and told me about things that I have done well but these are just ordinary things that I do and I feel embarrassed when you say these things. (Staff evaluation, SE4).

There were a few excellent examples in the data set where staff had heard and responded to feedback in a very positive way:

Beth (a patient who had a dementia) was served a cup of tea and a couple of biscuits were carefully placed on the table beside her cup. She said to me – ‘where is the plate – you wouldn’t serve it like that from your own kitchen at home would you?’ Sometimes things just happen on the ward and because you work there all the time you become de-sensitised to them and don’t notice them. The absence of plates was one of these things. It made us think about this for all the patients on the ward. We need to think about changing this. It’s those little things that matter sometimes. How important it is to hear Beth’s voice. (Staff Story, SS10).

This demonstrated staff responsiveness to feedback rather than defensiveness. It is not known whether the normal reaction of staff to this type of interaction would have been one of defensiveness, as the process of the research was such that there was constant role

modelling of asking curious questions, suspending judgment, considering other perspectives and discussing new understandings. The process of the research in itself was perhaps promoting a different way of relating in practice.

That said, the key thing that happened in the example above was that the feedback was given in a very clear and direct way, from the patient, and staff were facilitated to support each other through discussion to find a better way of giving care that took cognizance of other perspectives.

Staff were concerned that they may not be able to act on feedback. Thus, supporting people to hear and respond to feedback could feel like taking a risk. It can ask people to respond in a way that does not seem possible in an already stretched service. In the main, when participants talked about the term feedback, they related this primarily to negative feedback. Thus one can understand that starting to ask may not be something that people feel able or motivated to do as part of day to day practice. This raised questions about whether there were systems that could be put in place to help people to connect and directly ask how they were feeling in a way that would encourage respondents to work together to articulate both what worked well and what needed to be improved.

4.4 Chapter Summary

This chapter has described the person knowledge that was developed by staff, patients and families about each other. This knowledge had two key domains: *knowing who I am and what matters* and *understand how I feel about my experience*. When this knowledge was developed, it enhanced relationships, and enabled development of care that was compassionate and relationship-centred. Key interpersonal skills were required to develop this person knowledge, which involved:

- having the courage to emotionally engage;
- asking direct and curious questions;

- working collaboratively with people to consider other perspectives through a process of ‘checking out’; and
- being confident to make compromises with people.

For many, these skills were the invisible aspects of caring that were rarely talked about, recognised and valued and thus were not celebrated. For some staff, engaging in discussions to generate this knowledge could feel like taking a risk, particularly if the discussions resulted in supporting people who were distressed or in trying to find creative ways to respond to a person’s needs which may be outside the usual repertoire of possibilities. In addition, not everyone felt confident to communicate in this way. A particular challenge related to working together to make decisions about, if and how, this knowledge could be used to inform care giving. People needed support to work together in this way. Development of this knowledge seemed to be influenced by the process of the research itself which role modeled a way of communicating that emphasised being considerate of others’ perspectives, being curious, being celebratory about times when this worked well and being confident to use this knowledge in an open and legitimate way to inform care giving. This process of engagement through caring conversations is developed further in the next chapter.

Chapter 5 – Findings: Relational Processes to enhance delivery of Compassionate Relationship-Centred Care

5.1 Introduction

This chapter examines the key processes required to develop the knowledge identified in the preceding chapter. It further addresses objectives one and two of the study. Two processes: *work with me to shape the way things are done* and *engaging in appreciative caring conversations* are discussed. These processes relate to the interactions that take place to discuss and negotiate caring in order to get the best experience for all, taking into account the context of care. Data to support the first process were drawn from stories and observations with staff, patients and families during the discovery phase. Data to support the second process were derived primarily from the exit interviews with staff participants.

When the process *work with me to shape the way things are done* worked well, people were aware of *when you can and can't do compassionate relationship-centred care* and developed ways of working that help *to shape the way things are to be done*. These included *thinking and talking about how we do things and how we can do them even better, spotting opportunities and knowing the possibilities* and *being proud and sticking to principles of person-centredness*. Engaging in *appreciative caring conversations* that connect people emotionally, and exhibit curiosity, collaboration, consideration of others'

perspectives, courage, compromise and celebration emerged from the data as key processes that enable people to *work with me to shape the way things are done*.

5.2 Work with me so we can shape the way things are done

Giving and receiving care in a way that met the needs of all those participating in care required involvement, negotiation and compromise. Dimensions of this process are presented in Table 16. Staff recognised the complexity of caring and reported ‘bending the rules’, and being creative about how they made decisions about care delivery. Patients and families did not necessarily refer, in their stories, to negotiation but talked about realistic expectations they had of the care environment and their appreciation of being involved in decisions.

Table 16 - Key process: work with me to shape the way things are done

Key Process	Theme	Sub-theme
<p>Work with me so we can shape the way things are done</p>	<p>Knowing when you can and can't do compassionate relationship-centred care</p>	<p>-working with what is in your control and what is not -taking the time to work with processes to get the best experience for all - confidence to challenge the way things are done -being open and real about expectations</p>
	<p>Developing ways of working that help to shape the way things are to be done</p>	<p>-thinking and talking about how we do things and how we can do them even better - spotting opportunities and knowing the possibilities -being proud and sticking to principles of person-centredness</p>

5.2.1 Knowing when you can and can't do relationship-centred care

There was general agreement from patients, staff and families that care could not always be 'perfect' and that everyone had to work creatively within the constraints of the organisation. However, a number of strategies were identified from the data that seemed to help working together to deliver good care. These strategies involved taking time to discuss how care could be given, considering all perspectives, challenging the way things

were done, and sticking up for agreed ways of working, even if they were out with the ‘normal’ rules. For these strategies to happen, people needed to have clear expectations and a vision for caring on the ward.

The theme of *knowing when you can and can’t do relationship-centred care* reflected the challenges inherent in the unpredictable world of practice. Staff had to negotiate and adapt practices to meet the needs of individual patients, families and their colleagues. The quote below from a member of staff illustrates the complexities of caring for a man who was a prisoner:

I have found it quite difficult caring for him. I have really tried to be professional by asking ‘how are you?’, ‘did you sleep well’?, things like this, but I haven’t chatted to him as much as I might have done with other patients. I don’t know if this is because he is quite withdrawn anyway, or if I have avoided doing this. It’s funny because it’s like the reverse of what you would do with other patients. You would try to get to know them as a person and I have not done this with him – I have just got to know him as a patient. (Staff Story, SS12).

In the case above, the staff nurse had to have a level of self awareness to understand why she was caring in this way. She did not feel able to give truly relationship-centred care in this instance. An element of compromise took place. There is evidence here of the importance of managing the self within the relationship, a point already discussed in Chapter 4.

A number of sub-themes related to developing this awareness of *knowing when you can and can’t do relationship-centred care*. These are illustrated with data extracts below.

5.2.1.1 Working with what’s in your control and what is not

Meeting individual choices and preferences was not always possible in the complex world of health care, where there were often competing priorities, organisational rules and different levels of expertise. Being able to work in a flexible way to get the best

experience for all stakeholders was a key consideration in the delivery of compassionate relationship-centred care. Having knowledge of what is within your control as a patient, family member and staff member seemed important to be able to work in this way. The following quotes illustrate an understanding people had of themselves or the system that enabled individual care:

I like this ward because I am given a lie in bed until the breakfast arrives or I am offered breakfast in bed. I like to lie in at home. I was always asked to get up much earlier in the other hospital; it made it a very long day. (Patient Story, PS1).

I like to take her out at visiting as sometimes I have to speak quite loudly to her and I am worried that I am disturbing the other people in the bay. (Relative Story, RS5).

I'm not a medical man so I couldn't necessarily answer all her questions but I said to her if there was anything she wanted to ask about – if I couldn't answer I would go and ask the nurse in charge to come and have a wee chat with her. (Staff Story, SS2).

Recognising what is not in your control was important, but could leave people feeling dissatisfied with the care they gave or received:

Some policies, for example, shoving filthy laundry in a bag for the relatives to take home – we are not allowed to clean this out or rinse it through – I feel really bad about this and it is so degrading for patients – this is not compassionate.... (Staff Comment, Beliefs and values, 6).

Feelings of dissatisfaction arose in this instance as the nurse was unable to act out her ideology of practice. Staff did not always feel able to challenge the system. Staff were uncertain about the consequences of challenging aspects of practice and did not

necessarily feel confident that they would be heard. This staff member felt that senior staff '*probably don't even know we are asking people to do this – they are not on the floor having to deal with this sort of thing*'. In discussing this example we found that special bags were available which could be put straight into the washing machine, thus avoiding the problem of a relative handling soiled clothes. Having the confidence to be curious to ask questions and not assuming that others do not care about what you are saying were key issues that emerged from this example. The process of the inquiry helped people to turn the negative narrative into positive discourse that focused on understanding perspectives and exploring possibilities.

Finding ways to collaborate and share control of situations was evident in the data extract below:

One of the relatives asked the charge nurse if her Mum could have her tea out of a china cup if she brought one in. The lady's mother had been in hospital for several weeks and was getting fed up of drinking her tea out of the plastic cups. The charge nurse said this was fine and put a label above the bed saying 'tea in china cup'. This was because the domestic staff who served the tea each day were not consistent and many did not speak English. On several occasions the patient did not get her tea in the china cup. The charge nurse had a further conversation with the family to ask if they could help when they were in visiting, by offering the teacup to the domestic and making sure that it did not go back on the trolley to be washed. (Informal observation recorded during field work, May 2008).

The hospital system did have certain constraints on the activity of caring, however patients, families and staff seemed open to working with what was in their control and accepting those things that were not. What seemed to matter, was having open conversations about constraints and possibilities and working together collaboratively around these. Patients and families seemed to accept compromises because they understood what was happening in the wider context of the ward and, in the case highlighted above, were invited to be involved in a shared responsibility for making

changes. These key skills of collaborating and compromising are developed further as significant attributes of appreciative caring conversations in a later section of this chapter.

5.2.1.2 Taking the time to work with processes to get the best experience for all

Working together with all those who were part of the caring process was an aspect of caring practice sometimes evident on the ward. Compromises had to be made which often required skilled communication. A key part of the process of taking time to get the best experience for all involved was ensuring that the patient and or family were seen as key collaborators, and included in decision-making:

The consultant approached one of the patients who had been in hospital for some time and would require quite an intensive package of care to enable her to manage at home. The consultant sat down beside her and asked her what she found difficult to manage at home and what she thought she needed to help her to manage at home. (Informal observation recorded as field work, May 2008).

Again the important skill of considering the perspective of another during dialogue is highlighted. Taking time to get the best experience for all through engaging in dialogue was not always seen as easy. One staff member articulated through her story the resilience, perseverance and time that was often needed to find out what the best experiences for all would look like. She talked about caring for a lady who had volatile moods and often swore or shouted at staff and fellow patients:

She said she didn't eat porridge and that she wanted something else. She didn't want a roll she wanted toast, then she didn't want the toast, then she wanted a brown roll. I gave her a selection. She had everything- she had brown roll, toast, butter, flora, cornflakes, rice krispies, porridge, she had everything we had, but there was no pleasing... I found it difficult helping her to eat. My concern was she was not eating and she would be hungry. I was making her cups of tea and coffee just to make sure she was getting fluids.

She was calling us names and she said she hated me – and I said to her ‘but that’s all right because I like you that’s why I’m trying to help you. ..’ I felt like giving up but then I asked her if she wanted to go for a walk. ... I know I had lots to do but prioritised spending time with her because she was getting the other staff down.

Going for a walk with her helped me to find out a bit about her – she was talking about her family and how they felt she would be safer if she went into a home. ..She felt that she had to walk to prove that she didn’t need to go there. .. Getting better at walking was the thing that was key for her, not eating. She started to say that I was her best friend. Not showing I was frustrated was important. I needed to find the key to get in. (Staff Story, SS5).

The tone of this account suggested that the staff member was frustrated by the reactions of the patient and her inability to provide ‘good care’ as she saw it. The staff nurse recognised her own emotion in caring, and took time to work with the processes of ‘*knowing who I am and what matters to me*’ and ‘*understand how I feel*’ in order to move to a place where both the patient and the staff member were working together to shape the way things were done, and gaining a sense of satisfaction with caring.

Taking time to get the best experience for all can however involve taking risks. When does a staff member decide that ‘the professional knows best’ and use this to influence care giving? The following quote illustrates a time when a member of staff made a professional judgment of what she felt was best for a patient:

The patient was in one of the bays and he smelt really bad. It was hard for the other patients. The smell lingered all day...I was quite firm with him. I did say to him that having a shower was going to make him feel really good. He felt great afterwards. I think it was good because I almost took it out of his hands in a way. Choices are really important for people, but I think for him he was just past making any. I kept on saying things like how bad we would feel that we hadn’t

even given you a wash while you were in hospital. I said I was going to be really quick and that it would be lovely warm water and things like that. ... I didn't mention anything about the smell or anything. I think initially I thought- yes this is your choice, but then after a few days I made that decision that it would be good for him to have a shower, after speaking to the family and thinking about others around him and thinking about him. Maybe I was just taking control of the situation. (Staff Story, SS1).

It is evident that the staff member considered the perspectives of a range of different people, including other patients on the ward, in making her decision. Including the family in the decision making helped to minimise risk in this instance. Risk relates to potential negative consequences of communicating in an open and honest way, and to making decisions with people that may be in conflict with organisational policies, cultural practices or personal philosophies. Taking a risk asks that people act in courageous ways. Processes involved in AI, of asking unconditional curious questions to get at the heart of why something happened, enabled staff to share times when they took a risk. In addition, actions that resulted from risk taking legitimised as compassionate by the research process, gave staff confidence to share other experiences of risk taking and negotiation. To ensure an optimum experience for patients, families and staff, an environment where it was safe to challenge the status quo was required. This is explored in the next section.

5.2.1.3 Confidence to challenge the way things are done

There was some evidence that staff felt able to challenge each others' caring practices. This was often witnessed at handover meetings where conversations about care were seen as legitimate, as the following extract demonstrates:

There was a patient on the ward with cognitive impairment who needed constant care. What had been happening on the ward was that when the bank nurse came to provide constant care – she was given a summary of the patient's needs and then spent what was sometimes a long day with this one patient. One of the staff

nurses on night duty challenged this by asking others at report – ‘ why do we ask the bank nurse who does not know the patient to do this job when we know that for the person with dementia they respond much better when they know the person. Is there a policy on this – can we think about changing this’. (Informal observation recorded during field work, Aug 2008).

Having courage to challenge each other seemed to be influenced by the perception that your opinion would be heard, considered and valued. Some staff had confidence to challenge behaviour irrespective of status in the organisation. The quote below illustrates this in an interaction that was observed between nurses and doctors:

One staff nurse was surprised at the way in which a new doctor to the ward spoke to a patient. .. The patient had difficulty in hearing and the doctor spoke loudly to the patient from a distance. The staff nurse said that the patient was very deaf and that he should get up close to speak to the patient. The doctor continued to raise his voice. The subject was brought up again after the ward round by the charge nurse with the staff nurse and two doctors. They had a discussion about the difficulty of communication and knowing the patients. (Staff Comment, recorded during field work, Aug 2008).

There were several examples, during the course of the study, where one of the consultants acted as an advocate for nurses on the ward in challenging processes that were not felt to be empowering, human and appropriate. For example, the ward had failed a recent audit for infection control. The consultant challenged the way in which staff received feedback, and the way in which opportunities for learning had not been seized.

There was evidence in staff-patient interactions that some patients did feel able to say what they wanted to and challenge what was currently planned or happening:

One of the staff nurses went up to a patient who had a degree of cognitive impairment and said ‘good morning Elizabeth – did you sleep well?’ The lady

said yes and that she could call her Beth if she wanted. The staff nurse said would she like her to change the name above her bed from Elizabeth to Beth so that we all knew this – ‘no, I don’t think so I think it is a bit childish to have the names above the bed because I know who I am’. The staff nurse asked the patient if she would mind if we left the name up there so that others who did not know her so well could address her by her name. The patient said yes that was fine. (Staff Story, SS5).

Staff recognised how difficult it was to challenge caring dimensions of practice and related this to the fact that the challenge was often personal and related to individual beliefs and attitudes.

It is not clear however if all had the courage to challenge practice. This raises questions about what needs to be in place to support people to interact in this way. From the data presented here, role modelling challenge and inviting people to examine situations through careful curious questioning seemed to be important. In addition, having a clear set of principles for caring, enabled people to challenge others. In order to have this clear set of principles, that people felt confident to defend, there needed to be open dialogue, and clear understanding of what the expectations were in the context of the environment in which care was given and received.

5.2.1.4 Being open and real about expectations

Patients and family members often had good understanding of what was possible on the ward and had realistic expectations:

When I was lying on the bed and the Doctors came round they asked me how I felt and what were my problems. The curtains were round me. I suppose other people in the ward could hear what I was saying – but you don’t think of that - you are just pleased to tell someone how you feel ... you are not thinking about anybody else. It’s hard because you couldn’t ask them to speak quietly. (Patient Story, PS6).

Staff enjoyed hearing about patients' realistic expectations as it helped them feel supported rather than criticized. Staff found that if they were open and real about expectations and had confidence to explore this with others they were able to defuse situations that had potential to create conflict in the relationship:

We had one lady who hated the hoist and hated the commode and yet it took a nurse half an hour to help to walk this lady to the toilet. The nurses could not always do this and the patient got exhausted doing this more than twice a day. The patient got really angry with staff and her family if she was not walked through to the toilet. We had to come to some agreement about the way forward. This was about walking through maybe once a day but at other times using the commode – coming to a compromise and reviewing this on a regular basis if this changed. I think we all felt more comfortable with the situation. (Staff Story, SS12).

This demonstrates partnership working through compromise, but not all staff had the confidence to engage in this way of working.

Being open and real through sharing uncertainty can also be difficult as there is potential to be thought of as 'somebody who does not know':

I had hopes, but I don't know how to help her." (Comment from Consultant, Observation 5).

In the above quote a degree of humility is evident, where the consultant did not assume that he would always know how to offer the best intervention. Role modelling uncertainty seemed to create a culture of openness and honesty where people could share real concerns. Sharing openly in this way could be seen to open up dialogue for *working together to shape the way things are done* in that others were invited to put forward suggestions.

Having collaborative conversations with staff, patients and families about expectations and being able to be open and real about this required confidence, as often the discussion needed to focus on what could be done. However, the benefits of the shared understanding that emerged often meant that people were more satisfied with caring.

5.2.2 Developing ways of working that help to shape the way things are to be done

Staff, patients and families developed a number of strategies that seemed to help them engage in meaningful conversations that meant that people felt they were working together to shape the way care was given.

5.2.2.1 Thinking and talking about how we do things and how we can do them better

When staff, patients and family members felt that individual needs were not being met or that they had concerns, talking together about how to make practice better was something that happened often on the ward. These conversations often involved listening to others' perspectives and negotiating a way forward that was manageable in the context of the care environment.

We often have a situation where a patient is reluctant to do things for themselves. It is hard to be compassionate in these situations. We had a woman, who if you were out of the room for two seconds, she would get up and walk herself to the toilet, but if you were in the room she would not do anything for herself. ... We were talking about this as a team and the frustration we felt... We talked about how we could make things better. What seemed to help was if we sat down and had a discussion with the patient about what they wanted and what we wanted and sort of made an agreement that we were going to work together. We kind of struck a deal – this really worked – she kept to her side of the bargain and we

kept to ours – it's like tough love – but it helped to be clearer about things and our roles. (Staff Comment, Recorded during field work, Jan 2009).

There was an element of risk associated with this type of negotiating that seemed to be eased when conversations were based on mutual respect and genuine caring.

Staff did involve patients and family in discussions about how to improve care, where appropriate:

One of the ladies on the ward was in her last few hours of life. There were so many family members involved in this lady's care and they all had their own idea about how the patient should be cared for... I felt I could not manage the night unless there was a clear plan of what we were going to do. I said to the doctor that the family were really anxious and concerned and could we talk together about how we can make the patient as comfortable as possible. I invited the family and the doctor to come into the meeting room to speak together about how things might go over the next few hours. We all came out feeling more confident that everything was going to be done to keep her comfortable – the family began to realise at this point that things were probably not going to get better. There was an acceptance – I felt we were all working towards the same objective. They even began to take a lead with some of the care. (Staff Story, SS10).

This nurse, through her connection with the family and understanding of the situation, was able to instigate the meeting to pave the way for the family to share the patient's last few hours of life.

Much of the thinking and talking about 'how things were to be done' related to times when caring was difficult or had not gone well. It was often related to crisis situations rather than day to day acts. Although the discussions were thoughtful, and in many ways empowering, the starting point was from a problem in practice. There is scope to learn to deliberately engage in conversations that help us to talk about how we deliver care when

things have gone well. This is highlighted further in the next findings chapter where one of the action cycles deliberately supported staff to identify what worked well and why, and debate how this practice could happen more of the time.

5.2.2.2 Spotting opportunities and knowing the possibilities

Working creatively to think about what could be done to enhance care experiences was evident on the ward:

We knew that she liked knitting ... She sat in her chair and started to fiddle with her knitting needles. Part of her knitting had come off the pin. She was struggling to get it back into place. I asked if I could help. She passed them over and I managed to get them back into place. I have not knitted since primary school but enjoyed the challenge and the memory this brought back for me. It made me think about how much I enjoyed sharing in the wider aspects of a person's life, not just the medical part. The knitting can be frustrating for her as it reminded her of what she can't do. After talking to her recently, we found out that she enjoys winding up the wool from the hanks to make the balls. We do this with her now when we have time. (Staff Story, SS7).

This intervention by the nurse resulted in the patient feeling that she had 'something to do' when she was restless. The quote highlights the mutual satisfaction for patient and staff member in developing and working with this knowledge. This type of person knowledge however was rarely recorded in notes, resulting in a missed opportunity for learning.

Spotting opportunities and knowing what was possible was not always straightforward and often involved an element of risk. The staff nurse who shared the story in the extract below was anxious about telling the story as she felt she may 'get into trouble':

When she was coming towards the end and I wanted them both to have a hand to hold – I said 'lets just disconnect the drip; it won't make any difference at this

stage' and they held her hand. I suppose the drip can be a symbol of hope – it's hard. .. I just sort of hugged them and they held her hand. They were sobbing. Then one of them really started to take the lead with things – it was when she said 'can we take the oxygen off' – and I said 'yes it was okay'. It's hard, the noise of the oxygen, and she had such a small face - the mask enveloped her face– they wanted to take it off. It was not natural to have it on. I said 'it's okay'. We just sat there and she passed away. (Staff Story, SS10).

This nurse was anxious as she felt that she had deviated from the rules and policies. Sharing practice, where risks had been taken, was not usual on the ward. This meant, however, that these practices could not be recognised as legitimate, with the result that the nurse was left with feelings of guilt and dissatisfaction about her care. This raises questions about what needs to be in place to help people feel safe to talk about times when they have taken risks. The processes inherent in AI created a space where this could happen.

In the extract below a care assistant thought creatively about how he might support a lady to take fluid in preparation for an investigation:

It was night duty and one of the patients needed to drink laxative mixed with two litres of fluid in preparation for a bowel examination the following day. The lady had a degree of cognitive impairment and had managed to be persuaded to drink all the fluid in one of the jugs but was reluctant to drink any more. One of the care assistants sat down with the lady and had a glass of water in his hand. He sat and drank his water and asked the lady if she would like a drink too. He poured her a drink and they both sat and drank their drinks together. The lady ended up drinking the full preparation and chatting to the care assistant over the next half hour. The ward was busy but staff prioritised this over other tasks. (Observation 10).

Again, there was an element of risk associated with this example in relation to both the coercive nature of what he was doing and prioritising this aspect of work over other competing priorities. The account recognises that sometimes decisions are made to meet one patient's care need at the expense of other important needs, in this case, the competing pressures about settling all patients down at night time.

Spotting opportunities and knowing the possibilities seemed to relate to context-dependent judgments made in real situations. Data suggested that clear communication with others about why particular care practices were happening or had been prioritized was important. This helped to validate actions and minimise risk of judgments being made about a particular action out of context.

What the extracts above illustrate was a desire by staff to be creative and strive to provide genuine and imaginative care through being considerate about the perspectives of others. This often meant compromising and being courageous in situations where the consequences of an act were uncertain.

5.2.2.3 Being proud and sticking to principles of person-centredness

Some patients, families and staff were able to stick up for what they believed in, to ensure that care was person-centred. In the quote below, the relative felt empowered to challenge what was happening and acted in a way that felt consistent with her beliefs and values:

Once Mum had died we did wonder if Jessie – one of the other patients - knew about this. Jessie and Mum had struck up a friendship when they were in the ward together. I said to one of the nurses – ‘oh can you tell Jessie that Mum has died’ – she looked at me, and had furrowed brows – I don't think she thought this was important. In the end we told Jessie that Mum had died. Death happens to us all and it can be important to some people to know what has happened. (Relative Story, RS8).

Informing other patients that somebody had died did not happen on the ward. Staff had not really considered this as important. What was important here was that the relative had the courage to speak out and influence what was happening.

The quote below demonstrates, albeit in a subtle way, how a patient felt able to shape care in a way that fitted what she wanted:

I get on well with all the nurses. I am able to do things for myself again and I love having my independence back. Some of the nurses still ask if they can help me with things. I like that but tell them I will manage. (Patient Story, PS4).

Having courage to stick up for what you believed in seemed to have a positive impact on staff. One staff member expressed a feeling of achievement in the following quote:

I feel a real sense of achievement here if I have stuck with something. You know if a patient is suffering and I need to get them to up the analgesia, then doctors get caught up and nothing is done – I have to go back and say it again. Sometimes it's been difficult, but if I get it in the end and I have made a difference to that patient that feels good. (Staff Story, SS3).

The data suggested that having the courage to stick up for what you believe in was influenced by having a clear sense of your own beliefs and values and the values of the ward. Such actions were further facilitated if they were deemed 'legitimate' by colleagues. Staff felt that it was not usual to openly share times when they had to 'bend the rules' or 'say they were sorry' and that the research process had given them an opportunity to share these experiences.

The process of *working together to shape the way things are done* often involved being flexible and open to possibilities. To do this, people had to engage in conversations about shared expectations to guide the way forward. The data reflected a number of strategies used to help people to engage meaningfully in these conversations. To be able to

implement these strategies people needed to have courage to take risks, aided by having shared responsibilities for actions. The data extracts above illustrate when this process worked well. Reference has been made in this section to the impact of the inquiry process itself on supporting staff to, for example, ask curious questions, consider others' perspectives, feel confident to stick up for what they believe in and collaborate in a way that meets the expectations of patients, staff and families. Thus, engaging in appreciative caring conversations was important. Indeed such conversations were identified from exit interviews with staff as the most important process that would help them to continue to grow and flourish. The nature of these appreciative caring conversations is described in the next section.

5.3 Engaging in appreciative caring conversations

The findings have already highlighted the importance of engaging in conversations to develop person knowledge and to work with this knowledge to shape the way care is delivered. In this section the process of appreciative caring conversations is explored further by analysing the findings of the exit interviews from staff that identified specific attributes of these conversations. The findings illustrate how staff were now using these attributes more consciously in their day to day conversations and how the development of this greater awareness enhanced their ability to provide compassionate relationship-centred care.

The data suggested that staff became more appreciative practitioners throughout the course of the research and that the key process necessary for them to develop in this way was engaging in caring conversations.

The key characteristics that helped people to engage more deliberately in a facilitative and appreciative way during conversations are shown in Table 17.

Table 17 - Key Process - Engage in appreciative caring conversations

Key process	Characteristics
<p>Engage in appreciative caring conversations</p>	<ul style="list-style-type: none"> • Being Courageous • Connecting emotionally • Being Curious • Collaborating • Considering other perspectives • Compromising • Celebrating

These attributes were commented on by staff both as aspects of the research process and as attributes of the way in which staff now felt they approached their practice.

Conversations were happening more often on the ward and people felt that they talked more about caring. All data in the next section were derived from the exit interviews with staff (Quotes are attributed using the following system: SE13 denotes staff exit interview number 13).

5.3.1 Being Courageous

Having courage to act in a particular way was related to willingness to take risks, feeling confident to ask questions, work with uncertainty and ability to stick up for practices that people believed in without feeling that there would be a negative consequence. For staff, there were many examples across the data where people took risks and felt they had more courage to stick up for these actions, and articulate what they believed in:

The biggest thing for me about doing the work on the project is feeling much more aware about how I behave, being braver to ask patients and families more direct questions, being stronger in sticking up for the things I believe in and being much

clearer about what it is we do well around here. To the senior nurses, go gently, it can be hard to look at yourself and change things that are at your core. (SE8).

Many staff felt that their increased ability to stick up for principles of personhood enabled staff to stimulate actions:

The ward has to have a routine and a structure but it does not have to be so strict. This has changed. There is more choice for people about when they get up in the morning, and more flexibility with, say, visiting times. Just not telling patients what to do. It used to be on here that all the washes had to be done by lunchtime but now you hear people saying 'oh they have had a bad night' or 'they are in pain I think we should leave them till later.' It's also given me the confidence to say when things are not going so well and be more open about this. (SE7).

People are more confident to stick with what they believe is right. Like the expectation that so many patients will be got up in the morning – people still expect this but it is easier now to do what you think is right. (SE11).

It was not just about feeling able to stick up for principles of compassion for patients, but with other staff. A staff nurse talked about a time when she did this:

It was like the other day when I was on I could see that the lights were still on in the ward next door. I went over to offer some help. We were not so busy, everything was done and I told the staff I was going to help out next door. I think the other ward really appreciated the help. When I got back one of the staff members made a comment about how long I had been away. I felt I was able to speak back calmly to her in a way that I might not have done before. I said that I thought it was the right thing to do and that I hoped one day, if we were in the same position as them and needed some help, somebody could do this for us. I think it is important to offer to step in and help without being asked. (SE11).

Advocating principles of person-centredness and doing this in a way that was measured and balanced felt good for this member of staff. However, knowing when to be flexible, listen to others and stick to principles you believe in, all at the same time, was seen as challenging:

It's funny, because on the one hand I think I am listening to others' points of view more but I am also being firmer and more vocal about what I believe in.

Sometimes I am not willing to budge if I think that the thing is the right thing to do and sits with what we have all agreed as a way of working. (SE3).

Many of the staff were more confident to stick up for practices that they believed in during conversations with each other. This gave them a degree of satisfaction in their work where their beliefs and values had more congruence with their actions.

It seemed that having courage was a central attribute that enabled the other attributes of caring conversations. For example people felt that it was risky to ask patients how they felt (connect emotionally) and what mattered to them (being curious) as they may share something that is difficult to respond to. Similarly efforts to collaborate, consider perspectives and compromise required courage particularly when the ideas expressed were different to your own. There is evidence also in the data that celebrating practices also took courage as this was outside the limits of normal practice and people could feel embarrassed when this was done.

5.3.2 Connecting emotionally

Staff seemed to have more courage to connect emotionally with others in a deliberate way than before the study commenced. For example they created more opportunities to express their own emotions about caring:

We had a situation where staff had to hold down a person with dementia – staff feel terrible about this. It's trying to think of other ways to support the staff. But I think we talk more about these emotional challenging situations. Doing the emotional touchpoint story with staff has been really useful. I think staff feel better about talking about it and it helped me to understand how they are feeling. (SE3).

Staff seemed to acknowledge expression of their own emotion in caring as legitimate and helpful.

In addition, staff felt that they connected more with patients by asking them how they felt:

It has made us more aware of the bonding with the patient. You are not just showering a patient, you are using the opportunity to be with them, to talk to them about how they feel, to help them to feel less embarrassed about being naked in front of you. I think we are much more aware of this. We know more about the little things that matter to them and this is talked about more. (SE2).

The increased awareness of the importance of the emotional connection with a patient and the fact that this type of dialogue could be weaved into day to day acts was evident. Making an emotional connection seemed to be more of a conscious act during dialogue:

I think patients feel more able to say what they would like now – they are more often asked and able to tell I think. (SE12).

The creation of an environment where people felt safe to express how they feel and were actively encouraged to do so was something that staff now valued and recognised as something they were committed to continuing.

5.3.3 Being Curious

The approach adopted in the research process was to be curious, and try to suspend judgment about a situation in order to truly understand what was happening. Staff valued this approach:

It feels as if you have asked us lots of questions. This felt a bit strange at first, but now we are used to it. I think we feel more comfortable with it and more sure that you are not going to jump down our throat if we say something that you don't agree with. (SE2).

Being more curious about what was happening in practice was becoming more deliberate:

Staff question practices more and realise that we need to check things out with patients. This feels like a normal thing to do now. It is expected. In the past people might have been a bit on the defense with questions like this. (SE9).

Staff were feeling more at ease with asking, hearing and responding to questions. It was becoming a legitimate way of working. Thus, there was something different about the way in which conversations about practice were facilitated. Conversations seemed to stimulate open discussion:

People talk about care more. They question things, but in a nice way. One of the staff nurses will say now – 'how could you have said that in a different way'. The project has kind of given us permission to say this kind of thing. (SE6).

Staff seemed to be supporting each other to consider other ways of communicating. This type of supportive challenge was now seen as a legitimate part of the way in which staff communicated. There was evidence that staff were offering their support in a more deliberate way:

Because of the photo-frame and the discussions we have had with this, I find myself saying to others, things like ‘what would help you with this? how can I help you?, what’s going to make it better?’, rather than moaning with them. (SE9).

Asking colleagues to reflect on care practice was also something that some staff felt more confident to do:

The other day I actually asked some of the nurses who were sitting at the nurse’s station and had seen me talking to a relative how I did. It was a difficult conversation with the relative and I was not sure if I had come over a bit bossy. I asked the others. They said it was fine but one member of staff felt I might have been a wee bit patronizing. We talked about this and how it could have been done differently. I would never have done this before, I suppose because I didn’t really trust people. (SE17).

What the evidence reflects is that people felt more comfortable about being curious and asking questions. Thus, there was evidence of a change in culture on the ward, where people felt safe to engage in this type of dialogue.

5.3.4 Collaborating

Being open to the direction of travel, to encouraging the contribution of others and facilitating joint decision making, were important aspects of the way in which staff interacted with patients, families and each other.

Not all staff had been practising in this way. As a result of participating in the study, there seemed to be greater awareness of the need to take the time to involve others. The practice of ‘pausing’ to bring others along with you was seen as a different way of working by one member of staff:

I think in the past if I wanted something to happen I would have bashed on and did it. Now I am trying to bring others with me. (SE3).

Collaborating with patients and families was something staff routinely did when working with them to plan their care, but this was less apparent with respect to other forms of involvement. However this too seemed to be changing over time:

I think more about how patients can help us to decide on what to do. It was like the booklet for helping people to understand what it was like here on nights as a relative – we would just have gone off and done this and not thought about what the relatives might think of it. We even asked them the other day if they could comment on our booklet for students. We are encouraged to put up charts on the wall about our infection rates and sickness. I asked a relative if she valued this information (it is on a board on the wall for everyone to read). She said she could not make sense of the information and would like to see a sheet up that tells relatives which staff are on duty and when they will next be on. (SE3).

It now felt more natural to collaborate with patients and staff on development issues related to the ward.

Recognising that not everybody wanted to collaborate in the study was something that participants also highlighted:

There have been some people who have just bolted – they have not wanted to be involved... ..I have seen some of them coming on board and they don't even realise it but there are still others who will just dig their heels in. (SE10).

Collaboration took more time and staff had to deal with the frustrations of those who did not want to be part of the work. Throughout the course of the study the charge nurse became clearer about what was optional in terms of collaboration and what was not:

It's like the images and statements, when we have decided that this is what we are going to do, it is not optional. It is the way, as a team, we have decided to act and deliver care. So although some people don't want to be involved, in say the discussions, they need to be involved in the agreed action and, I as the leader, have to put that forward. (SE3).

Thus opportunities for collaboration, and what this meant to staff, both within the study and within their practice, were considered more and acted on in practice.

5.3.5 Considering other perspectives

Processes used in the research study considered a wide range of perspectives. So, for example I consistently checked out what a piece of data meant to others in the context of the care environment. Consideration of others' perspectives was something that staff felt they were more conscious of, during conversations:

When we talk about things now, I feel I listen to other people's perspectives. More people are involved in decisions. (SE5).

Another key thing the project has brought out is highlighting that we make a lot of assumptions about things and we need to be much better at checking things out. This has been one of the biggest things for me. (SE3).

Hearing the patient side of things has been an eye opener. (SE1).

The reference to eye opener, in this quote, reflected the fact that the patients' perspective was often different to the professionals'. Considering another perspective enabled people to value different expertise that could contribute to caring. A degree of humility was required to feel comfortable to hear another's perspective:

It is hard sometimes, because the patient has come up with things that are sort of unexpected. It is not necessarily what you think is right but you have to back down and think, well they are not going to come to any harm if we do it this way so why not. I feel more confident to do this now. (SE17).

Creating opportunities where people had permission and space to consider perspectives seemed to be important:

We get together at 11 o'clock now and we talk about care. We did this before, but maybe not everybody did it. It is expected now that you would put your point of view across. (SE16).

Considering perspectives was not just about considering the perspectives of others but considering and being aware of your own perspective and how this has an impact on others:

For me, I am much more aware about how I treat patients. Not that it was bad before, but little things about what to call people and asking people things in a much more direct way. I am much more aware of my attitudes towards things and how that can affect what I do. It does not mean that I am a bad person. I think it's okay to have done some of these things in the past but now I know another way. (SE7).

Further evidence to support the centrality of the attribute of considering another perspective was highlighted in the photo elicitation worked carried out with staff, towards the end of the study. These images and statements can be found on page 111 in Chapter 3. What was strong in these messages was a realisation that something not previously considered important was now seen as important – that of the voices of those who receive care. Thus, being open to hearing perspectives, recognising that they may not be the same

as yours and feeling comfortable to discuss this in an open way was something that staff felt more able to do.

5.3.6 Compromising

Ability to compromise was a skill that staff felt they had developed throughout the course of the study:

I think we are more open now about saying what we can and can't do. The project has sort of helped us to say what we feel, and our opinion has counted in decisions that are made about care. It has not all been about what the patient thinks and wants because sometimes this can be unrealistic. (SE7)

Staff felt more comfortable to share examples of when they had made compromises and these were documented as part of an agreed plan of care:

We might have negotiated things with patients before, but we did not always say to others what we had done, possibly because we were a bit embarrassed that we had to compromise and not give the best care we could. (SE5).

Thus, the act of compromising seemed to be something that was more openly acknowledged on the ward.

5.3.7 Celebrating what works well

Celebrating what was working well was inherent in the approach of AI. This felt like a new way of working to staff. Some staff recognised the sensitive nature of the topic of exploration (compassionate care) and the appropriateness of an approach that celebrated what was working well:

I think it has been good that you have looked at the good – it would have been too hard for us all if you had looked for problems because Compassionate Care is about you as a person – so you would have been criticising us as people and that is hard – it’s not like looking at say infection control and saying ‘you have not washed your hands enough’ – that would not hurt – but saying something about you as a person would. (SE5).

Staff felt that they already gave positive feedback to patients and families by encouraging them with their recovery and thanking them for contributions. The comments they made in exit interviews related more to how they celebrated each other.

Staff responded to positive feedback in different ways:

There have been little things that you have noticed that we do well and it’s nice when you share that with us and I can think ‘oh I do that’ – it feels good. (SE14).

I think you have picked up things that I have taken for granted, good things – but as I said, this does not feel good – praise. (SE4).

Being celebratory was something most staff valued about the process of the work and began to recognise this as a way in which they now worked:

I try to commend people for good things more now. Before, I think when I thought people did things well, I didn’t say anything because I just thought it was part of their job. I do try to say these things more to people. (SE17).

The approach has made us more appreciative of each other – I know that that is what you were trying to do – appreciate us – but I think this has rubbed off on the whole way we are with each other. (SE3).

Thus many of the staff were making a conscious effort to be more celebratory in their interactions and were valuing the outcomes of this:

I think we try to see a way round things now, instead of getting bogged down with things that get in the way. (SE7).

Celebrating care practices that worked well seemed to help to legitimate compassionate caring practices:

Learning about all the things that have come out of the project has been so useful. On one of the charts on the wall it talked about how important personal sharing was – so learning a bit about who the patient was and sharing a bit about who you are as a nurse. In the past I would not have said that I do this to others as they may have thought it was unprofessional, but seeing it up there on the wall – it's like we have agreed it is okay to do this – it is recognised as important. (SE12).

If compassionate caring acts are to be recognised as significant ways of working then these acts need to be celebrated. Celebration of these acts emerged as a key consideration in a model of compassionate care.

Whilst these ways of engaging were evident in many data extracts presented earlier in the findings chapters, staff were not necessarily conscious of and deliberate about this way of working during their interactions. Thus, through the exit interviews staff identified how the study had enabled them to engage in conversations in a different way. The findings present evidence that staff themselves were becoming appreciative practitioners. The findings reveal a set of dimensions of these caring conversations. Key dimensions mirrored many of the elements identified in the set of principles I had chosen to work with as an appreciative inquirer (see page 70). Analysis of the findings reveals a set of dimensions of these caring conversations called the 7 'C's'. These are shown in Table 18.

Table 18 - Dimensions of caring conversations – the 7 ‘C’s’

Key attribute	Dimensions	Key questions/statements that support the attribute in action
Being courageous	<p>Being clear about what it is we do and strive to do around here. Persevering.</p> <p>Having courage to stand up for things.</p> <p>Promoting the vision with flexibility and humility</p> <p>Spotting windows of opportunities. Seeing ways round things. Trying things out. Feeling brave to take a risk</p>	<p>What do you value?</p> <p>How does this fit with what we believe in?</p> <p>What matters?</p> <p>We do this around here, help me to understand why you have done that?</p> <p>What are the possible consequences of giving something a go?</p> <p>Do we feel able to take a risk with this?</p> <p>What do we need to help us to take this risk?</p>
Connecting emotionally	<p>Inviting people to share how they are feeling.</p> <p>Noticing how you are feeling and sharing this.</p> <p>Using ‘windows of</p>	<p>How did this make you feel?</p> <p>You made a difference to my day because.....</p> <p>What needs to happen to help you to feel comfortable to share how you feel?</p>

Key attribute	Dimensions	Key questions/statements that support the attribute in action
	<p>opportunity' to create openings for people to discuss emotional and personal issues in the context of ordinary conversations.</p>	
Being curious	<p>Using micro-noticing practices by being attentive and open to what is happening.</p> <p>Asking curious questions about even the smallest of happenings.</p> <p>Allow people space and ask questions that encourage people to consider possible unconscious motivations behind actions. Be curious about assumptions.</p>	<p>What strikes you about this?</p> <p>Help me to understand what is happening here?</p> <p>What prompted you to act in this way?</p> <p>How do you feel about this?</p> <p>How do you think others feel?</p> <p>What was the impact of this?</p> <p>How do you think I did?</p>

Key attribute	Dimensions	Key questions/statements that support the attribute in action
	<p>Inquiring appreciatively. Exploring things with the purpose of making new discoveries. Questioning, weighing up this or that, hunting for meaning. Looking for the other side of something that's said, and checking things out.</p>	
Being Collaborative	<p>Talking together, involving people in decisions, bringing people on board, and developing a shared responsibility for actions. Hearing the voices of others and working creatively to</p>	<p>How can we work together to make this happen? What do you need to help you to make this happen? What would shared responsibility look like here? How would you like to be involved?</p>

Key attribute	Dimensions	Key questions/statements that support the attribute in action
	<p>integrate these into the dialogue; using the group to challenge or support ideas from others rather than assuming this role yourself; constantly checking out with others if your interpretation is accurate; looking for the good in others to encourage participation and collaboration.</p>	
<p>Considering other perspectives</p>	<p>Creating space to hear about another perspective. Showing humility. Recognising that we are not necessarily the expert.</p>	<p>Help me to understand where you are coming from? What do others think? What matters to you? Which voice do we need to listen to here?</p>

Key attribute	Dimensions	Key questions/statements that support the attribute in action
	<p>Checking out assumptions.</p> <p>Acknowledging the limitations, strengths and emotions of all parties.</p> <p>Being open and real about expectations.</p> <p>Being open to hearing perspectives, recognising that they may not be the same as yours and feeling comfortable to discuss this in an open way.</p>	<p>What is real and possible?</p> <p>What would it look like if we did nothing?</p>
Compromising	<p>Working hard to suspend judgment and working with the idea of neutrality</p> <p>Helping people to say what support they need to make things better.</p>	<p>What is important to you?</p> <p>What would you like to happen here?</p> <p>How can we work together to make this happen?</p> <p>What do you feel you can do to help us to get there?</p> <p>What would you like me to do?</p>

Key attribute	Dimensions	Key questions/statements that support the attribute in action
	<p>Working with the principle that what is said is not right or wrong, rather the questions raised are about why might the person say what they said, and in which circumstances is what was said valid.</p> <p>Helping the person to articulate what they need and want and share what is possible.</p> <p>Talking together about ways in which we can get the best experience for all.</p> <p>Thinking about what should</p>	

Key attribute	Dimensions	Key questions/statements that support the attribute in action
	happen, could happen and must happen.	
Celebrating	<p>Making a point of noticing what works well. Explicitly saying what works well and asking questions that get at ‘the why’.</p> <p>Continually striving to reframe language to the affirmative.</p> <p>Looking for where the energy is, the thing that touches hearts and minds, the thing that sends a buzz around the room and hook onto this.</p>	<p>What worked well here?</p> <p>Why did it work well?</p> <p>How can we help this to happen more of the time?</p> <p>If we had everything we needed what would be the ideal way to do this?</p> <p>What are our strengths in being able to achieve this?</p> <p>What is currently happening that we can draw on?</p>

5.4 Chapter Summary

This chapter has addressed the first two objectives of the study. Findings show that two key processes were evident in helping people to deliver compassionate relationship-centred care, enabling them to draw upon and utilize the forms of knowledge identified in Chapter 4. These processes of *working together to shape the way things are done* and *engaging in appreciative caring conversations* were evident in many interactions between staff, patients and families. When *working together to shape the way things are done*, people felt involved and empowered and were able to be flexible in their approaches to caring in trying to meet the needs of all those involved. It was evident from the data however, that these exquisite examples of caring, which were carefully considered and adapted, were not often shared with others. This resulted in a missed learning opportunity and lack of recognition for the special and often complex negotiation involved in caring.

Working together to shape the way things were to be done involved taking risks, and having courage to challenge and stick firmly to principles of person-centredness. People were helped to act in this way if there were opportunities to collaborate and talk openly about care, to discuss sharing responsibility for action and to have a clear understanding as a team about the real vision for caring practice that was valued on the ward. Many of these opportunities were role modeled by one of the consultants on the ward.

A model of interacting with people to develop relationships that would enable delivery of compassionate care was beginning to emerge. In this model, appreciative caring conversations play a central role in helping to develop knowledge about who people are and what matters to them and in understanding how people feel, already identified in Chapter 4. Person knowledge forms a firm base on which people can then continue to have appreciative caring conversations that help them to work together to shape the way care is given that means something to those who give and receive it. Key dimensions of caring conversations are; being courageous, connecting emotionally, being curious,

collaborating, considering other perspectives, compromising and celebrating. These represent the 7 'C's' of caring conversations and are important as they specify how to support people to effectively communicate in delivering compassionate relationship-centred care.

The process of inquiry, role modeled appreciative caring conversations and the findings showed that staff became more conscious and deliberate in acting in this way. They became appreciative practitioners.

Key domains and processes that seemed necessary to deliver compassionate relationship-centred care emerged from the findings. These are synthesised in the next chapter and presented as a practice model. The processes were not considered by staff as 'easy' and indeed many did not consider that they had the courage to engage this way all of the time. Key strategies or action cycles were implemented to support staff to engage in these appreciative caring conversations that promote compassionate relationship-centred care to happen more of the time. These are described further in the next chapter.

Chapter 6 - Implementing a Model of Compassionate Relationship-Centred Care (Design and Destiny Phase)

6.1 Introduction

This chapter presents a synthesis of the findings in previous chapters through explication of a model for delivering compassionate relationship-centred care. The model's key component is appreciative caring conversations, enacted through the 7 'C's'. Key dimensions (the 7'C's') of these conversations are described and their relationship to the domains of person knowledge and working together to shape the way things are done is highlighted. The chapter then presents findings from three action cycles designed to make more transparent the domains inherent in this model. The action cycles were developed in the design phase of the study and tested out in the destiny phase of AI. The action cycles were: *asking a key set of questions to develop knowledge about who people are and what matters to them, using emotional touchpoints as a strategy to understand how people feel about their experience and developing and debating positive caring practices in order to create a live and dynamic vision to guide compassionate relationship-centred care*. In testing out this model through the action cycles, key factors that supported practitioners to implement this model in practice are discussed. The chapter concludes by summarising the domains and dimensions of the model, highlighting the complexity of these domains and emphasising the level of support and facilitation necessary to encourage implementation of this model in practice. This chapter addresses objectives 3 and 4 of this study which were:

- to develop, implement and evaluate strategies that promote compassionate relationship-centred care, in the context of practice both at ward and organisational level; and
- to examine the processes that need to be put in place to enable these strategies to be sustainable over time.

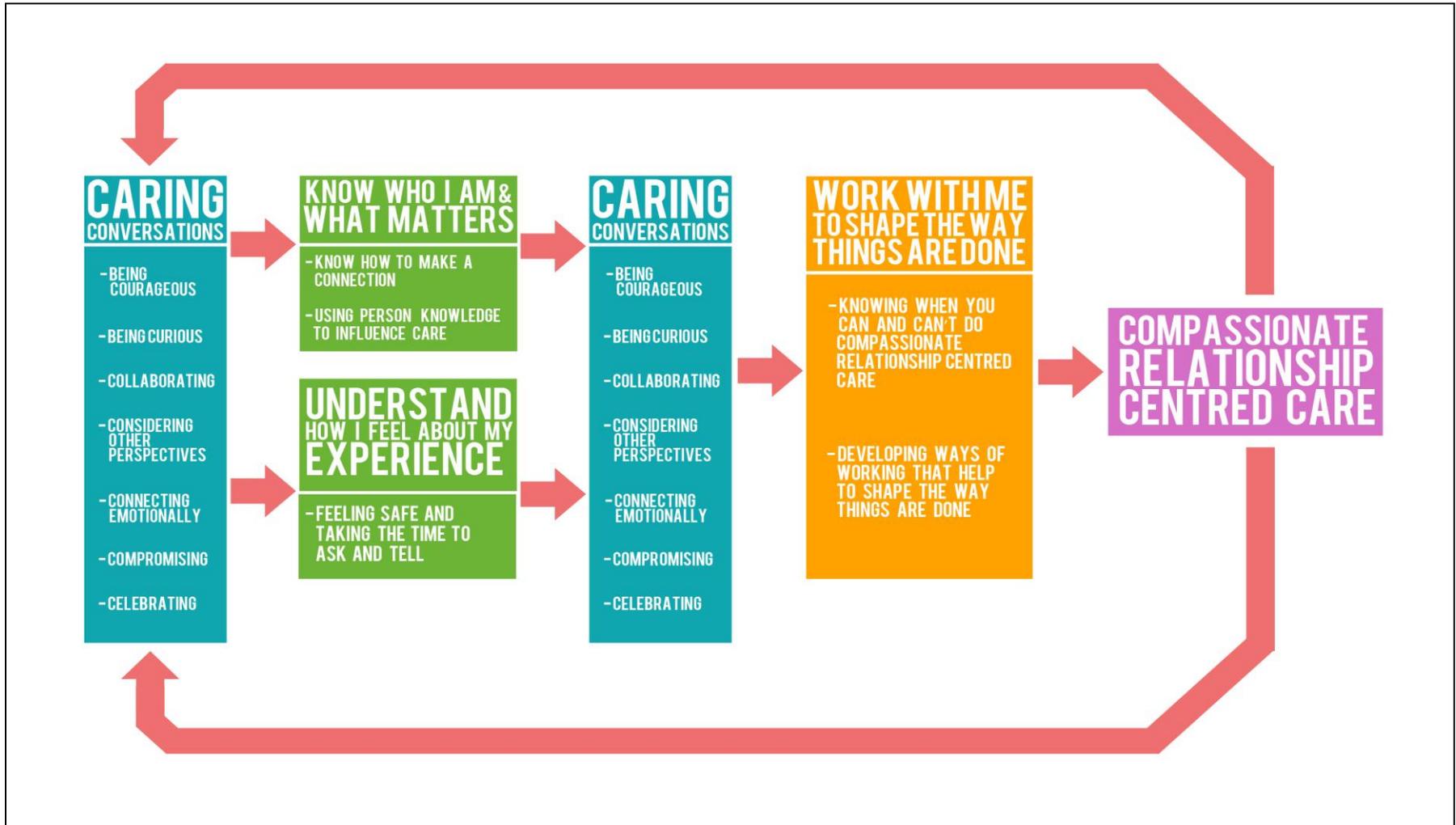
6.2 A model of compassionate relationship-centred care

The last two chapters illustrated the importance of interactions amongst people involved in caring as the foundation of compassionate relationship-centred care. Engaging in *appreciative caring conversations*, helped to build knowledge about who people are, what matters to them and how they felt about their experience. This knowledge was then used to inform the nature of the caring conversations in order to work with people to shape the way things were to be done and thus provide care that felt compassionate to patients, staff and families. Thus 3 key domains were important in enabling the delivery of compassionate relationship-centred care:

- Appreciative caring conversations;
- Development of person knowledge - *knowing who I am and what matters to me and understand how I feel*; and
- The relational process of *work with me to shape the way things are done*.

These 3 domains are central to a model of compassionate relationship-centred care. Figure 2 illustrates the domains and dimensions of this model and their relationship to each other. The model is applicable to staff, patients and families and works in the context of relationships.

Figure 2 - A Model of Compassionate Relationship-Centred Care



The dimensions of these domains and the relationship between them are now discussed.

6.2.1 Caring conversations

In the preceding chapters appreciative caring conversations were central to being able to develop, value, share and act on knowledge about the patient, family member or staff as a person. This core domain is the cornerstone of the model of compassionate relationship-centred care developed in this study. The model illustrates that these caring conversations happen throughout the care-giving relationship.

It is important to note that caring conversations were identified as one dimension of the model in the wider programme (LCCP) but they were not explicitly identified as **the core** process, nor were their nature and characteristics developed as fully as they have been here. Therefore, the key difference between my study and the LCCP is that my work explored the nature of caring conversations more deeply and consequently developed a more sophisticated conceptualisation, as demonstrated in the 7 'C's:

Be Courageous: Be brave enough to ask questions, take risks, innovate and stand up for things that matter to people.

Connect Emotionally: Invite people to share how they feel and notice your own feelings within the interaction.

Be Curious: Ask questions that genuinely seek to explore feelings and experiences and that consider possible assumptions and look for the other interpretations.

Be Collaborative: Talk together, involve people in decisions, bring people on board, and develop a shared responsibility for actions.

Consider Others' Perspectives: Actively ask questions to explore another perspective and be open to hearing such perspectives, recognise that they may not be the same as yours and feel comfortable to discuss this in an open way. Share expectations.

Compromise: Talk together about ways in which we can get the best experience for all. Think about what should happen and could happen.

Be Celebratory: Notice and explicitly say what works well and ask questions that examine why things work well.

These dimensions make up the framework of the 7 'C's of caring conversations. Being courageous is the pre-eminent attribute that facilitates enactment of the others.

Furthermore engaging emotionally, although identified as a separate attribute, is implicit in all others. Engaging in these caring conversations asks the patient, family member or staff questions such as:

What matters to you most while you are in hospital?

Tell me something that will help us to care for you here?

How do you feel about your experience?

What helps you to feel up beat and well?

How would you like us to respond if you are feeling low?

Who are the most important people for you?

What worries/concerns do you have?

What things have worked well for you here?

The domain of caring conversations is central to using the model in practice and can be seen as the 'grease' that enables the development of person knowledge and the enactment of processes necessary for delivery of compassionate relationship-centred care. These two further domains are discussed below.

6.2.2 Development of person knowledge

Engaging in caring conversations enabled the development of person knowledge (see Chapter 4). In this model of compassionate relationship-centred care the domain of person knowledge has two dimensions – *know who I am and what matters to me* and *understand how I feel about my experience*.

It is suggested that this knowledge can be developed using caring conversations in the context of everyday practice.

In striving to deliver compassionate relationship-centred care, practitioners would actively and consciously engage in caring conversations that had the above characteristics, to explore with one another and with patients/families who they are and what mattered to them (*Knowing who I am and what matters to me*). This involved making a connection with the person through caring conversations that promoted, for example, a deliberate welcome, or personal sharing. In addition, practitioners would ask curious questions to find out what mattered to the person in the context of the care experience. Practitioner reflections suggested that to communicate in this way required a degree of courage to connect emotionally (evidenced in the sub-theme *feeling safe and taking the time to ask and tell*), and be curious to find out what matters to them in order to develop this person knowledge crucial for the delivery of compassionate relationship-centred care.

Similarly, practitioners actively and deliberately tried to find out how people felt about their experience of care or care-giving. Developing this dimension of person knowledge required that the practitioner encouraged, through caring conversations, people to share how they were feeling and to consider this in relation to their own feelings. Again the key attributes required to develop this dimension of person knowledge included, being courageous to connect emotionally with another and to consider their perspective. It also involved celebrating this knowledge particularly when this was related to the expression of positive emotion.

6.2.3 Work with me to shape the way things are done

The third inter-related domain of the model is the process of using person knowledge, *to work together with people to shape the way things are done* through caring conversations. The two dimensions of this domain were *knowing when you can and can't do relationship-centred care* and *developing ways of working that help to shape the way things are done*. Caring conversations were used to enact these two dimensions where people needed to consider others' perspectives, compromise, feel confident to stick up for what they believe in, have courage to take risks and collaborate in a way that meets the expectations of patients, staff and families.

Developing the domains of compassionate relationship-centred care provides an accessible framework to explicate the knowledge and skills staff need to support the development of compassionate relationship-centred care for older people and their families in an acute care setting.

In addition, this model maps these dimensions for staff, patients and families thus supporting the relational dimensions in practice. Although it is desirable for all parties involved to engage in these conversations, Chapter 5 highlighted that it is the nurse who may often take the lead to role model this way of interacting. Indeed in this study, patients and families appeared to be encouraged to enter into reciprocal relationships when staff adopted an approach that was characterised by the 7 'C's. Thus the model embraces the concepts of mutuality and reciprocity.

Other influences also supported enactment of this model of caring in practice. These included transformational leadership, role modelling these domains in practice, a system that acknowledged and valued the reciprocity that exists within a relationship, which prioritised learning in and from practice and that explicitly celebrated those care practices

that worked well so that they can be supported to happen more of the time. However, it was the key domain of appreciative caring conversations that created the conditions necessary for the other domains to develop and flourish.

Key outcomes of implementing this model were that people felt comfortable expressing emotions, developed stronger relationships, and were more consistent in delivering compassionate care practice across the team.

This model provides a unique perspective for nursing in that it explicates the ‘how’ of delivering compassionate relationship-centred caring. The next section examines the findings from the design and destiny phase of this AI where the domains of this model were tested out in practice through the development, implementation and evaluation of 3 action cycles.

6.3 Action cycle one: knowing who I am and what matters to me

6.3.1 Developing the action cycle

The data presented in Chapter 4 illustrated the knowledge people developed that related to who people were and what mattered to them.

All data extracts relating to the theme of *knowing who I am and what matters to me* were fed back, primarily to nursing staff, through a variety of media, already articulated in the methods section. Other staff, for example doctors, allied health professionals and domestic staff, read and commented on quotes when they visited the ward.

As part of knowledge development, staff explored the data extract and its relevance to the theme under which it was grouped. They were invited to challenge and discuss the data and themes. Following this, several short meetings were held (often around the nurses’

station) with groups of staff to discuss their interpretation and reflection on the data extracts. Some interpretations have already been discussed in Chapter 5, but other reflections on the theme of '*knowing who I am and what matters to me*' included:

It's hard because you don't always remember a person's name (when you are away from the bedside) and I think it is better to say love or honey rather than bed
23.

I don't want to know some of the staff well. I don't get along with them.

The thing is, about knowing something about the person, say they like knitting – this is fine, but at the end of the day it is not always clear how this information helps us to give the care. It's nice to know, but maybe not essential to know.

(Staff Comment, Recorded during field work, Oct 2008).

These comments highlight the importance of the real, personal and contextual information related to the theme of '*knowing who I am and what matters to me*'. It is clear that staff felt comfortable to debate the data extracts. Again, the ease with which people were able to share their opinions was enhanced by the facilitative style inherent in the research process, which was to explore with people how they felt, be open and responsive to their comments, and stimulate dialogue that worked with possibilities rather than limitations. Data presented in Chapter 4 demonstrated aspects of good practice that had been observed or discussed.

Running alongside discussions about feedback from the data, I held beliefs and values sessions with groups of staff to explore their views about caring compassionately. They were asked to consider, as a staff member, what they valued about the place in which they worked, and if they were a patient or relative, what would they value. It was through this process that their ideal or dream way of practising began to form. For example, staff talked about getting a great deal of satisfaction when they were able to develop relationships with patients and families and found this helped them to care better. They

enjoyed finding out what mattered to an individual. They were able to use examples from data already gathered to provide concrete evidence of what their broad beliefs and values meant to them in practice. So, staff were able to reflect on the extent to which the data mapped to their own beliefs and values. Linking data specifically to beliefs and values emphasised the relational nature of knowledge generation.

It was clear from debate and discussions on the findings that although people did try to find out about staff, patients and families as people, and use this knowledge to influence care, this was done on an ad hoc basis and was not necessarily systematically recorded and shared with others. This was in contrast to the many other questions staff asked of patients, which were important and focused on the assessment of health and health related problems. Finding ways in which questions that tried to find out about the person, and thus focused on building a relationship with patients, was what staff wanted to develop further.

Making a decision about what action to take to facilitate '*knowing who I am and what matters to me*' was eased by the fact that staff had evidence from data that this relational activity was valued. Furthermore, staff believed they were already doing it, and it was possible for it to happen more often. Thus, staff had a strong sense of ownership of this process.

Staff decided to develop a set of key questions that would help them explore what mattered to patients and families on a regular basis, and to find ways of sharing this information and debating its influence on care, more widely with the staff team.

The organisation had already set up a working group to develop patient documentation to elicit more specifically information about the patient as a person. The charge nurse and I joined this group to develop questions that would enable this process (Table 19). Questions were piloted, shared with staff, relatives and patients, modified and then 'rolled out' across the ward. The plan was to ask these questions as part of the admission

process. In reality, however, they were used on a continuous basis throughout the person's stay in hospital.

Table 19 - The 'All About Me' Framework

<p>All about me</p> <p>What would you like staff to call you?</p> <p>How would you feel if staff use terms like 'darling', 'love', 'honey' when they speak to you?</p> <p>Who are the people closest to you and who do you want us to communicate with?</p> <p>What are your thoughts and feelings about being in hospital?</p> <p>What is your understanding of why you are in hospital?</p> <p>Is there anything that is worrying you about being in hospital?</p> <p>Is there anyone you would like to speak to? (doctor, chaplain, family member, friend, neighbour)</p> <p>What is important to you while you are in hospital?</p> <p>What support do you need from the people that care for you?</p>

6.3.2 Implementing the action

Key process issues that arose in the piloting of this activity included:

- issues of confidentiality;
- the emotional consequences of the interaction;
- getting to know who I am and what matters over time; and
- relevance of the information to care-giving.

6.3.2.1 Issues of confidentiality

The issue of confidentiality prompted much debate, in that information obtained from interaction, which was often quite personal, between one patient and one member of staff, would be made available to the care team. One staff nurse talked about the responsibility that she felt:

I feel enormous pressure to get it right when I am writing it down. I need to make sure I have written it as they say it because it's going to be shared with the rest of the team. I felt uncomfortable when the patient was sharing deep stuff with me, I made sure I gave the completed sheet back to him and checked again that he was happy for this to be shared with others. (Staff Comment, Recorded during field work, Oct 2008).

The practice of showing the patient the completed sheet went some way towards checking out their willingness to share information more widely. It was also important to acknowledge however that, in reality, much private and intimate information is gleaned during the in-patient experience and shared with the care team. Consent to share this information is probably assumed, rather than explicitly sought. Checking for consent explicitly with patients was seen as important. It was interesting that, at one point, staff felt it would be more appropriate if the patient or family member completed the question sheet themselves, responding just to selected questions. However, when this was done, staff felt that they 'missed out' on an important opportunity to engage and develop relationships with the patient and their family through the very act of asking the curious questions. Staff were encouraged to check out with patients and families which process felt most comfortable, and in the main they tended to state no preference. Thus, staff reverted to using the questions as a basis for face-to-face conversations.

6.3.2.2 The emotional consequences of the interaction

Staff had found asking certain questions and dealing with responses quite difficult, emotionally. For example, in relation to the question 'what is important to you', one

patient responded by saying they wanted to die. Another patient, when asked about why he was in hospital, said that he knew he was not going to get any better. Staff often felt quite emotional. Anxiety was felt, in that they could not predict what the patient might say. Staff wondered at times whether they indeed should be ‘prying’ in this way into another person’s life and felt that their questions ‘caused’ the patients to become upset. One nurse said:

What right do I have to open a can of worms. The patient agrees to you asking these questions but they don't know that it might have this reaction – it feels uncomfortable. (Staff Comment, Recorded during field work, Oct 2008).

Staff needed opportunities to talk about how they felt, but also to acknowledge the patients’ responsibility in their willingness to share. Discussing the process with staff raised issues about the importance of knowing and managing the self within a relationship. This would include being able to manage your own concerns within the dialogue. Staff felt they needed support with this.

In response, monthly meetings were set up with the chaplain and the charge nurse, to provide an opportunity for staff to share their reflections about the emotional aspects of caring. This proved successful and the frequency of meetings was increased to weekly. In addition, staff were observed to be talking informally about their reactions to some of the questions during other discussions. This was important, as we were acutely aware of the potential temporary nature of ‘sessions’ run by external people. Integrating conversations about how people felt about caring, into day-to-day interactions, was seen as essential to complement any additional resource.

6.3.2.3 Getting to know who I am and what matters to me over time

Many of the questions that were asked in the ‘All about me’ question framework were of a personal and intimate nature. Staff found that they made decisions themselves during the interaction as to which questions to ask on admission and which to ask later once they had built up a relationship with the patient and their families. They felt that this process

of getting to know who people are and what mattered to them needed to be built over time. Staff recognized that questions could not be seen as a 'set' framework to be 'ticked off' and signed as completed. Rather, questions had to be asked with sensitivity and thoughtfulness, and this happened over a period of time, rather than as a one-off activity. Furthermore, it was difficult for patients to answer questions without any knowledge of the context in which these questions were being framed. Asking a patient what is important to them at the beginning of their stay may yield important information, but it is through time, and living and being in the context, that a person is better able to identify these aspects. Thus, questions were to be used on an ongoing basis rather than seen as a one-off activity on admission.

6.3.2.4 Relevance of the information to care-giving

On a number of occasions information was sought but not shared with the rest of the team. Staff members could not always make links between what they had learnt and how this influenced care giving. It seemed easy, for example, if a patient said that it was important to have a daily newspaper, to provide this. It was perhaps more difficult when a patient said that what was important to them was not to upset people, for staff to reflect on how this influenced care they might deliver. Thus, information did not always relate specifically to a care task but to the way in which people developed relationships. Debates and discussions were needed to help staff to unpick what this meant for them in practice. This was facilitated by the research process and there was evidence that staff began to feel more comfortable in facilitating this type of discussion themselves.

It became evident that the question sheet in itself was not enough to facilitate changes in interpersonal practice and that the framework should be viewed as an initial point of connection with the person. What was needed were opportunities for further discussion with the patient or family, and a chance to share and explore aspects with staff to inform care-giving. In addition, people 'picked up' on specific aspects from patient and family responses and arranged to discuss these further with them.

The issue of feeling able to act on this learning, within the constraints of the organisation, was another area of tension for staff. In one situation, a patient who was blind was asked what was important to her, she replied 'Being read a chapter from the Bible, John 14'. Staff realised there were no longer any Bibles in lockers. They had been removed some time ago, they understood because of equality and diversity issues and infection control. Staff tried to locate a Bible on neighbouring wards and found nobody had one. They finally went to the Chaplaincy Centre and managed to retrieve one from a large storage cupboard full of Bibles. Following discussions with the chaplain, copies of Bibles and Korans were reinstated in all wards in the hospital. It would have been easy for staff to fall at the first hurdle with this example, but they persevered. Staff did worry that they would not always be able to provide the aspects that patients felt were important to them, making them feel that asking the question in the first instance involved taking a risk. It could feel safer not to ask. However, this example demonstrated that the organisation could be challenged, based on powerful knowledge, which was person knowledge. Working as a team to deliver on this, and persevering, were key attributes contributing to a successful outcome.

6.3.3 Impact of the process of asking key questions to elicit person knowledge

Staff commented about the value of this person knowledge to care-giving:

I think doing the 'all about me' sheet has made a big difference. When we were using the questions on this with one of the relatives, they said that the patient, who had dementia, loved to root around in their toilet bag and liked to have this beside them. We had been putting the toilet bag in the locker right round the other side of the bed – we would never have known that about her if we hadn't taken the time to ask these questions – like what is important to her while she is in hospital. (SE7).

Patients and families, although pleased to be asked these questions, were generally quite surprised to be invited to take part in such discussions. Patients and families did not necessarily initiate the conversations about what was important to them. Some patients were anxious about what would be done with the information. Another patient commented:

I am not sure I answered any of the questions very well but I suppose it was nice to be asked. Even if I couldn't think of answers, it makes you think that staff are interested to know what's important to you and that you would not feel silly saying something about this later. (Patient Comment, Recorded during field work, Dec 2008).

Thus, the benefit of asking questions to open up conversations and develop a more trusting relationship was evident. Being asked questions seemed to validate them as an important part of the caring process.

It was difficult to access patients' views about the impact of this initiative as they were not necessarily aware of how care practice was before. What we were able to determine was the individual impact of learning about them as people and integrating this into care. For example, the story, of reading the Bible, had a direct impact on the patient's well being, as was evident in the fact that she became calm and less agitated.

In some ways, the act of formalising the process of asking such curious questions could be seen to move this type of knowledge generation to a 'one-off process' that was static, and which gave more power to the professional as questioner. In reality, staff became more aware and therefore more deliberate in asking such questions. On a day-to-day basis, staff felt pleased that, over time, asking the questions did not feel strange and many acknowledged that they were integrating questions into their day-to-day practice, for example when they were carrying out personal care. Using opportunities during care-giving to get to know what matters to the person seemed more natural and took no longer.

The value of the question sheet was seen to be more about recording this information so that it could be shared with others.

The answers to questions often challenged staff's assumptions, for example, about what was important to patients and how they understood their reason for being in hospital. One patient said he was in hospital because of exhaustion, when in fact the nurses thought it was because he was no longer able to cope at home. This subtle difference in perceptions can influence the way in which we care for patients. This created an enhanced awareness about the importance of checking things out with people, rather than making assumptions. Staff talked about feelings they had when this happened as 'the light bulb moments'. The majority of staff did not feel defensive about their assumptions being challenged, rather they felt interested and surprised. Staff talked about how, in the past, they would base many decisions about caring on how they would want to be cared for themselves. This realisation that good care is dependent on finding out what is important to the person, rather than assuming that your beliefs and values about caring are common to everyone, I believe was a fundamental shift for staff in the way that they began to communicate with patients at other times during their stay in hospital.

Staff wanted to explore whether a similar set of questions would have applicability to learning more about each other. Developments began to take place on the ward to explore the value in 'all about me' questions for staff. Questions that tap into staff as people, with needs and expectations of their own, such as 'what do you value at work?', 'what helps if you are feeling low?' were developed and piloted with a number of staff. These questions were used with new staff on the ward, but there were still pragmatic decisions to be made about where this information was kept and how it was used by the team.

This action cycle made a difference to caring for staff, patients and families in that it helped staff develop a language to ask curious questions in a more direct way, and develop person knowledge that in turn helped them develop relationships in which they could work collaboratively to discuss and make joint decisions about caring. The key activity of careful, thoughtful questioning, focusing on being curious and checking things

out, was shown to elicit important information that challenged staff's assumptions about caring, opened up conversations with patients and families, and helped them recognise the individuality of patients. It gave staff a language framework to talk about what mattered to people. It also provided important evidence for staff to have more courage to take risks, as this important person knowledge validated their actions.

The implementation of this action cycle also highlighted the potential risk, and thus complexity and skill in asking questions and using the responses to build relationships. Important process issues were uncovered, including the personal and confidential nature of this type of information and that it often asks us to engage emotionally with people and hear responses that may challenge our assumptions. Staff needed support to feel more confident to ask and respond to such questions, particularly when this revealed instances where the organisation could not meet the person's need. These issues need to be recognised and people need to feel supported, if developing this type of knowledge is to become a part of everyday practice. The process of AI helped to recognise when this worked well and supported people to discuss challenges and look for possibilities.

In addition, staff were supported to feel more at ease with emotional engagement through reflective sessions. What is important here is that the question sheet alone was not enough to change the ways that people related to each other, rather it was a starting point that made this type of engagement more visible and conscious. What was needed in addition was support, facilitation using an appreciative approach and leadership that role modeled and prioritised this as legitimate practice. The action cycle confirmed the value of the domain of *knowing who I am and what matters to me* to patients, staff and families and further reinforced the importance of the 7 'C's of caring conversations in eliciting this dimension of person knowledge. Furthermore it highlighted the complexity of the interpersonal skills of the 7 'C's and the support that is necessary to enable staff to feel confident to integrate this way of working into day to day practice.

6.4 Action cycle two: supporting staff to engage emotionally

6.4.1 Developing the action cycle

Data were fed back to staff, either at the time of data generation or through opportunistic discussions on the ward. Staff recognised that they did not always actively seek out information about how people felt about their experience. This seemed to be related to concerns about the response they might get, particularly a negative response, and a feeling that, by specifically asking for this feedback, you were seeking out praise which felt rather self congratulatory.

I am not sure I could ask for feedback more. I feel a bit embarrassed doing this. It's nice to get it but I don't think I would feel confident to ask – you never know what people might say. (Staff Comment, Recorded during field work, July 2008).

In the beliefs and values sessions, staff explicitly and repeatedly talked about how what they valued was knowing they had made a difference to a situation or a person. Thus, in staff's reflections on the data extracts, they noted how good it felt to receive positive feedback but there remained apprehension on how to ask, share, and respond to hearing comments about how people felt about their experience. Staff did not talk about the impact of bottling up emotions. This may have been because a key aspect of the research process was about sharing how people felt about experiences and staff were actively doing this at the time of the study. Rather, their focus was how they could have more courage to ask people how they felt, feel comfortable enough to hear what people were saying and respond in a way that opened up possibilities through shared dialogue rather than closing conversations down through defensiveness.

Evidence from data presented in Chapter 4 reflects the value of expressing emotion within the relationship. Staff however did not always feel confident and comfortable to lead on this within the interaction and therefore an action project that supported them to do this was implemented.

Decisions about what action to take forward were influenced by the data generation activity of using emotional touchpoints to hear how people felt about their experience (see page 104/105 Chapter 3). Staff felt this activity was a powerful way of learning about the experience of others and wanted to see whether this could be implemented as a part of normal daily practice on the ward. The technique is essentially about understanding how people **feel** about experience through the vehicle of story telling. This decision to use one of the processes of inquiry from the research study as the intervention reinforces one of the principles in AI, that inquiry and intervention are interdependent.

Other developments also took place at this time to make feedback more explicit and regular on the ward. For example, 'feedback fortnight' for staff where they used a framework of questions to ask other staff about their abilities and specific feedback cards which asked all visitors to the ward (including bank staff, students, families) to share what 'we got right for you on the ward' and 'what would help to make your experience better'. Reported here is the development of the action cycle about using emotional touchpoints.

Staff had already gained experience and confidence in using this method when they had shadowed me working with people to generate stories using emotional touchpoints. The charge nurse created regular opportunities on the ward where patients and families were invited to share their experiences using emotional touchpoints. He felt confident to lead this process and to invite other members of staff to join him.

The charge nurse created an easy to use pack of touchpoints and words, and ensured there were ample copies of the consent form. He also identified stories as a development activity in the personal development reviews that were taking place with all staff at this time. All staff were encouraged to aim to work towards eliciting a story from either a staff member, family member or patient at some point over the next four months.

6.4.2 Implementing the action

Described here is the use of emotional touchpoints with patients and families. This process was also used with staff, particularly following a distressing or uplifting experience in caring. Several staff became involved with this activity and identified a number of benefits to using this process. Some of these are detailed below. A fuller account of benefits is detailed in an article the charge nurse and I wrote together with other colleagues, (see Dewar *et al.* 2010).

6.4.2.1 *Enabled development of relationships with patients, families and staff*

Staff found that working with emotions helped strengthen the relationships they had with patients and families and with each other. Consciously working with emotions was seen to help people make a real connection in the dialogue between patient and staff:

“One patient had a problem that had bothered her on night duty. I did not know the lady but asked her if we could sit down and talk about what happened. I used emotional touchpoints. I felt that we were able to quickly connect with each other where she was able to tell me how she felt about a number of things that had happened both positive and negative. In the past I would have just heard the complaint and would not have necessarily developed a connection with her in a way that helped us to make the experience better for us all. I think it would have taken me longer to build this relationship – using the touchpoints speeds the relationship building process up. It also gave me a chance to say to her I was sorry that this had happened and how difficult I found it to hear complaints.”
(SE 5).

Thus, being able to share emotions together in the nurse-patient relationship was seen as a positive experience.

6.4.2.2 Seeing both positive and negative aspects of experiences

Because the process of using emotional touchpoints does not directly focus on blaming the service, it helped people to see both the positive and negative experiences in a more balanced way. A balanced approach can be less threatening for staff, patients and families. One staff member commented:

Doing the emotional touchpoints has been amazing. At first, when I was doing this with you, when a patient picked out an emotional word say, uncomfortable or annoyed – I would feel terrible. I know I went red in the face just thinking about what he was going to say about us. It felt really personal sitting there waiting for him to tell me why. But actually it felt okay, because he was not really blaming me, he was sharing how he felt and not in an angry way. It felt more like we were having a conversation about how he felt rather than feeling attacked. (Staff Comment, Recorded during field work, Jan 2009).

Being open to the flow of the conversation, allowing the meaning of the experience to surface, and having the courage to go with the uncertainty were aspects that were important here. Thus, this process of doing emotional touchpoints enabled people to enter into a dialogue where there was less emphasis on what was right or wrong or good or bad but rather staff, patients and families were encouraged to re-live happenings, express their perceptions, feelings, assumptions, regrets and wishes with the purpose of developing understanding, rather than finding fault or making judgments.

The example below of a relative's experience of 'being around' when his mother was taken to the toilet shows the range of emotional words that summed up the experience for him:

Emotional touchpoint: Going to the toilet

Emotional words selected: irritated and misunderstood, belittled, proud

With a few staff, they need to develop their communication skills. On these occasions I felt irritated and misunderstood. I asked a nurse if she could help Mum get to the loo. The nurse said yes and asked if I wanted to help her – to which I said yes, as I had done this at home. What I was expecting was to take her into the loo, let her sit down and shut the door while I wait outside. The nurse brought a commode to the bedside, stood her up and took down her pants in front of me. I think my Mum felt belittled. I just accepted that it had happened and did not say anything. There were so many examples of good communication though from domestics, nurses and doctors – the whole team. My Mum needed the loo and I told somebody – they said this was not a problem and asked me to wait outside. I could hear them outside the room and they were chatting away to Mum at her level – they were having a laugh together and sharing things. I felt proud as the staff had probably heard what she was saying so many times already but they reacted as if they had heard what she was saying for the first time. This felt good. (Relative Story, RS2).

The key learning identified by staff related to the challenge of helping somebody to speak out when they were upset about something and the real skill of ‘being with’ a person with a cognitive impairment and sharing these skills with others. We can see that even where a negative feeling was expressed this did not always mean that there was a deficiency in the service, but rather there was misunderstanding about the staff’s intention, which led to a negative experience for the relative. It is important to note however that supporting staff to see the balance in the story needed careful facilitation.

Also evident here is that this method helped us to tap into positive experiences of caring that often remain hidden as they are not easy to articulate. Listening to a person with dementia’s repeated story as if you have heard it for the first time is an expert skill that would not have been recognised by the nurses on the ward as something they do well.

6.4.2.3 Helped staff, patients and families to be involved in shaping the service

Emotional touchpoints were useful in identifying key aspects that patients and families could be directly involved in developing with staff. The story below prompted staff and relatives to work together to develop the service.

Emotional touchpoint – being here at night

Emotional words selected: out of my depth, unsure, intruding

I felt out of my depth when I was here at night initially... I felt unsure of what rules and regulations applied, e.g. was it still OK to use the kitchen, was there a vending machine for drinks/snacks in the building or if you went out of the building would you be able to get back in? . At times we felt like intruders and we were unable to speak to staff about our concerns because we did not know what we were entitled to or if what we had been offered or given previously had been purely a kind gesture from a caring member of staff. (Relative Story, RS1).

For staff, this raised awareness of the importance of consistent and specific information about the routine of the ward and the need to create opportunities where patients and their families are routinely asked to share how they are feeling about the experience of being in hospital.

Aspects of the service were developed in response to this story, including the co-design (with staff and relatives) of a booklet for patients and relatives about ‘being here at night’.

The process helped people to go beyond bland statements of ‘that was good’ or ‘everyone is so helpful’ and to describe more specifically why something was good and how it made them feel. One patient talked about how she was ‘scunnered’ by the fact that her cereal was sloppy with too much milk. It would be hard not to pay attention to this and take action. Indeed, this prompted the purchase of milk jugs for the ward, and for all patients

to be invited to put their own milk on their cereal rather than staff doing this for them. The fact that a person's emotion cannot be disputed, in the same way that a description of events may be seen as inaccurate, gave power to the voice of the person who has had the experience.

It proved to be a powerful resource to use in busy care settings to elicit a range of feedback from staff, patients and their families. Staff commented that it was quick to use when they were pushed for time, and they were constantly surprised by the fact that every story uncovered a new piece of learning. It helped staff to be more specific about feedback and the structure of the process gave people a 'language framework' to have more courage to express emotion, to ask direct curious questions and hear responses. Findings also demonstrated that, through learning, staff developed a capacity for openness in dialogue. In that I mean there is evidence that staff were able to respond in a way that showed they listened to the perceptions of others, good or bad, and to people's regrets, wishes, dreams, and assumptions, without making 'snap' judgments. They began to see that the purpose of their interactions was about expanding understanding rather than making judgments or striving to fix situations.

There was some evidence that the process also gave patients and families a language framework to describe more accurately and honestly how they felt:

I like the fact that you have got positive and negative words lined up here. It makes me think that you have sort of given me permission to use those negative words. (Relative Story, RS2).

6.4.3 Key process issues

Key process issues that arose from carrying out this activity included:

- recognition of the therapeutic value of this method; and

- supporting people to hear and act on stories.

6.4.3.1 Recognition of the therapeutic value

Both staff and patients alluded to the therapeutic value of sharing a story about how they felt.

I am amazed - this story is me – I have never spoken to others in this way – even my family - they don't know how I feel. I enjoyed doing this. I was so worried before doing this I didn't know what to expect. I am glad I said this and I am glad I have this story. I can share it with my family to tell them how I feel - something I have not been able to do. (Patient Story, PS 6).

I feel really grateful as this has been a learning experience for me. I have not been able to talk about how I felt about caring for him before. (Staff Comment, Recorded during field work, Jan 2009).

Thus, there seemed to be an additional benefit to this way of working that was reciprocal for participants.

Naming emotions, particularly positive emotions, and being able to discuss these together was valued by staff. They felt energised and motivated to do this more in their work.

6.4.3.2 Supporting people to hear and act on stories

Using this process could, however, be challenging for the listener. Knowing how to react when people talked about aspects of their lives, or indeed their care, that were distressing was felt to be potentially difficult.

This type of work requires emotional investment. I was acutely aware that, even as an experienced facilitator, I too found the process challenging, as the entry from my field notes highlights:

I noticed feeling pleased today when one of the patients said that he did not feel like doing an emotional touchpoint story. I felt light and free – what was that about? In thinking about this I began to think about the uncertainty and risk that went with this activity – uncertain about what the patient was going to say, uncertain about how the staff member I was doing this with was going to react, would we open up a can of worms, did I have the emotional energy that day to deal with others' emotion? (Researcher Comment, Field notes, July 2008).

Recognising the emotional energy required to undertake this process was thus important. People needed support to hear the positive as well as the negative aspects in a story. It was often the case that, when staff were invited to read a story, they focused on negative feelings. Facilitation that focused on appreciation was needed to enter into discussions that encouraged people to be open and interested in hearing and acting on the perspective of others.

The stories were debated and discussed with staff and actions developed. One story could generate a number of different actions. This did become overwhelming for staff and clear documentation of the actions, even when planned but not carried out immediately, was needed.

This section has highlighted the value of a deliberate process of using a framework to understand how people feel about their experiences. Data from the discovery phase emphasised that when this worked well, people felt safe to do this and prioritised this as a deliberate way of working. However, developing knowledge about how people feel about their experience does ask people to engage emotionally and be open to responses. This can be difficult, and requires a supportive culture, as well as leaders who can facilitate discussions. Findings show that this supportive culture can be enhanced by implementing

a framework such as emotional touchpoints, which makes this way of engaging emotionally feel safer, and helps people to feel confident to use a language that asks us to share explicitly how we feel about an experience and why.

Emotions became more visible and conscious in day-to-day work on the ward. Rather than driving emotions underground or suppressing them, they became part of the way staff communicated.

Hearing and responding to feedback did enable people to reflect on the care they gave or received and thus enhanced people's understanding about what was happening. For staff, it enabled them to adapt practices to meet the needs of all those involved in compassionate caring and developed relationships that were based on interactions that were genuinely curious about other people's perspectives and experiences.

Expressing positive emotions about experiences was an affirming process for staff in particular. For patients and families, they welcomed the opportunity to discuss how they felt, and were able in this process to share both negative and positive feelings. In addition, it helped people to recognise more explicitly what worked well and to value the contribution they made to the caring process. Again, the development of this type of knowledge, similar to '*knowing who I am and what matters to me*' was enhanced by having leaders in the care environment who valued and role modeled this way of working and were thus emotionally sensitive leaders.

The action cycle implemented here is one practical way of supporting people to express emotions in real time. It confirmed *understand how I feel* as a key dimension of person knowledge that helped people explicitly to develop relationships in the context of care-giving. Dimensions of the 7 'C's that were particularly evident during the implementation of this action cycle were: connecting emotionally, being courageous, considering the perspective of others and being celebratory. Again as with developing the dimension of person knowledge of *knowing who I am and what matters to me* staff needed support to feel confident to develop the skills inherent in the 7 'C's.

6.5 Action cycle three: developing positive caring practices

6.5.1 Developing the action cycle

As part of the process of AI, positive care practices were identified from a large number of the data extracts. A positive care practice is an act that happens in practice or is developed as an outcome from feedback and is considered by those in this setting to be an important practice that supports people to deliver compassionate care (Dewar, Pullin & Tocher 2011).

Reflections on data generated during the discovery phase of the study helped staff develop positive caring statements that meant something to them, and that they felt able to defend. They were encouraged by the fact that practices that mattered to them and to patients and families were being validated as part of their work.

Criteria for developing positive caring practice statements have already been discussed in Chapter 3, page 109. In addition specific wording that staff used when debating the extracts was noted and used in the statements. For example, a staff member talked about being human and not always being able to remember to do these positive caring practices. The use of the word ‘remembering’ was used at the beginning of some of the statements for a number of reasons, which included:

- implies the action is already happening;
- recognises that it may not always be possible; and
- implies a process rather than an order or rule.

A sample of the statements is illustrated in Table 20.

Table 20 - Positive Caring Statements

Positive Caring Statements
<ul style="list-style-type: none">• Finding out from families little things that they know can help us to care for the patient, for example, what side the patient normally lies on.• Learning what is important to a patient and using this to influence routine practice for others on the ward, e.g. always offering the patient hand-washing facilities after they have used the toilet, whether they have wiped themselves or not.• Remembering to check out what people would like to be called and not assuming they want to be referred to as for example 'sir', 'love', 'honey' or 'poppet'.

By personalising statements, and giving examples from their own practice, many staff felt a connection with them in a way that was different to the messages conveyed in, for example, best practice statements. Statements were mapped to appropriate images to enhance knowledge transfer. A selection of images and statements can be found on page 111 Chapter 3. The mapping of statements to images builds on the photo elicitation method described in Chapter 3 page 101, where it is suggested that photos can stimulate a greater cognitive response than words alone.

These positive caring practices were observed on the ward during the study, thus they represented something real and possible. They may have been observed during one interaction or commented on by one patient, thus the extent to which all staff embraced

this way of working was not always evident. Rather, they were carried out by particular individuals. It was not necessarily an agreed way of working on the ward.

Following discussions with staff, they felt committed to continue the work inherent in the research in their normal daily practice which was highlighting and celebrating caring practices that worked well and discussing how these practices could happen more of the time.

6.5.2 Implementing action

An activity was developed and implemented to try to capture positive care practices. Staff were encouraged to get together on a routine basis, during a shift, to share with each other ‘what it was that they did today that they felt pleased about.’ These statements were put up on the wall in the office and were shared during the handover meeting at the start of the next shift. Sharing these positive care practices at the start of the next shift often created a sense of positivity among staff:

When you hear about the things that went well on the previous shift it kind of sets you up to approach your work in a positive way, rather than moaning at the start of the shift how awful it is going to be because you are short staffed. (Staff Comment, Recorded during field work, Jan 2009).

It was interesting that staff did not find it easy at first to articulate these aspects of their caring practice. They talked about feeling that they were boasting and that these practices were ‘*just what you do, nothing special*’. Some staff also felt that sharing practices openly in this way could be embarrassing, as others may not feel what you have done was ‘good’:

I feel embarrassed saying something I was pleased about that day – others may think it was a rubbish thing to do. (Staff Comment, Recorded during field work, Jan 2009).

Nevertheless, as the study progressed, staff felt more comfortable with articulating positive caring practices openly.

In addition to this activity, staff felt that by continuing to use emotional touchpoints, as a way of learning about experiences of caring, they would capture other instances of positive caring practice. The positive caring practices were continually updated, transferred onto images and displayed using a digital photo-frame at the nurses' station. Time was made each day for staff to consider one or two of the statements in relation to the framework of questions detailed below:

- how do you feel about the statement?;
- does this care practice happen by everyone most of the time?;
- what helps it to happen?;
- what would we need to put in place to make this happen more often?; and
- how could we take forward this action?

Statements were adapted in light of these discussions and actions were agreed if appropriate. A range of actions were taken forward as a result of the discussions. A sample is given in Table 21.

Table 21 - Actions to enhance compassionate relationship-centred care

Actions to enhance compassionate relationship-centred care
<ul style="list-style-type: none">• Organisation of care changed so larger number of nurses had key responsibility for small number of patients from admission to discharge• Ward booklet reviewed to include excerpts from patient, family and staff stories to reflect experiences of care• Documentation reviewed to include key questions to ask of patients and their families about what is important to them while in hospital• Patient given more choice e.g. asked about how much milk they would like in cereal, flexibility about what time to get up in the morning• Relatives welcomed to the ward within 48 hours of admission and asked what is important to them• Gathering patient and family stories became key aspect of staff's personal development plan• Bibles were now available on all wards in the hospital

Thus, what developed was a collective vision for the ward that was live and dynamic, and included contributions from all staff.

It was interesting that many positive caring examples focused on what appeared to be routine day-to-day acts. This gave staff permission to talk about these acts as well as other more crisis-orientated situations that would normally have been the focus of discussions about caring.

6.5.3 Impact of action

One member of staff felt that this was the most significant intervention that had taken place during the study:

I think the photo-frame has made the biggest difference to staff in the project. It has really got them valuing what they do and discussing care. It has really helped me as a charge nurse, because it has meant that the things that are on there are what we should be doing. It has given me the support to help them to happen.
(Staff Comment, Recorded during field work, Jan 2009).

There was no doubt from the evaluation comments that the statements had contributed to staffs' ability to articulate the 'invisible' knowledge embedded in compassionate caring practice:

Just spending time discussing the things on the photo-frame has improved my knowledge of compassionate care – you do it without knowing – I am more conscious of it now and can say to others what it is. I couldn't do that before. I think that is a good thing because it helps to stand up for things that you believe in – I mean care things – if you can say why you think we should do a particular thing. I think being more aware has helped me to give compassionate care more and also to pay more attention to the impact this has on people. (SE14).

Being able to articulate this knowledge made it more visible, but it also began to help people to align local practice-based knowledge with the evidence base.

The other day we got a booklet about best practice in older people settings – it was quite interesting because normally I would maybe think I did not have time to read this, but I had a look at it and lots of the things that are in there are what is on our photo-frame, except the photo-frame gives us the examples of what happens here and how you do it here which makes more sense'. (SE6).

This activity seemed to give the ward team a way in which to communicate, on an ongoing basis, aspects of good practice that could become a real and collective vision for the way care was to be delivered on the ward. Thus, drawing together expertise that was often not articulated, and gaining multiple perspectives on that knowledge, was a powerful strategy in maximising the core strengths of care-giving on the ward.

In addition, having a common agreed vision, gave people a 'benchmark' with which they could defend practices they wanted to see happening on the ward:

It has been good having the photo-frame. Because it is out there and something we have signed up to, it makes it easier to say to others, no that is not the way we do things here. (SE10).

Thus, the activity helped people to have more courage to challenge practice. The relationship of this activity with the process of measurement is articulated in an article I developed with others (Dewar, Pullin & Tocher 2011).

There was evidence that the activity led to many changes in practice. Some related to specific changes in routines of the ward, e.g. providing milk jugs so that patients could pour their own milk on their cereal, and others resulted in a consciousness raising, which changed the way people acted with patients:

That thing about saying 'I'll be back in a minute'. When I read that I thought, I sometimes do that. It made me realise, and now I say I will be back as soon as I can. (SE10).

The strength of the lever for change related to the fact that these aspects of practice were seen as possible, since they had already been identified as happening in practice. Positive outcomes, however, relied on facilitated discussions, using the framework of questions previously articulated in this Chapter.

As well as using the statements as a tool of evidence to influence the way care was delivered, it was seen as a tool that affirmed to individuals that care they were giving was 'good':

I have learned that I am compassionate – the project has confirmed this for me. With the photo-frame – when I look at the things that are on that – I don't disagree with any of them – I do a lot of them and there are some I don't do but it doesn't feel difficult to think about how I could do it. It all sits comfortably with me. (SE17).

One member of staff also talked about how looking at care with this positive slant and being able to discuss this, helped him to come to terms with the boundaries and limits on caring within the organisation, and focus more on possibilities:

We are so used to moaning about how targets and management get in the way of caring. I think realising all the good ways in which we do care and having time to discuss these has made me realise I need to look for a way round some of the barriers. (SE3).

Thus, the activity helped staff to have a sense of achievement about their work.

There were around 72 statements of positive caring practice displayed visually for staff to debate. A negative impact of this was expressed by one of the staff nurses:

I look at these (statements and images) and ask myself, do I do all of these things in my practice? Is this what is expected of me here? There is the potential to feel a bit low – I think I probably do about half of them so I have some way to go – this can feel a bit demoralising. (SE4).

This highlighted the importance of dialogue about statements, so that feelings could be raised and shared, and people could be supported to develop their practice. The value of

facilitated discussions was crucial in this study in helping people to enhance the quality of debate and interaction that could actually lead to change and action.

It was not possible to debate these caring practices with patients and families as those who had generated the data were no longer on the ward, and other patients were often too sick or frail to embark on such discussions, particularly since there was no immediate connection for them with the data.

There were a number of spin off initiatives from this activity. For example, consultants asked if the photo-frame could be used as part of the induction to the unit for new doctors. Staff also used this to introduce all new members of staff to the ward, including students.

In addition, the charge nurse saw the potential of this activity in supporting staff to have real and meaningful debates about compassionate caring practice and decided to use some of the images and statements as part of the interview process when recruiting new staff. In the past he commented that when you asked questions at interview to try to tap into their beliefs and values about caring it often resulted in rather bland statements from interviewees. Using these statements and images resulted in more meaningful discussions at interview that helped in decision-making. The charge nurse was able to share this with other members on the unit and a decision was made organisationally to include a selection of the images and statements in the recruitment packs.

What this initiative did was encourage people to notice what worked well, affirm it as part of their vision and develop actions to enable these practices to happen more of the time. It gave staff the opportunity to share, in a meaningful way, the complexities and realities of practice. It seemed to prompt them to take another look at what they do. It validated for them the important skills that made up caring and celebrated these actions. It gave staff the courage to take risks, and challenge care practices by sticking up for what they believed in. Thus what can be seen again is the importance of the dimensions of

caring conversations as in the 7 'C's in supporting staff to *work together to shape the way things are done*.

In describing these action cycles, it is evident that some data generation activities became interventions in the action cycles. Seeing inquiry as intervention helped blur boundaries between research and practice and encouraged staff to consider the possibilities of this research approach to their own work. Indeed, values inherent in AI in many ways are congruent with values of compassionate caring. Thus it is perhaps no surprise that staff, in mirroring the process inherent in AI, were developing more as compassionate carers themselves. For example, they considered the perspectives of others more, by directly asking them what they thought and felt about situations. They seemed to be able to accept and welcome complexity more, and were able to identify what compassionate care meant to the team. There was evidence that they challenged others if the ideal caring practice was not carried out, and developed skills of asking curious questions and giving more direct feedback to others about when practices worked well. They, in effect, became appreciative practitioners, a powerful outcome of the research process.

6.6 Chapter Summary

In this chapter I have synthesised the findings from the study to present a model for compassionate relationship-centred care. The model has at its core appreciative caring conversations which have key dimensions encapsulated in the 7'c's. These conversations are the important link between the development of person knowledge and processes inherent in the model. It is through these conversations that practitioners can work together with patients and families and other colleagues to share what matters and to understand how people feel about the care-giving experience. This information contributes to the development of person knowledge which can then be used through engaging in appreciative caring conversations to work together to shape the way things are done.

The 3 action cycles tested out dimensions of the model in practice. The action cycles supported staff to engage more deliberately in caring conversations, in order to develop knowledge about who patients, families and staff were and what mattered to them, and to understand how they felt about their experience.

The data from implementing these action cycles provides evidence that it is insufficient only to develop new activities. Rather, development of compassionate relationship-centred care needed to consider the whole system, where relational aspects such as having courage to take risks, feelings of safety and valuing one another were essential. Implementation of these activities was carried out within the context of AI, where people were supported to engage in appreciative caring conversations to enable relational aspects to develop and to acquire a deeper understanding of the principles that were at the heart of the activity. What is evident in the last three chapters, is the importance of the interactions amongst people as the foundation of compassionate caring. The project activities themselves provided a forum for dialogue between staff, patients and families about what was important to them, how they felt about issues and how they could work together to shape the way care was delivered. It is such dialogue, in the form of the appreciative caring conversations that is necessary for all of these interventions to happen in the context of every day practice.

The next chapter discusses the findings and this model in the context of theoretical and empirical literature and makes recommendations for future research, education, policy and practice.

Chapter 7 – Discussion, recommendations and conclusions

7.1 Introduction

The aim of the study was to explore, develop and articulate strategies that enhanced compassionate care in an acute hospital setting for older people using an AI approach. The study achieved this aim by developing a model for compassionate relationship-centred care that explicitly identifies key processes necessary for delivery of this type of care. The study's objectives were to explore experiences of staff, patients and families in giving and receiving care in order to develop an understanding of compassionate care within the practice setting; to develop, implement and evaluate strategies that promote compassionate care, in 'real time', both at ward and organisational levels and to examine processes that need to be in place to enable these strategies to be sustainable.

Findings discussed in the previous chapters have addressed these objectives. They have provided in-depth examples of the 'how' of compassionate care from the perspectives of patients, families and staff. Through in-depth analysis of data a better understanding of the processes enabling compassionate caring acts has been developed, and a model of compassionate relationship-centred care is presented. The model suggests that through *caring conversations* knowledge about the person and how they feel about their situation can be developed in order that all groups can *work together to shape the way things are done*. The final objective of this study was to identify lessons learnt to inform practice, education, policy and research. This will be discussed more fully at the end of the chapter.

Study findings in relation to these objectives are discussed here in the context of the extant literature. In addition their theoretical and empirical significance is explored. This chapter highlights, in particular, how the findings support, challenge and add to contemporary theory related to processes that enhance person-centred and relationship-centred care, that in turn promote compassion.

The literature previously discussed (Chapter 2) highlighted that people value interpersonal components of caring that make up the professional/patient relationship. Whilst relationships are at the heart of caring, little is known about strategies that help people engage in relation to others, be it staff, patients or relatives. In particular, there is a lack of evidence about key processes that support relational behaviours that lead to practising compassionately.

My research adds to the body of knowledge by developing the meaning of compassionate care and identifying processes that enable this to happen in the context of everyday practice. It contributes to our understanding of ‘the what’ and ‘the how’ of compassionate care. It demonstrates the potential of an appreciative approach in supporting people to develop a way of communicating (the 7 ‘C’s) that helps staff make emotional connections, be curious, collaborative, considerate, courageous, able to compromise and be celebratory.

The chapter comprises the following sections. These sections examine the components of the model in the context of the literature and explore implications of the results for policy, research, practice and education. The first provides reflections on methodology, beginning with an analysis of issues of using the approach of AI and illustrating how this contributes to the claims made and conclusions drawn. This concludes with a review of the study’s key strengths and limitations, in light of findings that emerged, so the reader can judge the relevance of these claims.

The second section (7.3) defines compassionate care as experienced in this study. It argues that current definitions of compassion are too broad and tell us very little about

how to be compassionate. A definition is suggested, which together with the model presented on page 211, is argued as useful in guiding practice. Central to this model is the development of **person knowledge** which comprises knowing the person and **connecting emotionally** to understand how they feel about their experience and **developing relationships** with people through being curious, collaborative, able to compromise, and considerate of other perspectives. All of the above depend on people being supported to have the courage to act in this way. In addition the further dimension of the 7 'C's, being celebratory, is examined particularly in relation to celebrating person knowledge and a collaborative way of working in order to influence culture and political change across organisations. These specific dimensions are examined in the various sections in this chapter and in the context of the literature.

Illustrating how study findings support theories of knowledge used to enhance caring, namely knowledge of the person, is the focus of the third section (7.4). It challenges existing theory about the development of knowledge for caring by arguing that person knowledge can be sought and celebrated in practice in all care settings, not just those where sustained contact is possible.

The fourth section (7.5) discusses a further dimension of the model, that of connecting emotionally, and argues that there is a need to develop capacity for working with a range of emotions (not just negative emotions) as part of the caring relationship, and challenges theory that relates to containment of emotions.

The model advocates that key dimensions within it are important in developing relationships which lie at the heart of compassionate relationship-centred care. Building on existing theories of relationship-centred care, the fifth section suggests that the process of inquiry, of which the 7 'C's of caring conversations form a part, is an important way to develop capacity to enhance relationships, rather than focusing on mechanistic models of skill acquisition to develop interpersonal competence.

The dimension, celebrating caring practices, is notably absent from existing models of caring. Section 7.6 illustrates how findings from this study enhance understanding about developing relational cultures that support evidence-based health care, knowledge transfer and sustainable practice development. It is argued that a central theme in this study is ‘the how’ of celebrating the knowledge and processes of compassionate relationship-centred care. If celebration happens, there is a real opportunity to raise the status of this type of knowledge. It can then be integrated into what counts as evidence. In addition, by naming this knowledge, there is a possibility that it will be more consciously shared and developed.

The final section summarises how findings from this study have contributed to existing theory and developed new knowledge for practice as well as considering implications of the findings for policy, research, education and practice.

7.2 Reflections on Methodology

Strengths and limitations of the study design were articulated in Chapter 3. This section reviews methodology in light of the findings that have emerged. A number of strengths in the design give weight to the findings and conclusions drawn. In addition, new insights about the approach of AI are highlighted.

AI is a relatively new research approach for exploring and developing nursing practice. Few studies have used this approach in the context of care for older people. Those that have used it (see Reed 2010; Reed *et al.* 2002) have focused on its implementation for service development with larger multidisciplinary groups. At the time of writing, no accounts have been identified of using this approach intensively over an extended period of time in one care setting as in this study.

One strength of my study is that it combined AI and AR in a way that celebrated the strengths of each of these approaches. By doing this, the study has produced clear

findings in the destiny phase of this work, articulated as both changes in practice and changes in thinking (see Chapter 6). A recent review highlighted that none of the AI studies carried out in older people care settings had reached the destiny phase of the cycle (Reed 2010). Through emphasising action in my study a number of developments took place and were sustained up until the time of writing this thesis (over a period of two years). There is clearly value in combining these approaches and I believe that the term identified by Egan & Lancaster (2005) of '*appreciative action research*' captures this methodological development. Further exploration of this methodology, as it relates to practice development and improving sustainable outcomes in the health care context, is needed.

AI literature says very little about approaches to data analysis. Important issues that emerged from using the analysis framework of immersion/crystallization (Borkan 1999) in this study were that key questions underpinning the framework enabled practitioners to engage meaningfully with the data and to become co-analysts. This I believe has supported the development of a model that has real meaning in practice for practitioners.

7.2.1 Transferability of findings

The study site was already selected, prior to its commencement (see Chapter 1 for details of selection criteria). The ward was one that had demonstrated, albeit from rather general criteria, that it was compassionate in its caring approach. This may have implications for limited transferability of the findings to other areas, however it could be argued the site had many characteristics of an 'ordinary ward' and that its context is described in sufficient detail throughout the thesis, so readers can judge the relevance of the findings to their own areas of practice.

In addition, I have provided rich descriptions of the cultural context and research methods so that readers can assess the relevance and fit of the findings to other care settings

(Sharp 1998). This study is thus orientated to analytical generalisability rather than statistical generalisability, appropriate given the theory-generating nature of the research.

As part of the wider programme of work (The Leadership in Compassionate Care Programme), I was able to test out the key processes identified in this study across two other care settings; long term care for older people and a surgical unit. The model that enhanced compassionate relationship-centred care had applicability in these settings, thus adding weight to the transferability of this work beyond this particular care setting.

7.2.2 Different levels of engaging with participants

As the study progressed the views primarily of staff, both registered staff and clinical support workers, were elicited, particularly when these were related to making decisions about implementing activities for development. The relatively limited engagement with patients/families is a limitation of this work, but reflects reality in areas where there is a high turn around of patients, making it difficult to engage with such individuals over an extended period. It was possible, through the approach to interviewing using emotional touchpoints, to involve patients and families indirectly in development of knowledge. They were asked during the interviews what would make care better, or to state a time when their experience had been different. These data were used in discussions and debates about developing practice.

7.2.3 Doing research ‘in relation’

The literature discussed in Chapter 2 suggests that perspectives of staff, family and patients about caring tend to be researched separately. Emphasis on interdependent relationships served as a useful theoretical foundation for this study. It encouraged me to examine not only perspectives from all social actors involved in compassionate caring, but to look also at common elements that helped people give and receive care, and consider interventions that have potential application across all three groups. This

dimension sat well with the paradigm of relational constructivism, discussed in Chapter 3.

A strength has been that data generation, analysis and strategies for implementation have focused on all three groups in relation to one another. Therefore these findings present evidence of the relevance of the model for all three stakeholder groups.

7.2.4 Developing the role of appreciative inquirer

Facilitation played a key role in the study's success. There are, for example, repeated references in the preceding chapters to the influence that the process of the research, and thus facilitation, had on outcomes. In the strength-based approach of AI, participants are asked to consider possibilities, to ask curious questions to try to understand why specific actions work well, and to engage emotionally with each other using affirmative language. A key finding is that staff were unaccustomed to talking in this way, and needed help to develop a language that would support this type of engagement.

Within the literature, there are many references to the presence and importance of the skilled facilitator role in participatory approaches to research and development (Kitson, Harvey & McCormack 1998; Meyer 1999; Webster & Dewing 2007).

There is less emphasis in literature on facilitation in practice development and research on supporting people to analyse and articulate what works well and supporting them in this consciousness raising exercise, in order to find ways of encouraging such behaviour to happen more of the time.

I would suggest that the role of facilitation may be better understood by the characteristics identified in the role of animateur, suggested by Boud and Miller (1997) and detailed in Chapter 3. Animation is the concept that they use because of its connotations to give life to, to vivify and to inspire. Animateurs seek to work with

people, situations and relationships. There is a social, emotional and moral relationship between those involved (Smith 1999).

The description of an animateur seems to capture more explicitly the **way** in which facilitation needed to happen in AI, where good practice was being uncovered and ‘brought’ to life. Evidence in my study provides a rich description of the facilitation process in AI developed through processes of reflection on my role and analysis of evaluation data from staff participants. In this study I have been able to expand the hitherto rather narrow definition of facilitation described in other accounts of AI and AR.

It became evident that facilitation or animation was a key factor in the study’s success. Development of these skills requires expertise and is resource intensive. This raises questions both about whether the same outcomes would have been achieved with a different level of facilitation, and how practice developers and appreciative inquirers can be supported to develop these skills. Further work is needed to explore in greater depth how best to support the role of the animateur in participatory research.

7.2.5 Inquiry as intervention

In this study, AI modeled a way of asking curious non-judgmental questions, celebrating practices that work well, which in turn valued people, and helped them to work more deliberately with such processes. These processes became practices that people began to adopt in their own work, as evidenced in the evaluation data detailed in Chapter 5 (under the heading of engaging in appreciative caring conversations). The approach of AI facilitated learning in and from practice and could be seen as one way to be more systematic about learning from practice.

Although the process of AI as a method was powerful, it would be unrealistic to propose that what is needed to guide practice development in compassionate caring is adoption of the research approach of AI. Rather, I am drawn to the ideas put forward by Hornstrup and Johansen (2009), where they eloquently suggest foregrounding inquiry as a relational

and linguistic process. They advocate moving the concept of AI as a noun, to the verb of inquiring appreciatively, where it is recognised as a relational process that occurs with day to day interactions during a range of conversational moments. I believe this more accurately describes what the staff in my study began to do in practice.

The notion of inquiry as intervention is made explicit in AI (Bushe & Kassam 2005) and findings from my study suggest that there may be value in other participatory approaches adopting this principle, particularly in relation to trusting that the process of research itself can result in transformational change in the way people think and act in practice. All too often, novice action researchers are set on implementing a practical change in a project that does not necessarily change the culture of the organisation. This can result in a ‘quick fix’ response where an activity is implemented but there is little change in the fundamental ways in which the organisation thinks and acts (Dewar, Tocher & Watson 2003b).

7.2.6 Judging the quality of the research

The authenticity criteria developed by Nolan *et al.* (2003) were used as a framework to judge the quality of this research (see Chapter 3). The criteria are:

- equal access – are views of all stakeholders solicited and represented in a balanced way?;
- enhanced awareness – do individuals better understand their own situation and that of others?;
- encourage action – is action stimulated and facilitated?; and
- enable action – to what extent have people been given the tools to change things?

7.2.6.1 *Equal access*

During the course of the research, staff, families and patients views were explored, particularly in relation to their experiences of giving and receiving care. Thus, attempts

were made to seek views of all stakeholders. In relation to actions that were then pursued in this work the views mainly of staff were accessed for pragmatic reasons already identified. It might be said that the principle of equal access was not fully met but that given the constraints of the caring context every effort was made.

Staff gave evidence of where they felt their ideas had been listened to and taken on board.

I have felt heard. But I think the patient is more heard really as a part of this project. If someone wants to sit up – we know there are times when we think they should go to bed – but if we listen to the patient and not just do things because they are convenient to us... I suppose I feel heard because when I argue this point with other staff – to let the patient stay sitting up if this is what they want to do – people listen to me now. (SE12).

Thus, the staff member felt heard in the process of the research but, in addition, she was able to change the way in which she worked, so that ‘feeling heard’ was an aspect of her interpersonal behaviour that she valued and tried hard to act on in her daily practice.

Staff felt that, through the processes of the research, they were able to hear the voice of the patient more: *I think patients feel more able to say what they would like now – they are more often asked and able to tell. (SE1).*

So although patients and families were not specifically asked if they felt heard or listened to, staff accounts give some evidence that they were asking patients and families questions and were more open to hearing responses.

Some staff felt really involved and enjoyed being part of the study and others felt less comfortable:

It’s been really good. It’s given me an opportunity to really look at myself. I have felt involved – and at a level I feel comfortable with. (SE6)

It's been strange. It's felt a bit insecure. I think it's made staff ask more questions and it's brought up some stuff that is hard to think about. I think being observed was a bit difficult. Staff are more defensive now. I tried to give a positive take on the project but I have just given up. I never felt I had time to spend on it. I had other things I wanted to achieve. (SE13).

This latter quote seemed to highlight that even although the approach to the study was appreciative in nature, the very act of asking curious questions about how and why people are acting in particular ways could feel threatening.

There was evidence that staff felt listened to, even if what they were saying did not sit comfortably with myself as the researcher:

I do feel I have been listened to and my opinions valued. It was like the time with the diabetic label above the bed. You didn't think that was a good thing. I didn't agree with you on that one – you listened to me and we did not take that one forward. (SE8).

There were different levels of involvement for staff. Some were involved in a number of ways and others remained on the periphery of the study. This was influenced by their willingness to be involved as well as pragmatic reasons, such as their availability. Data were shared with participants through, for example, wall charts showing themed data, and a final report. This seemed to help people to feel connected to the study.

The majority of staff felt that their input was valued and that processes inherent in the research enabled them to hear the voices of patients and families in a more deliberate way. Views of patients and families were elicited as part of the research, but more importantly, methods used in the research enabled staff to incorporate processes of asking direct questions into their day to day work, which in turn gave patients and families more of a voice.

7.2.6.2 *Enhanced awareness*

Staff expressed, through the interviews (Chapter 5), increased awareness of how they acted. They were more conscious of their behaviour and used this to change the way in which they interacted with people.

It was clear that it was the process of the study as well as the outcomes that had encouraged people to have greater awareness of the way they acted:

Having sessions with you when we were able to express our opinions – having this opportunity was good. It made me really think about what I was doing. Like the situation when you worked with me when we were caring for the person with dementia. I really learnt through discussing things afterwards about how to do things better. With a patient with dementia – sometimes you think they are not talking sense but if you really listen they are. I think I maybe used to judge them – and think they were talking nonsense and not really listen – but this has changed for me. (SE2).

Enhanced self-awareness had an added benefit of being able to articulate this to others:

It's improved my knowledge of compassionate care – you do it without knowing – I am more conscious of it now and can say to others what it is. I couldn't do that before. I think that is a good thing because it helps to stand up for things that you believe in – I mean care things – if you can say why you think we should do a particular thing. (SE15).

The changes that occurred in practice arose out of a deeper fundamental understanding of processes that were important to people; for example, not making assumptions about care and finding out what is important to the individual. Not assuming that they would want to be cared for in the same way as you, changed the way people thought rather than just what people did. There was a shift to a new lens.

I realise that compassionate care is more than I thought it was at the start of the project – it's physical, emotional and its not just about patients, it's about staff too. (SE7).

Many staff felt positive about the impact of the study on enhancing their awareness of situations and were able to see this as a learning opportunity rather than criticising something that was wrong. There was also evidence that staff developed an enhanced awareness of themselves and of the emotions that guided their behaviour. The majority of staff made comments in their exit interviews that the study had resulted in an enhanced awareness of their actions and made compassionate caring a more deliberate act.

7.2.6.3 Encouraged and enabled action

Evidence presented in the preceding chapter highlights a number of actions that were taken forward to enhance compassionate caring. Bushe and Kassam (2005) suggest, when trying to achieve transformational change, that letting go of control in the action phase and nurturing a more improvisational approach where numerous diverse ideas for change are pursued by a range of actors is more appropriate. A wide range of actions was taken forward (see page 241 Chapter 6). One of the main tools people had been given to help them to develop practice, was a new language framework in the form of the 7 'C's of caring conversations (Being Courageous, Connecting emotionally, Being Curious, Collaborating, Considering other perspectives, Being able to Compromise, and Celebrating caring). This framework helped staff to be more deliberate in communicating in appreciative ways so that compassionate care could be enacted. Evidence to support acquisition of these skills in the form of the 7 'C's is highlighted in Chapter 5.

There is evidence that the criteria identified by Nolan *et al.* (2003) were met in this study. A summary of the strengths and limitations of my work is detailed in Table 22.

Table 22 - Strengths and Limitations of the Methodology

Strengths	Limitations
<p>Combination of AR and AI enhanced ability to achieve outcomes during the destiny phase.</p> <p>Relational perspective gave a more complete understanding of perspectives.</p> <p>Process of data analysis was flexible, inductive and engaged emotionally with participants enhancing co-analysis and as a result making the model more meaningful to practitioners</p> <p>Study achieved changes not just in what people did but in the way that they thought, thus enhancing sustainability of development.</p> <p>Research can be regarded, by mapping it against the authenticity criteria, as ‘good participatory research’.</p>	<p>Transferability of the findings may have some limitations and further work could be done to test the framework in other care settings.</p> <p>Patients and families had less access to data than staff.</p> <p>Facilitation of the research process in line with the principles of AI required considerable skill and expertise. It raises questions as to whether the same results could be achieved by another facilitator who may be less experienced. Facilitation is resource intensive.</p>

Thus, in considering my reflections on the use of AI in this study I argue that the findings support development of knowledge in this area, in particular, related to:

- the value and outcomes of using the combined approach of AI and AR;

- aligning the analysis of data using immersion/crystallization with the approach of AI;
- identifying key attributes of an effective appreciative inquirer or animateur;
- key practical considerations in carrying out this approach in a culture that is characterised by hierarchy; and
- the important contribution that seeing inquiry as intervention had on a key outcome of this work, that is, staff themselves developing skills of appreciative practice, which in itself was compassionate.

7.3 On defining compassion

My study did not set out with a precise definition of compassion. Rather, a key objective was to examine what the term meant to patients, staff and families. The literature discussed in Chapter 2 identifies compassion as a response to suffering, rather than to vulnerability. There is a lack of literature that explores the term as it applies to day to day nursing practice. Indeed, it is argued that current definitions of compassion are too narrow and tell us very little about **how** to be compassionate.

The findings of my study demonstrate that acts of compassion happen in numerous encounters between patients and staff, staff and staff, and staff and families. In addition people are driven to respond to others in compassionate ways when they recognise vulnerability, not just suffering. For example, picking up from a patient that they have no shower gel and that they have no family to bring this in and making an effort to bring some in from home is about recognising vulnerability and acting in a compassionate way. Also missing from current definitions is the issue of whose frame of reference we use when we decide to act compassionately. Making careful judgments about how to act based on what will have meaning for all parties was seen as crucial in this study.

Discussions about compassion in the literature helpfully identify a number of key dimensions including the importance of recognising suffering (Chochinov 2007; Jormsri

et al. 2005) the centrality of relationships (Peters 2006) and emotion to the process of compassion (Snow 1991) and the process of reaching beyond our own self interest (Peters 2006). Definitions do not necessarily draw these dimensions together. A definition of compassion from my study that relates these elements, as well as emphasising compassion as a day to day act, and its subjective and relational nature requiring a process of exploring and establishing meaning is suggested.

Compassionate relationship-centred care is thus defined in this study as a relational activity:

*the way in which we relate to other human beings when they are **vulnerable** . It has to be nurtured and supported. It involves noticing another person's vulnerability, experiencing an emotional reaction to this, and acting in some way **with** the person, in a way that is meaningful for people. It is defined by the people who give and receive it, and therefore interpersonal processes that capture what it means to people, are an important element of its promotion.*

The interpersonal processes that capture what it means to people are delineated in the model identified at the beginning of Chapter 6. These processes of caring conversations that help people to *know who I am and what matters to me, and understand how I feel* are central to being able to *work together to shape the way things are done* .These processes support people to deliver compassionate relationship-centred care. The definition and model presented in this study contribute significantly to the 'how' of compassionate relationship-centred care. Whilst the proposed definition and model were tested out in a number of settings in addition to that described here, further exploration through research would confirm whether the domains and concepts require additional elaboration. Key domains of the model are discussed in relation to the literature in the following sections.

7.4 Developing and validating person knowledge in the context of everyday practice

Findings emphasise the importance of knowing the person and identify *knowing who I am and what matters to me* to be a key dimension of knowledge necessary to deliver compassionate relationship-centred care (see Chapter 4 and Chapter 6). Sub-themes of *knowing the little things that matter* and *not assuming how people want to be cared for* were identified as important elements of *knowing who I am and what matters to me*. Evidence confirms that this knowledge was valued by staff, families and patients. Person knowledge was related, for example, to information about people's background, the context of their life, their likes and dislikes, and what mattered to them.

This finding is consistent with literature that discusses knowing the person in the context of the caring relationship (Bridges, Flatley & Meyer 2009; Dewing 2004; McCormack 2004; Nolan *et al.* 2006; Walsh & Kowanko 2002). More recently, systematic reviews by Bridges, Flatley and Meyer (2009 and 2011) have identified knowing the person, as 'see me', and as a key process that is valued by patients, families and nurses, in older people care settings. They found that when nurses were able to do this in their practice, the experience was fulfilling.

There is strong evidence in my study of the value of person knowledge for staff both in helping them to develop relationships with people and in informing care decisions. Many staff developed this knowledge as part of everyday action and often used the information to influence care. This resonates with findings from a study carried out in care homes by Brown Wilson, Davies and Nolan (2009), where much of this knowledge is generated through daily care routines. There is some evidence to indicate that staff valued this knowledge about each other and used this to enhance team working. Whilst the literature review highlighted that patients value person knowledge about the staff (Atree 2001) there is less evidence in my study about the extent to which patients and families deliberately sought out person knowledge about staff or indeed where staff offered this type of knowledge in the relationship. Where there was evidence of this happening (see

data under sub-heading of *personal sharing* page 140) this was valued by all, but there was a sense that personal sharing both ways was not seen as something that was legitimate and might involve taking a risk. That said, the process of AI helped staff to see the value of this aspect of relationship building.

Bridges, Flatley and Meyer (2011) suggest that nurses view relationship building skills, such as personal sharing, as primarily serving the patients' needs, rather than being related to their own needs for human connection. They suggest that nurses are limiting their understanding of relationship to its therapeutic dimensions.

Findings from my study concur with those of Bridges, Flatley and Meyer (2011) in that the primary purpose of personal sharing and reciprocal dialogue was viewed by the nurse as helping the patient. It is suggested that evidence needs to be further developed to support the claim that person knowledge about staff for patients is of benefit to the relationship in acute care settings.

It is useful to note in Liaschenko and Fisher's (1999) theory about knowing the person that 'person-knowledge' is not always necessary, especially in acute or emergency settings, but is crucial when long-term goals are the focus. In their theory they suggest that three broad types of knowledge can be used to inform health care: case knowledge (biomedical, scientifically derived knowledge that is independent of a particular individual or context.), patient knowledge (concerning an individual's reaction/response to a disease and its treatment) and person knowledge (an appreciation of what it is to live a certain kind of life, to be a person with a unique biography). Interviews with staff, patients and families reflected primarily the value of person knowledge to the care experience. This finding is consistent with claims in the literature where patients and relatives largely take the technical and clinical aspects of care for granted and that their experiences are largely shaped through the relational aspects of care (Bridges, Flatley & Meyer 2011).

Although Liaschenko and Fisher's (1999) knowledge typology of case, patient and person knowledge, is useful in identifying different types of knowledge nurses use in their work, the typology is represented in a rather hierarchical way. Furthermore, Liaschenko and Fisher (1999) argue that knowing what is important to the person is not desirable for all patients in all contexts. It tends to be more relevant in situations, for example, in which an illness has markedly disrupted a person's life. This claim is not supported in my study, and I would suggest that this is a narrow view of where person knowledge is appropriate. Rather, findings illustrate that staff tried hard to use windows of opportunity to glean person knowledge and saw this as a priority. There was evidence that patients and families made decisions about what to share and when. The key issue, tested out in the action cycle (see Chapter 6), was that patients and families were asked and invited to share such information if they wished.

Scepticism regarding when and where the search for this person knowledge should happen may be associated with the fact that much of the empirical work that supports Liaschenko and Fisher's (1999) conclusions is derived from intensive care settings where patients' conditions may mean that there are difficulties in communicating such knowledge, and the priority for care may relate more to physical interventions. Findings in my study suggest that rather than there being a hierarchy of the types of knowledge used to inform care-giving, all are important and can be gleaned together. Evidence in my study demonstrates that even the most transient of contacts can reflect an orientation towards a supportive connection between those involved. If person knowledge is considered optional in care settings, then it will continue to be difficult to articulate and celebrate.

Thus, findings from my study add to the body of knowledge that informs care-giving, and support the value of development of person knowledge in an acute care setting. To further support this claim, I have had the opportunity to test out the value, development and use of person knowledge in a range of sites, including surgical areas, where data have highlighted staff, patients and families value this knowledge and see it as important to inform care-giving.

Fosbinder (1994) presents strong empirical data expressed as a model of interpersonal competence that has four processes (Chapter 2, page 40): translating, getting to know you, establishing trust and ‘going the extra mile’. Whilst there is strong evidence in literature that processes such as these are important, there is less evidence on how these can be supported in practice. Specific skills identified in my study, and detailed above, provide important empirical data about *the how* of developing person knowledge.

Liaschenko and Fisher (1999), in their theory about the knowledge nurses use in their practice, identify the concept of social knowledge that they believe nurses use to link case, patient and person knowledge. Social knowledge is knowledge about human beings as social actors in social contexts. They argue that social knowledge is complex and includes knowledge of “*people’s commitments, priorities, competencies, style of working, vulnerabilities, emotions that accompany human interaction and the appropriate languages to use with these multiple others*” (Liaschenko & Fisher 1999, p. 36). They suggest that this knowledge can only be accessed through local interactions and relational practices. To date there has been little clarification in the literature of how this social knowledge can be developed in practice.

The findings from my study provide some evidence for articulating how social knowledge can be enacted. For example, in relation to the knowledge dimension of *knowing who I am and what matters to me*, discussed in Chapter 4, the implementation of asking in a sensitive way, questions to generate person knowledge highlighted the skill and challenge involved, particularly in eliciting information about what matters to people that reflected their priorities and commitments. In addition key skills such as personal sharing, use of humour, and use of language that reflects personhood were important. These skills have been advocated by other researchers (Brown Wilson 2009; Brown Wilson 2007; Haggstrom *et al.* 2004).

The example of the ‘Bible’ story described in Chapter 6, page 223, illustrates the use of this social knowledge well. After discovering that it was important to one lady, who was

blind, to be read a chapter from the Bible, staff had to carefully negotiate a series of interactions characterised by dimensions of the 7 'C's (being courageous curious, collaborative and able to compromise), with the chaplain, infection control nurse and other wards in order to access a Bible for this lady and have Bibles reinstated in all wards in the hospital.

These interactions helped to move case and patient knowledge, which is primarily concerned with helping staff understand people's response to illness, to person knowledge which is more about maintaining a person's integrity. What people were doing through caring conversations, that helped them to understand what mattered, was create patterns of connectedness between people, the environment, actions, perceptions, ideas, feelings, events, beliefs and contexts and to use these to influence care. It is important to note that, in understanding what matters to people, it may be that an individual would wish that people did not ask them how they were feeling or indeed engage with them in a personal way. This is part of knowing what matters to the person.

Findings in my study reveal however that person knowledge was not always shared with others, therefore minimising the extent to which knowledge might be used to inform care. The action cycle, discussed in Chapter 6, that focused on development and implementation of a set of questions (for patients) to ascertain *knowing who they are and what matters*, revealed important practical knowledge. It was evident in the findings of implementing the action cycle, that developing person knowledge was a complex process that asked people to make connections quickly, emotionally engage with each other and discuss this knowledge in order to understand how it could impact on people's experience in the context of the wider organisational setting. The findings have identified challenges in eliciting this type of knowledge. These included, uncertainty about dealing with responses, and dissatisfaction when staff felt they were unable to act on this knowledge due to organisational constraints and the emotional tension this could create when the knowledge gleaned challenged professional assumptions. Being able to have conversations about the challenges of developing this type of knowledge, and acknowledgment of this in the care process, was something that required interpersonal

confidence and expertise and required support. When staff were able to develop person knowledge about the patient, family member or other members of staff, they found it fulfilling and there is some evidence to suggest that it helped them to make decisions about care.

My study argues that, whilst there is evidence that person knowledge is important in caring, acquiring and using it is a complex skill for which people need support. Empirical studies have not explicitly sought views about what it feels like to generate and use this type of knowledge. Findings from my study claim that skills necessary to develop it require expertise. The expertise is delineated in the framework of the 7 'C's. Dewing (2004) notes that whilst all of the person-centred and relationship models emphasise the importance of knowing the person and 'being in relationship', this is skilled work and a process that demands expertise. Support required to develop this competence will be discussed further under the heading of 'developing relational capacity'.

The literature review has already highlighted the invisibility of this type of work (Liaschenko and Fisher 1999; Pearson 2006). My study has made these interpersonal skills required to develop person knowledge more explicit and thus provides a unique contribution to the body of knowledge. It was apparent, however, that staff did not feel that such skills were validated by others as an important part of their work. This lack of validation is supported by Liaschenko's comment:

...the kind of interventions this (person) knowledge demands is increasingly seen as fluff, not essential to users of health care in which people are cared for only on the basis of case and patient knowledge
(Liaschenko 1997, p. 24.)

Liaschenko (2002) suggests that new nurses learn very quickly what the 'official' and 'unofficial' work of an organisation is, and that emotional work may be seen as an extra. National performance targets may work against the existence of a reflective culture, making it difficult for staff to feel able to value this knowledge and see it as a priority.

Contemporary literature also argues that, for compassion to be realised, such knowledge and the processes inherent in its use need to be accorded value and status (Williams, Nolan & Keady 2009). Indeed this type of knowledge is rarely audited in assessment of quality and is seen in care contexts as optional rather than necessary. There is evidence from the findings in my study that the approach of AI helped to validate this knowledge, at least for staff, and enable them to value it, raise it into their consciousness, deliberately use this in practice and celebrate it. Evidence for this can be found in Chapter 5 where staff talked in exit interviews about using such knowledge in practice.

Key strategies were adopted in the care environment to raise the profile of, and celebrate this knowledge, e.g. the consultant including ‘what was important to the patient while they are in hospital’ as a key question in team meetings to facilitate learning about progress with patients on the ward.

Gordon and Nelson (2005) argue that we need to move beyond the virtue script that underpins nursing and develop a knowledge script. This study identifies this knowledge script by expanding our understanding of person knowledge, and its related skills, so that they can be assessed and valued in the context of health care. Staff enjoyed learning about what helped them to deliver effective care. However, these dimensions were very rarely questioned or asked about by others in the organisation. Managers, for example, visited the ward regularly to collect figures about bed status, sickness, clinical quality indicators, such as falls and infection rates, but rarely questioned staff about evidence related to the patient experience of caring. Although the organisation was promoting a range of quality initiatives that focused on values-based care, the extent to which this was truly integrated into management processes within the system was questionable. Reed and McCormack (2007) raise concern that issues such as dignity that cannot be captured through traditional measurement, may not be seen by managers to have equal importance in their reporting of monthly performance. Goodrich and Cornwell (2008) and Maben, Cornwell and Sweeney (2010) point to the current emphasis on *counting* and measuring activity as focusing attention away from the little things that are so important to the

quality of the patient experience and see this as one factor that impedes delivery of compassionate care.

Griffiths et al. (2008) argued the need to develop a set of indicators to measure the patient experience. My study provides important dimensions of person knowledge that could be included in, for example, audit tools. This work is currently progressing within the wider organisation in which this study took place, as a direct result of its findings and the work of the other senior nurses in the wider programme. Whilst there are opportunities to integrate some of the key findings from this study into traditional measurement tools there is also a need for policy makers to adopt a more eclectic view about what counts as evidence and the extent to which traditional measurement is the only and most appropriate way forward. It is suggested that certain methods adopted in this study e.g. use of images and of emotional touchpoints created important evidence not captured by more traditional tools such as questionnaires.

This section has discussed the findings of *knowing who I am and what matters* in relation to existing literature and contemporary theory. Findings add weight to the theoretical claim that knowing the person is important in care-giving, and suggest that this may be the case for patients, staff and families. Findings challenge existing theory that suggests that this knowledge may not always be necessary in all care settings, and it is argued that person knowledge should and can have equal footing with other types of knowledge used in health care. Findings highlight the complexity of using person knowledge in interactions and identify new knowledge about what it feels like for the nurse to elicit this type of knowledge. An appreciation of the challenges in using such knowledge in practice is largely absent in literature. The framework of the 7 'C's supports practitioners to explore these challenges. Findings build on the theory that the interpersonal processes used by nurses to develop and use person knowledge make up what Liaschenko and Fisher (1999) call social knowledge. It is suggested that this study identifies important dimensions of person knowledge so that it can be included in, for example, audits and student assessments, and can be valued and assessed. This may go some way to support

the plea by Isles and Vaughan Smith (2009) when they argue for systems where both transactional and relational models can co-exist.

A further component of person knowledge, explicit in the model of compassionate relationship-centred care described in this study, was finding out how people feel about their experience which required that the person engage emotionally. This dimension is discussed in the context of the literature in the next section.

7.5 Developing capacity for working with emotions as part of relational practice

Findings demonstrate that sharing how people feel about their experience, in dialogue with each other, helped people understand the person and themselves in the context of health care. Development of this dimension of person knowledge helped people build stronger relationships and negotiate care-giving that met the needs of all groups. Being able to negotiate care was made easier by the fact that people began to understand how others felt about a particular situation. Often this meant that, through expressing emotions, they exposed mutual vulnerability in the interaction which in some ways helped mediate the power that is inherent in the nurse/patient relationship.

Developing capacity for working with emotions in the context of the relationship was achieved through the process of using emotional touchpoints. This supported people to *feel safe and take the time to ask and tell*, a sub-theme of this dimension. Through the process of the research, staff, patients and families identified challenges of sharing emotion which included identifying or naming emotions and feeling safe to ask and tell. Key outcomes of the process of using emotional touchpoints were that it encouraged;

- expression of emotion within the relationship;
- expression of both positive and negative emotion; and

- expression of emotion as part of day to day work.

7.5.1 Expression of emotion within the relationship

Research into the emotional work of nurses and the way they manage this in the context of the health care relationship is not new (Akerjordet & Severinsson 2007). Indeed, the seminal work by Menzies Lyth (1959) as discussed in Chapter 2, observed that nurses protected themselves by adopting defences that enabled them to avoid or gloss over elements of the emotional demands of their work. Contemporary literature suggests this self-protection continues (Allan 2001; Eriksson & Saveman 2002; Mackintosh 2007; Smith & Gray 2001). The danger of suppression of emotions is that they have the potential to resurface as unconscious non-therapeutic action (Holman, Meyer & Davenport 2006; Smith 2008). Thus, there has been emphasis in literature about the negative impact of emotions and the need to contain them. Findings in my study suggested that the invitation to express emotion in the touchpoint activity gave legitimacy to emotions, whether they were positive or negative, and permission to express them.

More recently, contemporary literature on emotions in health care emphasised the importance of recognising and valuing the emotions involved in nursing work and in particular in compassionate caring (Barker & Barker 2004; Finfgeld-Connett 2008; Freshwater & Cahill 2010; Kooker, Shultz & Codier 2007; Smith 2008; Theodosius 2008). Absent in this literature however is how to support this in practice. Literature has examined emotions in health care in the context of either the practitioner or the patient. There is little evidence of examining the relational nature of emotions. More recently, Theodosius (2008) suggests that the concept of emotion management, as portrayed in the literature, has potentially limited the relational aspects of emotion, particularly the processes that take place during the patient/ nurse interaction.

The process in this study of deliberately engaging with emotions in the context of dialogue, acknowledges this limitation and puts forward a strategy that is relational. This

study has provided evidence of how people can be supported to explore emotions **together** during interactions (see action cycle in Chapter 6). Using emotional touchpoints as a language framework to help people express emotions during interactions, enabled people to share their feelings about a particular situation. The expression of emotion in these interactions was viewed positively by patients, families and staff. Some participants talked about the therapeutic benefit of being able to share their emotions in this way. Thus, this practical strategy makes a unique contribution to the growing body of knowledge related to enhancing emotional capacity during the patient/staff encounter in health care work, by explicitly telling us **how** to do this.

7.5.2 Expression of both positive and negative emotion

Findings in my study also demonstrated that there was real value to the relationship if there was an emphasis on expressing both positive and negative emotion.

This study has provided many examples of the positive emotions felt by staff, families and patients:

I felt proud as the staff had probably heard what she was saying so many times already but they reacted as if they had heard what she was saying for the first time. (Relative Story, RS2).

I am amazed - this story is me. (Patient Story, PS6).

I feel really grateful as this has been a learning experience for me. (Staff Comment, Recorded during field work, Jan 2009).

We all came out feeling more confident that everything was going to be done to keep her comfortable. (Staff Story, SS10).

It made me think about how much I enjoyed sharing in the wider aspects of a person's life not just the medical part. (Staff Story, SS7).

Explicitly expressing positive emotion was seen as a valuable experience for staff, patients and families. It helped promote feedback about what people valued. Findings demonstrated that this helped people develop relationships and have a more balanced view of negative emotions. Much of the work of positive psychology in health care focuses on the patient and how positive thinking, expressed through positive emotions, can help them to cope with illness (Post 2005). Little work has been done with nurses and how positive psychology can influence the emotional labour inherent in their work. There is more scope to integrate theories of positive psychology into current work that examines the emotional world of health care practitioners. This study has begun to explore the benefits of this.

Literature on emotional work has not only focused on negative emotions but has viewed their expression negatively, as something that has to be carefully managed (Bolton 2000; Mazhindu 2003; Payne & Cooper 2001). These writers emphasise emotions as potentially disruptive, interfering with a rational approach to situations, rather than viewing emotions as fundamental to human experience and enhanced understanding. Other authors have articulated their concern about this approach. For example, Stickle and Freshwater (2002) talk about 'rehabilitating' the emotions deemed to be inappropriate back into the nurse patient relationship, so that we change from adopting a model of 'keeping your distance' to one of meaningful engagement. Furthermore, Theodosius (2006) proposes that emotional relationships connect individuals to each other, which in turn may help people to contain their emotions.

In exploring the literature on emotions in healthcare there is limited reference to an examination of the expression of positive and negative emotions in the dialogue of the nurse/patient/family relationship. My study explicitly focused on this and outcomes were that it enhanced relationships, resulted in more equitable relationships, and enhanced staff and patient experience of caring (see action cycle 2 Chapter 6). The study findings thus

add to our understanding about how to support people to express the range of emotions experienced in the health care relationship.

7.5.3 Expression of emotion as part of day to day work

Isles and Vaughan Smith (2009) suggest that leaders need to open up to the anxiety, risk and uncertainty inherent in health care and to be courageous and creative in bringing themselves to work rather than leaving their values, emotions and desires at home. Findings from my study demonstrated that, through the use of emotional touchpoints with staff, patients and families, people used this language framework to help them to recognise both positive and negative emotions and share them in a way that felt comfortable. Staff were thus able to develop the emotionally sensitive leadership described by Isles and Vaughan Smith (2009). Staff began to ask questions about how people felt in their day to day practice. In addition, there was some evidence that they were more aware of their own emotions and felt more comfortable to share them with others. Thus, the action cycle (Chapter 6) helped people embed the expression of emotion into their day to day work.

This expression of emotion in day to day work is in contrast to strategies advocated in the literature to support practitioners emotionally. Much of the literature on how to support people to express emotion centres around strategies such as reflective groups and supervision, and there is evidence to suggest that nurses rely on informal networks rather than using more formal support mechanisms (Nordam, Torjuul & Sorlie, 2005; Quinn 2003). Holman (2006), in her study, argues for reflective groups, suggesting that these can act as a way of containing emotions. She advocates helping people to ‘be with emotions’ rather than acting on them. She supported staff through reflective sessions ‘off the ward’ as part of the research process. Although such support sessions were seen as valuable in helping people to express and ‘be with emotions’, Holman (2006) argues that integrating this into the culture of the wards was difficult in her study, since the custom

and practice of the ward systems supported psychological defences, similar to Menzie's work carried out over thirty years ago.

This raises questions about the readiness of organisations to see expression of emotion as central to caring, and suggests that attention needs to focus on sharing emotion as a normal part of day to day caring interactions in the health care environment, if this aspect of work is to be valued. Bringing people out of the practice environment to express emotion could be seen as negating the important role that expressing emotion plays in the interaction within the environment and that helps to humanise interactions. There is evidence in my study that the use of emotional touchpoints as a regular part of routine work can help to create a culture where it is normal to share emotions as part of the interpersonal dialogue.

Negative emotions expressed by patients, families and staff in this study related to when they felt care was not given in a way that people wanted. There is increasing evidence in the literature that another key source of emotional labour is managing the dissonance generated by the co-existence of conflicting ideologies of practice (Hunter 2005; Milner 2003). This is further supported in the systematic review of nurses' experiences of caring in older people settings (Bridges, Flatley & Meyer 2011), where they report that if nurses were not able to meet their personal aspirations for care they experienced moral distress. It is evident in Bridges, Flatley and Meyer (2011)'s systematic review that when nurses were able to deliver care that matched their personal aspirations and was seen as best for the patient, they experienced gratification, personal enrichment and privilege.

The potential for dissonance and resultant emotional labour is perhaps more acute than ever in contemporary health care practice, where the focus is on a public management model which has characteristics of achieving efficiency and cost effectiveness, and not perhaps on the factors that facilitate meaningful caring.

Findings from my study provide an interesting perspective on this relationship between the ideal care practice and emotion. Evidence showed that staff felt more positive about

relationships if they could be open and honest about expressing their feelings, particularly if this was in relation to difficulties in providing care that people wanted. This was highlighted in one of the stories presented in Chapter 5 where it was unrealistic to help a patient to walk to the toilet all of the time and she was encouraged, through thoughtful and sensitive interaction, to use the commode some of the time. The openness and honesty that staff valued in this study is highlighted by Shapiro (2008, p.7) who argues that human connections

need to support expressions of vulnerability, sharing mistakes, incorporating not knowing; awareness of and transparency of the emotional impact of health care work; and acknowledging the common bonds of humanity with patients, relatives and colleagues.

Thus, findings from my study suggest that *working together to shape the way things are done* supports people to identify and work towards more achievable shared goals and to develop a collaborative model of practice. It is suggested that the process of *working together to shape the way things are done*, minimised dissonance between the ideal and practice reality which resulted in a reduction in negative emotion associated with such dissonance.

This relationship of emotional well-being and collaborative models of practice links closely with recent empirical work identified by Freshwater and Cahill (2010). They highlight two potential areas of dissonance in the caring profession that impact on staff well being. One is emotional labour and suppression of emotions; the other is reliance of the professional on evidence, both of which may result in the need to compromise. Freshwater and Cahill (2010) explore the construct of ‘compromise’ and develop a framework where this can be used positively to help staff to cope with the dissonance that arises when suppressing emotion and trying to implement evidence from propositional sources. Processes identified in my study of *engaging in appreciative caring conversations*, where being able to compromise is a key dimension and *working together to shape the way things are done* could provide important knowledge to support

development of this work. It is argued that these processes may help nurses take a more active role in shaping care that is more realistic and meets the needs of all parties. If nurses are constantly judging successful care on their personal aspirations then they may often fail. Adopting processes identified in this study during appreciative caring conversations may result in a closer match of people's philosophies and actual practice of care, which in turn could result in a better experience for all parties.

In my study, understanding how people feel about their experience was important in developing relationships and trust within the caring relationship, and was seen as a key dimension of person knowledge that was valuable in delivering compassionate care. Recognising and expressing emotion is not easy, and in the fast pace of contemporary health care this could be seen as a luxury (Dingwall & Allen 2001). There is a danger, within the current climate of health care, that staff will put up emotional barriers and that these will become the norm. Rather than thinking about strategies of self management, containment, and support groups separate from the world of practice, findings from my work support the value of celebrating emotion that is a natural part of interactions and being human, and encouraging this in the day to day work of the nurse.

If we acknowledge the growing evidence that emotional distress can result from the dissonance experienced when care aspirations cannot be met (Bendall 2006; Freshwater & Cahill 2010; Maben, Latter & Clark 2007), this study provides important evidence of how to develop more realistic and achievable goals for care that meet the needs of all parties, which in turn can result in positive emotions related to fulfillment and achievement.

Although the activity of using emotional touchpoints was developed initially by the NHS Centre for Improvement and Innovation (<http://www.institute.nhs.uk>), it has not been subject to systematic analysis. The findings in my study provide important evidence of the value of emotional touchpoints in everyday health care practice. They supported practitioners to understand how people felt about their experience of caring, a key dimension in implementing the model of compassionate relationship-centred care. This

value to contemporary practice and research can be evidenced by my publication with colleagues about use of emotional touchpoints (see Dewar *et al.* 2010) and repeated requests from policy, practice and education to support people in developing expertise to take this activity forward.

7.6 Caring conversations the key to enacting compassionate relationship-centred care

My study provides important evidence about the micro-level processes needed to develop relationships in the context of health care. In particular, it highlights attributes of caring conversations necessary to work in relationships to enhance compassionate care giving. Attributes of connecting emotionally, being curious, collaborative, considerate of other perspectives and able to compromise, being courageous to take risks and to stick up for what you believe in, and celebratory were seen to be important. Such attributes enhance caring conversations and are the key domain in the model presented in Chapter 6.

Nursing theories emphasise the relationship between the professional and the patient as being a condition for good quality care (Dewing 2004; Hem & Heggen 2004). The practitioner/client relationship is core to releasing caring through nursing (Benner & Wrubel 1989; Freshwater & Cahill 2010). Furthermore, relationships in caring for older people have been identified as central to positive caring experiences (Brooker 2004, Dewing 2004; McCormack 2004; Nolan *et al.* 2006; Williams, Nolan & Keady 2009).

The term ‘relationship-centred care’ was first used by Tresolini and the Pew-Fetzer Taskforce (1994). They suggest that respectful collaborative relationships are a critical foundation for humane and effective health care. Being genuinely present for self and others in relationship-centred care includes dimensions of patient-practitioner, practitioner-practitioner, practitioner-community, and a dimension of self-awareness often referred to as reflective-practitioner. Concepts of mutuality and reciprocity are elements in the interactive process that make Tresolini and the Pew-Fetzer Taskforce’s

model (1994) for practice different. These concepts were highlighted in my study and identified as underpinning concepts that support understanding of the practice model described in Chapter 6.

The work of these writers is important in that they identify dimensions of the knowledge, skills and values required to deliver relationship-centred care:

- willingness to negotiate and compromise;
- willingness to see another perspective;
- promoting and accepting the emotions of others;
- sharing personal information;
- openness to other ideas;
- sharing insights when things are not going so well; and
- recognising what people are good at.

Notable in these dimensions is that promoting and accepting emotions, and recognising what people are good at, are identified explicitly, which is in contrast to other models of interpersonal nursing practice that foster relationships (e.g. Fosbinder 1994) . These dimensions were also recognised as important in this study in helping staff to develop relationships with others. Indeed these are two key dimensions of the 7 ‘C’s framework of caring conversations. Table 23 maps Tresolini and Pew-Fetzer Taskforce’s dimensions to the attributes of caring conversations identified in my study.

Table 23 - Knowledge, Skills and Values to Deliver Compassionate Relationship-Centred Care

Attributes of Caring Conversations to enhance Compassionate Relationship- Centred care	Key Dimensions of Relationship-Centred Care Tresolini and Pew-Fetzer Taskforce (1994)
Being collaborative and considerate of others' perspectives. Being courageous.	A willingness to negotiate and compromise.
Being considerate of others' perspectives. Being curious.	Willingness to see another perspective.
Connecting emotionally and being courageous.	Promote and accept the emotions of others.
Being collaborative and courageous.	Share personal information.
Being collaborative, curious and considerate of others' perspectives.	Openness to other ideas.
Being curious, collaborative and being courageous.	Sharing insights when things are not going well.
Being celebratory.	Recognising what people are good at.

Thus, attributes articulated in my work may go some way towards identifying the ways of acting in conversation that can realise the knowledge, skills and values necessary to deliver and sustain relationship-centred care as identified by Tresolini and Pew-Fetzer Taskforce, and thus make an important practical contribution to this knowledge base. What is less evident in Tresolini and Pew-Fetzer Taskforce's work is the dimension of having the courage not just to recognise what people are good at, but also to name, value

and defend these aspects of practice. In my study, this dimension was key in raising the profile of caring work, so that it was valued and not seen as optional. This dimension is recognised as ‘intentionality’ in Hatrick’s (1997) description of relational capacities discussed later in this chapter. If the dimension of courage is not explicitly identified then there is a risk that the important domains of the model presented in Chapter 6 will remain invisible and on the periphery of contemporary thinking about ways in which to influence excellence in caring.

Building on Tresolini and Pew-Fetzer Taskforce’s work, development and use of relationship-centred care in the UK has been led by Nolan and colleagues in developing care in older people care settings (Nolan *et al.* 2004; Nolan *et al.* 2006). Nolan *et al.* (2004) emphasise interconnections and interdependency in giving and receiving care by arguing that there needs to be a focus on everyone’s needs, not just patients’, thus reflecting the reciprocity that is crucial to relationship-centred care. They developed the six senses framework that is useful to consider in assessing outcomes of relationship-centred care. This approach is guided by the belief that all parties involved in care should experience relationships that promote a sense of security, belonging, continuity, purpose, achievement and significance. This framework has been rigorously tested. Part of the attraction has been that it is expressed in a language that practitioners understand and it values their contribution to caring. The framework helps us to understand what it would feel like (in relation to the senses) if relationship-centred care was operating, but it does not necessarily provide the detail about how people could be supported to do this in a way that fits into the everyday practice of nursing.

Nolan *et al.* (2004) believe that nurses and other practitioners need guidance in identifying ways of interacting with older people and their families that best support relationships. Findings from my study provide important detail about the **how** of interpersonally communicating in caring conversations to develop relationships that can help to meet the senses for patients, staff and families.

For example, in achieving the sense of significance and sense of continuity, staff in my study deliberately asked particular questions to elicit this information from patients and families. This helped staff to have a sense of purpose and achievement in their work as they integrated aspects that mattered to the person into care-giving activity. Staff expressed feeling a sense of achievement, and purpose in being able to deliver care in a way that people wanted. Patients and families valued the sense of continuity, significance and belonging that caring conversations promoted.

Emphasis on a relational approach to caring has also been given high profile within the most up to date best practice guidelines for care for older people. These guidelines were developed from a recent systematic review which identified that older people in acute care settings value processes that help to 'see me', 'connect with me' and 'involve me' (Bridges, Flatley & Meyer 2009). Furthermore the processes required to enhance spiritual care identified by Daaleman *et al.* (2008), although presented as a preliminary analysis concur with the processes identified in this study. Table 24 shows the relationship of processes identified in these other studies to my study.

Table 24 - Relational processes to enhance caring from 3 studies

Relational processes identified by Bridges, Flatley & Meyer 2009	Relational processes identified by Daaleman <i>et al.</i> 2008	Relational processes identified in my study
‘See me’ - maintaining the identity of the older person.	‘Opening eyes’ – understanding the person and their unique experience of their illness and life story.	‘Know who I am and what matters to me’.
‘Connect with me’ - creating a two way relationship.	‘Being present’ – giving attention to the emotional, social and spiritual needs of the person.	‘Understand how I feel’.
‘Involve me’ - engaging the people as partners in care.	‘Co-creating’ – mutual activity where there is a shared plan of care focusing on humanity and dignity.	‘Work with me to shape the way things are done’.

It is evident that the key domains of the model presented in my study concur with findings from other studies. What other studies do not explicitly state is whether these processes are relevant for patients, staff and families. My analysis indicates that these processes do have relevance for all groups similar to the Senses Framework advocated by Nolan *et al.* (2006). Furthermore the element that is absent from these other studies is how to enact the domains of, for example ‘involve me’ co-create’ and ‘work with me to shape the way things are done’. It is the appreciative caring conversations identified in my study that enable these domains to be realised in practice.

Looking at developing interpersonal skills through a relational lens raises questions about the part that patients and families play. Although I argue that these attributes (the 7 'C's) are necessary for the nurse in entering into relational dialogue with patients, they also have relevance and meaning for patients and families. It is suggested that, in this study, nurses began to lead and role model a way of communicating in caring conversations that had these attributes, and that acting in this way encouraged and empowered patients and families to respond similarly. The data extract from a staff story (already shared in Chapter 5) illustrates this point:

It was on night duty, I had had handover and was thinking about the night ahead. I had not really met the relatives of the lady who was dying before but could see that they were extremely anxious. I spoke to them as soon as handover had finished (being curious, connecting emotionally) and realised that part of their anxiety was that they were not sure what might happen, whether they should go or stay and what we were going to do (being considerate). I called the doctor and arranged to have a meeting – all of us together to discuss things (being collaborative). It became clear in that meeting that there was nothing more that we could do for their mother and that she would die probably within the next 24 hours (being courageous). We came out of that room and I felt we all knew what was ahead of us that night. They went into their Mum's room and I said that I would come along later, once I had settled other patients down, but if they needed me at all they were to press the buzzer (I said this because I know that feeling of coming out of a room and trying to find a nurse and not finding anyone) (being considerate and celebratory – in relation to past experience). Later I went into the room and I could see that they were both really upset. I asked them how things were and they felt their Mum was a bit uncomfortable (being curious). I went to get some more pain relief. I then asked them if they would like me to stay (being courageous, being curious). They nodded.

I could see that the daughter was trying to hold her Mum's hand but it was difficult as she had a venflon in her hand. When she was coming towards the end

– I said we could take out the needle in her hand so that you can hold your Mum’s hand properly - ‘it won’t make any difference at this stage’ - and they held her hand.(being courageous, compromising) I suppose the drip can be a symbol of hope – it’s hard. .. I just sort of hugged them and they held her hand. They were sobbing (connecting emotionally). Then one of them really started to take the lead with things – it was when she said ‘can we take the oxygen off’ – and I said ‘yes it was okay’ (being curious and courageous on the part of the relative). It’s hard, the noise of the oxygen and she had such a small face - the mask enveloped her face– they wanted to take it off. It was not natural to have it on. I said ‘it’s okay’ we just sat there and she passed away. They spent a long time afterwards in the room. When they felt it was time to go they said to me thank you for being there with them and for helping them to cope (being celebratory on the part of the relative). I felt good about what I did (being celebratory). I was able to share the story afterwards (being celebratory) and felt a bit nervous to see this in print. I wondered what others might think about what I had done. I felt I had taken a risk and was not sure if I would get into trouble (being courageous). What happened was that I did share it with others and they began to tell me about other situations when they had taken a risk. In talking to others it sort of legitimised what I had done as good practice (being courageous and being celebratory). (Staff Story, SS10).

So although the model of the 7 ‘C’s is presented in this study as primarily to guide staff in caring conversations, there is some evidence that if staff role model this way of working, then patients and families are given an invitation to respond in similar ways.

The emphasis on caring conversations might imply that this limits the voices of those who are unable to communicate in this way. A broad interpretation to caring conversations is necessary where attention is given to non-verbal cues, communicating with others who know the person well and being acutely aware of what well-being looks like for individuals who are unable to communicate in this way. Using the case of the nurse who made a decision to put makeup on the lady she was caring for who was

unconscious, (see page 149), the nurse in this instance asked herself curious questions about what this lady might have liked, was actively considering the perspective of another, and was courageous in taking the risk to put the makeup on even though others felt that this was ‘time wasting’. There was also evidence of the important contribution that the relative made in validating the decisions she made to celebrate what had happened. Thus caring conversations happen between staff/patient, staff/relative and staff/staff.

My study has been able to uncover explicitly the interpersonal knowledge and key processes for developing relationships that enhance compassionate caring. It is interesting that participants, in their accounts of development of these interpersonal skills, referred to more than careful questioning and listening and rarely talked about the concepts of trust, respect and mutuality, often referred to in the literature as key concepts and processes that enhance relational caring (Tarlier 2004). Rather they referred to ways of relating that were about developing an openness to hear about experiences (being curious, collaborative and considerate), focusing less on saying the right thing and working with people based on what is said in the moment, and embracing ambiguity and uncertainty to shape the way things could be done together (being courageous and collaborative). Although aspects such as courage and openness have been identified by other authors as key interpersonal attributes (Firth-Cozens & Cornwell 2009; Gutierrez 2005; Kociszewski 2003; Maben, Cornwell & Sweeney 2010; Nicholson *et al.* 2010), the processes to support nurses to act in this way were less evident. One of the strengths of this study is that evidence for the presence of these interpersonal skills was developed in the context of everyday personal experience and contextual factors. Thus, ways of relating are relevant to contemporary health care situations that are increasingly characterised by competing demands and values.

7.6.1 Developing Relational Capacity

Developing relational capacity was defined in Chapter 2 as a form of responsive interaction (Schultz et al. 2007) where fluid interpersonal processes based on mutually recognised human values and experiences are important, rather than a prescribed set of actions and roles (Daaleman et al. 2008). It seemed that AI helped support staff to develop these skills of relating in a way that captured this fluid process. The process of AI, for example explicitly role modeled curious questioning, consideration of other perspectives and celebration. These attributes were evident in staff perceptions of the way in which they now worked.

The relationship of inquiry to the development of relational practice is advocated by Doane (2002, p. 402) where she describes relational practice as “*a humanely involved process of respectful, compassionate and authentically interested inquiry into another’s (and one’s own) experiences*”. She believes that relational practice is a skilled action of inquiry. She argues that the process of interpretive inquiry provides a strong foundation for learning about relational practice, rather than a more mechanistic model that focuses on a set of sessions aimed at enactment of behavioural communication skills, such as listening and questioning aimed at goal directed communication and problem resolution. A model that focuses on the process of inquiry, she argues, is more about human relating through an appreciation of people’s connectedness and emphasises being with people rather than doing for them.

In a similar way, I argue that approaches that support people to inquire appreciatively could be a more powerful and sustainable way of learning about developing relationships for compassionate caring. Rather than developing a set of specific techniques to ask curious questions, the skill that needs to be nurtured, supported and developed is more about a way of working that responds to human beings and works with them to look for ways in which feelings, situations and contexts are woven into new understandings, which in turn shape relational ways of acting.

Hatrick (1997, p. 526) argues that this way of relating is characteristic of responsive relationships, where people “*acknowledge and support the significance of people’s health*

and healing as they are meaningfully experienced". She developed a relational capacity model of communication based on her experience as a nurse and educator. Within this model she identifies five relational capacities that help nurses to engage. These capacities have not been subject to further examination in empirical studies but do provide important insights into a more in-depth understanding of interpersonal competence in caring practice. The attributes in the form of the 7 'C's developed in my study relate well to these relational capacities. In addition they provide strong empirical evidence that they can be developed and have an impact in delivering compassionate relationship-centred care.

Table 25 shows the relationship of Hatrick's relational capacities to the attributes of caring conversations developed in this study.

Table 25 - Relationship of Relational Capacity to Caring Conversations

Relational Capacities (Hatrick 1997)	Attributes of Caring Conversations to enhance Relational Capacity
<p>Initiative, authenticity, responsiveness – an active concern for and about others, expressing feelings and thoughts as they emerge.</p>	<p>Connecting Emotionally: Using 'windows of opportunity' to create openings for people to discuss emotional and personal issues in the context of ordinary conversations.</p> <p>Being Considerate: Being open to hearing perspectives, recognizing that they may not be the same as your own and feeling comfortable to discuss this in an open way.</p>
<p>Mutuality and synchrony – accepting difference and commonalities and authentic receptivity on the part of the participants to be changed by what you hear.</p>	<p>Being Collaborative: Talking together, involving people in decisions, bringing people on board, developing a shared responsibility for actions.</p>

Relational Capacities (Hatrack 1997)	Attributes of Caring Conversations to enhance Relational Capacity
<p>Honouring complexity and ambiguity – Learning to be curious and question feelings, thoughts and meaning of the experience. Discover and make connections, realising the relevance of these and using this to help make choices about action.</p>	<p>Being Curious: Using micro-noticing practices by being attentive and open to what is happening. Asking curious questions about even the smallest of happenings. Questioning, weighing up this or that, hunting for meaning. Looking for the other side of something that’s said, checking it out.</p> <p>Compromising: Working hard to suspend judgment and working with the idea of neutrality. Helping the person to articulate what they need and want and share what is possible.</p>
<p>Intentionality – question and step out of taken for granted values and beliefs that underpin practice.</p>	<p>Compromising: (see above)</p> <p>Being Courageous: Being clear about what it is we do and strive to do around here. Persevering. Having courage to stand up for things. Promoting the vision with flexibility and humility. Feeling brave to take a risk.</p>
<p>Re-imagining – compels people to wonder about and question the structure and experiences that make up one’s own and other people’s lives and helps people to transform meanings and experiences by creating opportunities.</p>	<p>Being Curious: (see above).</p>

Findings from my study provide empirical support to Hatrick’s (1997) model, but in addition, provide a more complete understanding of and make explicit interpersonal

processes that are often implicit in interactions in health care. The 7 'C's are also expressed in a language that is arguably more accessible to practitioners. The one attribute of the 7 'C's that could not be easily mapped to Hatrick's framework was the attribute of 'celebration', where people explicitly notice and say what works well and try to understand why. There are repeated references in the literature to the difficulty nurses have of articulating their contributions (Sparrow & Draper 2010; Weinberg 2006) and the 'invisible' nature of relational practice (Parker 2002; Pearson 2006). Celebration therefore seems an important component of relational capacity. The framework of the 7 'C's identifies attributes in language that has meaning for practitioners, and I would suggest gives clear guidance about how to enact these in practice. This framework thus makes a significant contribution to guide education and support development of these skills in others.

In this chapter several frameworks have been presented and compared to the model developed in this study. Whilst this discussion is necessary and important in clarifying the unique contribution that the model makes to the growing body of knowledge, there is a danger that this can confuse rather than clarify. Indeed, Dewing (2004) warns us of the potential for framework overload. It could be argued that this study presents another framework for practice in an already overloaded world of 'models'. Although attempts have been made here to draw together some of the existing frameworks and relate these to this study e.g. the Senses Framework, there needs to be clearer exposition of how frameworks relate to each other if practitioners are to feel confident in adopting an appropriate and eclectic approach.

7.7 Celebrating and raising the profile of compassionate relationship-centred caring

7.7.1 The evidence base, knowledge development and translation

Using the approach of AI, staff were encouraged to explore what they did well and what they valued, and to use this to construct and implement an ideal vision of caring for the future. Through this process, they identified strategies that would help ideal practice happen more of the time, implement these processes and adopt a range of strategies to check out the extent to which they had achieved their ideal. Thus, staff were developing their own knowledge about compassionate care **in and for** practice (their local theory made up of situated knowledge). What they developed was a collective construction of knowledge about compassionate caring that was promoted through the process of inquiring appreciatively. Staff did this through the key process identified in the model of *work with me to shape the way things are done*. Participants' needs, values, interests, emotions, beliefs, skills and responsibilities were considered in the search for the most appropriate knowledge to guide action, through caring conversations. Thus, this study not only generated context specific knowledge with respect to compassionate care practices, it also created a culture which would support application of this generated knowledge. This section will explore these findings in the context of theory about knowledge development and implementation, and cultural change.

The action cycle discussed in Chapter 6, developing positive caring practices as a way of *working together to shape the way things are done*, provided important evidence about how knowledge can be developed and used in practice. This process has an important contribution to make to theories about knowledge development and translation.

Knowledge development has been classified in a number of ways, including its mode of production and its source. Gibbons *et al.* (1994) identified two modes of knowledge production. Mode 1 is characterised by traditional university research and is based on notions of the objectivity of knowledge. This knowledge is commonly produced by individuals and is discipline specific. This is in contrast to Mode 2 knowledge which is produced in the context of application, in diverse sites, characterised by knowledge production in teams, and is subject to social accountability and reflexivity. The

knowledge generated in this study is characteristic of Mode 2. Whilst there is growing recognition of the value of both modes of knowledge, we know less about how to develop, value and celebrate mode 2 knowledge so that it is acknowledged, and respected in a similar way to Mode 1 knowledge. In my study, AI helped to uncover knowledge underpinning compassionate caring as it was enacted in practice through the lens of a number of different stakeholders. The starting point for the development of this knowledge was from participants' experience. Focused conversations considered how this knowledge could be integrated with knowledge derived from other sources, such as research, organisational policies and wider policy directives.

Pawson (2003) identifies a source based model of knowledge classification with five categories of knowledge that are important to inform professional practice:

- organisational knowledge – standards, governance, organisational policies;
- practitioner knowledge – personal, contextual, often unspoken and tacit;
- user knowledge – reflecting lived experience, often undervalued;
- research knowledge – gathered systematically with a planned design; and
- policy/community knowledge – derived from social and political drivers and priorities (Pawson 2003).

He argues that all sources of knowledge development have a vital role to play in building the evidence base, and that there is no hierarchy of knowledge source. The importance of not neglecting tacit sources of knowledge is stressed and a wide range of knowledge that is useful to inform the development of professional practice is recognised.

Given the tacit nature of much of the knowledge uncovered in my study, it seemed appropriate to develop knowledge initially with those who had had the experience and were able to clarify what mattered. Although staff did value practitioner and user

knowledge, they did not feel that the organisation gave this significant recognition, with emphasis being on the valuing of other sources, such as organisational and policy knowledge identified by Pawson (2003). So, whilst such knowledge frameworks are useful, there is a need to consider **how** all sources of knowledge can be valued in the organisation. It is suggested that AI and more specifically the framework of the 7 'C's was one way by which this could be achieved.

The focus in AI is to generate internal knowledge as opposed to implementing externally validated knowledge (Bushe & Kassam 2005). Some might argue that this is a narrow view of evidence-based practice and that there is a risk of ignoring externally validated knowledge. In my study we did work primarily with internally validated knowledge. However, in my role as appreciative inquirer, I had extensive knowledge and experience of working in the context of older people care settings and had worked in educative and research roles where I was continually using a range of knowledge, including research, to inform practice. In addition, there was a wealth of organisational and research knowledge embedded in the multidisciplinary team with whom I worked. Thus, emergent knowledge from the clinical context was implicitly shaped by other existing knowledge that I and other participants held. Although there may have been an element of 're-inventing the wheel', in relation to the discovery of good practice, the strong ownership people felt to this generated knowledge provided a powerful lever for change.

It may be the case that, whilst all the knowledge sources identified by Pawson (2003) are important to inform professional practice, a good starting point when working to develop sustainable change, is practitioner and user knowledge, that is, the internally validated knowledge.

The evidence-based practice movement is concerned not only with the generation of knowledge but its translation into practice. The literature review highlighted key elements that were important to support implementation of knowledge in practice (Schouten *et al.* 2008; Thompson *et al.* 2007) but there is little work that identifies how to enact these elements. In particular there is a lack of recognition about the relational process of

change. Gabbay and Le May (2004) suggest in their ethnographic study, that professionals rely on “*mindlines*”, which they describe as “*collectively reinforced, internalised, tacit guidelines*” (p.1015). These mindlines are reinforced through interactions from valued sources, such as fellow professionals and opinion leaders, and represent socially constructed knowledge in practice. The process of developing positive care practices in my study appears similar to the concept of mindlines, albeit that the starting point for developing positive care practice/mindlines in this work was from those who had the experience, including patients and families. If, as Gabbay and Le May (2004) suggest, mindlines are important, then this study offers a practical and effective way of systematically developing these in practice through positive care practice statements.

The importance of dialogue to knowledge translation was also highlighted by Gabbay and Le May (2004), where they found that clinicians rarely accessed and used evidence in the format of, for example, NICE guidelines or best practice statements. Instead, knowledge transfer was mediated through a series of informal interactions in groups of people. Thus they recognise the importance of dialogue. Other authors have referred to such groups that focus on collaborative learning and dialogue that is responsive to the interests and needs of participants, as communities of practice (Dewar and Sharp 2006; Dopson *et al.* 2002; Kilbride 2007). Wenger, McDermont, and Snyder (2002, p. 4), describe communities of practice as “*groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis*”. It could be argued that when staff *worked together to shape the way things were done* through their daily meetings they were, in effect, acting as a community of practice. An important conduit, however, for knowledge sharing among members in communities of practice is conversation (Zeldin 1998). What is less evident in the literature about communities of practice is what supports these conversations and their nature. Birleson (1998, p. 217) defines dialogue as “*adopting an open and explorative attitude to each other in order to understand something better.*” The 7 ‘C’s articulated in this study build on this definition and I suggest provide a useful

framework to guide and support practitioners in such dialogue to support continual learning and develop knowledge and action, within the context of practice.

The development of knowledge through the positive care practices had strong contextual relevance, and had been co-created, thus people felt able and willing to defend them. The fact that they had already been observed or talked about by patients and families as 'happening' meant that they were achievable. The positive caring practices in effect became local benchmarks for compassionate caring practice, and were different to other benchmarks for quality that nurses are commonly asked to consider. Indeed Nolan (1999, p. 67) suggests limitations of such benchmarks:

to present benchmarks for quality which are either unrealistic, unachievable or simply inappropriate does nothing to enhance quality of care, and indeed might even hinder it. They are particularly important for staff who, if they set unrealistic or unattainable goals, are likely to become increasingly disenchanted.

In my study realistic and achievable benchmarks were developed in the form of the positive caring statements. This process makes an important contribution to the development and use of best practice statements. This contribution is articulated more fully in an article I wrote with colleagues (see Dewar, Pullin & Tocher 2011).

The model for compassionate-relationship centred care presented in this study has contributed not only to our understanding of how to deliver this type of care, but also how to constantly develop local practice theory about compassion and implement this in practice in response to the needs of all stakeholders and the changing contextual landscape of healthcare. This is a unique aspect of the model.

7.7.2 Addressing culture, policies and the organisation

My study also contributes to understanding of how knowledge can be used and sustained in practice, thus changing cultures. This was achieved primarily through an appreciative

approach that facilitated the process of caring conversations in the workplace. Caring conversations supported staff to talk about knowledge in a way that connected with their emotions, was curious, and helped them to consider other perspectives to work collaboratively and make compromises. This supported courage to try out new practices, take risks and celebrate practices in an open way. The outcome not only related to change in caring practice but to a change in the culture on the ward. For example, there was a shift in the way staff thought about and discussed practice. The process of inquiry penetrated deeply enough to change background assumptions about caring. The assumption, for example, that staff wanted to care for people in the way that the person wanted to be cared for, rather than the previously held personal philosophy of caring for people as you would like to be cared for yourself, was evident in staff accounts. This shift to a new lens then formed the basis of a number of caring actions. Thus, there was synergy between the process of inquiry and the way staff acted in practice.

Current literature highlights that culture is important to changing practice in relation to caring (Dewar 2007; McCormack, McCance & Slater 2008; Powell, Rushmer & Davies 2009; Smith *et al.* 2010). Although recent literature has recognised that culture and care are interdependent, culture is often seen as a separate dimension that needs to be developed, rather than inextricably linked to the process of caring (Carter *et al.* 2008; DoH 2008c). In this study, actions necessary to develop capacity in caring were also the key aspects that promoted an effective caring culture. *Knowing who I am and what matters to me, understand how I feel, and working with me to shape the way things are done* through caring conversations enabled staff to influence care and culture. This was enabled through, for example, feeling able to question themselves and others, being confident to hear feedback about their service, and having the courage to take risks that enabled them to more specifically meet the care needs of staff, patients and families. What this study has done is explore the boundary where culture and caring meet. Other research would benefit from more explicitly recognising this interrelationship.

The findings from my study, illustrated by the 7 'C' s of caring conversations, highlight the complex interactions that were necessary to develop knowledge. These conversations

helped staff to appraise knowledge, validate it, action it and support it. The importance of interactions to successful cultural change is supported in the literature by Powell, Rushmer and Davies (2009), where they conclude that change or quality improvement initiatives have to take full account of the '*complex social interactions*' that occur. Furthermore, one of the assumptions of social constructionism is that knowledge is sustained by social processes (Burr 2003). How reality is understood at a given moment is determined by the conventions of communication in force at that time. It was interesting to note that at the start of my study, staff, families and patients could find themselves stuck in a 'negative narrative' when care was not going well. For example, when staff came on duty in the morning and found they were short staffed, conversation was characterised by much negativity. Similarly, when there were challenging and difficult situations with patients and families, some staff tended to be defensive and perhaps ignore interpersonal cues. This seemed characteristic of what I would describe as 'learned helplessness', or lack of control over factors that enable the formation of therapeutic relationships. This is confirmed in other studies (Kociszewski 2003; Nordam, Torjuul & Sorlie 2005). Through adopting an appreciative approach, staff changed their approach to negative situations and began to respond in a way that was more characteristic of 'learned hopefulness'. Zimmerman (1990) describes this as the "*process of learning and utilizing problem-solving skills and the achievement of perceived or actual control*" (Zimmerman, 1990, p. 72). Whilst this definition is useful in that it clearly states the outcome of such an approach as empowerment I would suggest a definition of 'learned hopefulness' to be one where people pose affirmative curious questions that open up possibilities for action which result in perceived or actual control. There is scope to further examine the concept of 'learned hopefulness' in the context of health care research that aims to promote cultural change.

Cultural change in healthcare depends on explicitly recognising the relationship between caring and culture and enabling frontline staff to engage in a way that promotes empowerment. These relational processes, evident in my study, are crucial to ensure that strategies, structures and processes advocated by more transactional and unidirectional models of cultural change actually happen in practice (Bate, Mendel & Robert 2008;

Patterson *et al.* 2011). There needs to be a recognition that responding to the caring agenda in health care cannot be done in a predictable and linear way.

Patterson *et al.* (2011) argue that in a pace driven NHS, emphasis has been on short term solutions and ‘quick fixes’ to complex health care challenges, with little recognition of the length of time to support enduring change. These approaches have limited success in the transformation of practice (CIHR 2005; Davis *et al.* 2003; Graham *et al.* 2006; Petersson, Springett & Blomquist 2009; Safran, Miller & Beckman 2006). It is argued that my study uncovered a number of relational processes, caring conversations and the process of *working with me to shape the way things are done*, that guide practitioners to move towards cultural change and support knowledge development and translation.

These relational processes enacted through caring conversations seem similar to the interpersonal activity of ‘brokering’ used by nurses in the context of discharge planning (Williams, Nolan & Keady 2009). When discharge planning worked well, staff used brokering which comprised skills such as mediating, negotiating and advocating. The authors argue that these are the chief forms of ‘relational knowledge and practice’ and that greater recognition needs to be afforded to the importance of ‘relational practice’ as the basis for high quality care. By explicating the skills and knowledge necessary for delivery of the relational practice through the model described in Chapter 6, the greater recognition advocated by these authors can be enabled.

Much theory related to implementation of knowledge or evidence-based practice and promoting change emphasises the necessary conditions and factors for successful change (Powell, Rushmer & Davies 2009). For example, if the culture is dominated by hierarchical ways of working, weak leadership, a punitive culture and an emphasis on task rather than process, this may limit the success of change programmes (Cummings *et al.* 2010). Patterson *et al.* (2011) describe such cultures as adopting a ‘perform or peril’ model which creates impoverished care environments that are less likely to achieve high quality care. In contrast, they argue for a ‘relational and responsive’ model of change, which emphasises the complexity of health care delivery which can be developed by

paying attention to relational components, that is, people and their perceptions. In addition, they stress the centrality within this model of transformational leadership and a focus on local cultural change.

Whilst these models have resonance in contemporary health care cultures, they raise questions about how to help people to move from a 'perform and peril' model to a 'relational and responsive' model. Appreciative approaches may be one way of transforming cultures and moving to a relational and responsive model of cultural change. Isles and Vaughan Smith (2009) suggest that we need both transactional (relates to 'perform and peril' model identified by Patterson *et al.* (2011) and relational models (see Chapter 2). I would suggest that adopting an appreciative approach can enable the celebration of both models in practice. The extract from this study presented below highlights the values of both models.

I arrived on the ward after a gap of 2 months. I had discussed with the charge nurse the possibility of auditing the 'all about me' question sheet that was included in patient documentation. (the 'all about me' questions had been developed by staff and they had identified the value of this type of interaction to care-giving – relational model). He was happy for me to examine documentation to assess the number that had been completed and to assess the content of the information. I was disappointed to find that only 3 out of the 24 patients on the ward had this documentation in their care plans. Those that had been completed were limited in the amount of information that had been recorded. This was disappointing since staff had valued the framework, and were now not using this. When I asked them about this they became defensive saying 'they had not had time'. I noticed when reviewing the documentation that all of the patients who had an identified nutritional need had food charts completed. I asked the staff what helped them to have time to fill out the food charts. They said that hospital policy was that food charts had to be completed for at least 3 days before they were 'allowed' to refer a patient to a dietician. They were asked about these referrals by the consultant at the multidisciplinary team meetings. If they had not achieved

this they would have felt embarrassed. We discussed if there was anything we could learn from this that would help us to prioritise completion of the 'all about me' sheets. We asked the consultant if he would also ask at the meetings relevant questions from the 'all about me sheets' such as what is the key thing that is important to the patient while they are in hospital. The consultant was keen to support this and began to integrate such questions into the meeting (transactional model). (Researcher Comment, Field notes, June 2009)

Thus appreciative approaches to cultural change may be one way of bringing the two models together and managing the 'correct dose' of each within any given situation. There is a need to influence the policy agenda by carefully noticing opportunities for aligning and integrating different approaches to development and change, rather than presenting opposing arguments. There is scope to develop this finding further in research. What is important however from the extract above was that skilled facilitation supported this to happen.

In the current economic climate resource implications of a relational and responsive model of change that is dependent on facilitation may not be good news to policy ears. Indeed Patterson *et al.* (2011, p. 67) highlight the tension in the current climate when they state:

however, the paradox remains that whilst on the one hand initiatives such as the new constitution for the NHS explicitly endorse the importance of compassion as a core value for health services, providers are at the same time under intense pressure to shorten, routinise and reduce the interactions that constitute such relationships.

Research findings, such as those articulated in my study, need to be fed into policy with clear messages about the benefits of facilitation, particularly in relation to changing cultures, as well as systems and processes.

In my study I worked with individual staff in one area, and used this as a starting point to influence aspects of the organisation. In many ways this was successful, but there were many examples of organisational processes and systems inconsistent with a relational approach, e.g. no leave entitlement permitted for any staff over Christmas and New Year. So, although the processes inherent in AI encouraged staff to question these policies, cultural change could have been accelerated, I believe, if the wider organisation was also working towards developing more relational practices. Importance of the wider organisation in the change process is supported by Parker (2002, p. 276):

Relational work in care-giving organisations thus depends, not only on the skills of individual practitioners and care workers, but also on the extent to which the workgroup and the organisation are structured and operated in ways that are supportive of relational work behaviours.

Patterson *et al.* (2011) emphasise the importance of making a difference to the culture through local unit change rather than wider organisational change in the short term. I would argue that this is important, but that we need to consider ways in which developing compassionate relational processes across the organisation can be promoted.

There is evidence from my study that change and developments at a local level influenced other developments across education in the University setting, and across the wider health care organisation. For example integration of findings into the curriculum, use of appreciative approaches to uncover what works well in the academic tutor/student relationship, and implementation of the 7 'C's as a framework for working with staff to analyse complaints were key developments that are ongoing.

AI supported staff to develop knowledge about compassionate relationship-centred care. They were able, through the process of acting as appreciative practitioners and inquiring appreciatively, to implement new knowledge and develop their practice. Kavanagh *et al.* (2008) put forward a powerful argument for use of AI as a knowledge translation process and relate this to improvement of pain control practices. They conclude in their paper that

more research needs to examine the methodological challenges of using AI in knowledge transfer. This study provides the first empirical data to support the link between AI and knowledge generation and implementation.

Findings from this section have shown how Mode 2 knowledge can be valued and celebrated in practice. There is greater need for researchers, managers, and policy makers to recognise and value this knowledge developed in practice.

Although this study argues for an appreciative approach to transform caring cultures, findings show that this was enhanced by strong leaders (in particular the consultant, charge nurse and myself as an appreciative inquirer) whose approach to practice was consistent and reflective and who role modeled a way of relating that was compassionate. By role modelling ways of relating, characterised by the 7 'C's, we promoted a culture in which the quality of interpersonal relationships was highly valued.

The next sections summarise the implications of the findings for policy, research, education and practice. Issues raised are of relevance to practitioners, practice developers, managers, educationalists, researchers and policy makers in the field of care for older people and, more generally, for those concerned with enhancing quality of health care through specific change or quality improvement methodologies.

7.8 Implications for Policy

The focus on caring in the policy agenda is encouraging at a time when the NHS is faced with increasing pressures on cost effectiveness, efficiency and measurement. Despite efforts however to address the caring imperative, through for example, initiatives such as 'productive wards and releasing time to care' (Smith & Rudd 2010) and 'confidence in caring' (DoH 2008c), much still needs to be done if this focus is to become more than rhetoric. The following considerations should be taken into account by policy makers;

1. There is a greater need for researchers, managers, and policy makers to recognise and value knowledge developed in practice. This study has shown that the value of tacit knowledge needs to be considered and given equal value to knowledge derived from more traditional sources.
2. Policy makers should define what they mean by compassion, so that there is a clearer and shared understanding of goals and development in relation to this concept in the context of health care. It is suggested that they utilise the model presented in this study that clarifies the defining elements of compassionate relationship-centred care.
3. There needs to be recognition that responding to the caring agenda in health care cannot be done in a predictable and linear way. The journey is influenced by many factors. There is a need to adopt an approach to quality that places the people and processes at the heart, if we are truly going to influence meaningful outcomes that result in changing the way people think and act.
4. The development of compassionate relationship-centred care needs to be adequately resourced and skillfully facilitated.
5. There is a need to influence the policy agenda by carefully spotting opportunities for aligning and integrating models for developing compassionate caring, rather than presenting opposing arguments.
6. There needs to be recognition that some of the most important contributions to quality of care may be difficult to observe and measure, such as compassionate care. It is recommended therefore that policy makers take a more eclectic view about what counts as evidence and the extent to which measurement is the most appropriate way forward (see Dewar, Pullin & Tocher 2011).

7.9 Implications for Research

This study provides some new insights and a possible framework that inform us about **the how** of compassionate relationship-centred care. It also however raises a number of issues that would benefit from further research.

These are:

1. Appreciative inquiry is relatively underdeveloped in research in health care. AR has wider recognition and methodological development. There were benefits to combining the strengths of these approaches, and further exploration of this methodology, as it relates to practice development and improving sustainable outcomes in the health care context, is needed.
2. More attention needs to be paid to development of the facilitator role in participatory research studies in general, and in appreciative inquiry in particular. It is suggested that the term facilitator does not capture the skills required to, for example, ask curious questions, feedback in the moment, reframe situations to the affirmative, and spot real time opportunities to try out actions. By considering the role of the amateur we may be better able to understand how to support and develop practice in this area.
3. There needs to be clearer exposition of how different 'caring' models or frameworks relate to each other if practitioners are to feel confident in adopting an appropriate and eclectic approach. Research that specifically draws these different frameworks together would be of value.
4. Emphasis on interdependent relationships served as a useful theoretical foundation for this study. Further research that adopts this philosophy would be helpful to evaluate the usefulness of some of the elements of this model to all groups.

5. Studies that analyse what works well should be encouraged, as this is seen as a powerful lever for validation of existing practices, development of important local based theory and change.

6. Further work that examines the emotions agenda in the context of care work should explore this in the context of relationships, its 'management' in 'real time', and the real value of identifying the effect of positive emotions on wellbeing and satisfaction.

7. Proposed attributes of caring conversations need to be further explored and elaborated. Do they, for example, capture all the important dimensions of caring conversations in all contexts?

8. Research needs to further explore how this model of compassionate relationship-centred care can become an integral part of strategic planning and implemented across the organisation.

9. There is a need to develop and evaluate effective education programmes to support staff to implement the processes identified in the model of compassionate relationship-centred care.

7.10 Implications for Education

1. A more appropriate model of education to develop relational practices that enhance compassionate care, is based on relational inquiry (Doane 2002) or appreciative inquiry. Educationalists should consider this approach, rather than a mechanistic model of teaching a set of behaviourist communication skills.

2. Leadership education needs to foreground ways of relating as a key component.

3. The model of compassionate relationship-centred care presented in this study could be used to facilitate development of knowledge and skills required to support people in relational and compassionate ways.
4. Facilitation of learning in the workplace needs to be afforded adequate resources if we are to respond to increasingly complex situations and the real life tensions in the care environment.
5. There is scope to consider some of the methodologies in this study as transferable to the educational environment. Creative teaching methodologies that help students to really explore and work with their experience are recommended if the complexity of compassionate relationship caring is to be understood and developed.
6. Compassionate care activities, such as hearing the stories of others, need to be considered as valuable and legitimate professional development competencies alongside more technical competencies. These need to be integrated into existing organisational systems such as staff professional development plans.
7. Given the complex skills that are required to facilitate or animate staff to learn in the workplace, education that supports this development needs to be recognised and supported. We should not make the assumption that clinical staff have expertise in supporting people to learn in practice.

7.11 Implications for Practice

1. There was real value in supporting and building on aspects of practice that were shown to work well. It is argued that this helped create cultures of hopefulness rather than helplessness that can be felt when the focus is on what is not right with practice. Specific strategies should be put in place in the workplace that encourage positive discourse.

2. It is recommended that any programme of work that intends to support practitioners to develop compassionate relationship-centred care needs to focus on day to day care not just crisis situations normally associated with compassionate acts.
3. The focus of many leadership and practice development programmes is with ward staff. Although the managers were interested in the progress of the programme of work in this study they were not fully involved with key responsibilities. There needs to be further consideration about responsibilities and development needs of managers in relation to leading compassionate relationship-centred care, along with other priorities of cost effectiveness, safety and efficiency.
4. This study has shown that AI facilitated learning and the 'knowing how' from practice. Given the increased call in NHS Boards for sustainability of outcomes from project initiatives, those involved in quality and Continuing Professional Development Programmes should consider this approach.
5. It is recommended that practitioners are supported to integrate a number of frameworks that demonstrate best evidence in care for older people settings. The Senses Framework offers a way in which staff can frame what needs to be achieved in practice in order to deliver quality relationship centered care. The toolkit developed by Patterson *et al.* (2011), as part of research carried out to examine culture and care in older people care settings, aims to support staff to identify what is currently working well and where further work is needed. This study offers a model of how to act on what emerges from using the toolkit in order to achieve the senses in practice. Practitioners should be encouraged to adopt this integrated approach.
6. Both implementing compassionate relationship-centred care and culture change require that relational practices in the form of caring conversations are acknowledged as a key skill that needs to be valued, promoted and supported in the workplace.

7. The emotional work of caring, inherent in the processes described in this study, needs to be acknowledged and celebrated. In addition, appropriate strategies need to be put in place both to encourage expression of this in day to day practice and support staff to understand the meaning of emotions in caring.

8. The emotional impact of the nurse-patient relationship needs to be recognised and a better understanding of the necessary support and of what does and does not work needs to be considered across a range of contexts.

9. Strong, consistent, reflective leadership that models compassionate relationship centered care needs to be recognised as one of the key factors in enhancing the quality of care. There needs to be recognition and celebration of the role the wider multidisciplinary team plays in leadership (for example in this study the consultant's leadership was significant).

In this final chapter I have drawn out key principles that can be considered for application in other care for older people settings, although there is some evidence that the findings have application to a much wider group of care settings.

7.12 Chapter Summary

My study achieved positive outcomes in relation to developing our understanding of compassionate relationship-centred caring and articulating a practice model to build relational capacity that supports people to deliver and sustain compassionate relationship-centred care. In particular, development of the interpersonal framework of the 7 'C's to support staff develop knowledge about what matters to people and their feelings, which in turn helps them to work together to deliver compassionate care, has informed us about the 'how' of compassionate caring. The framework has made explicit the quality and nature of the interactions that promote compassionate relationship-centred care. It has

given new insights into successfully developing knowledge, implementing and celebrating this in practice, so that the profile of this knowledge and practice is raised.

A number of important contributions have emerged from the theoretical and conceptual discussion in this chapter. The study findings provide empirical support for the value of person knowledge in caring. Liaschenko and Fisher's (1999) theory categorised nursing knowledge into case, patient and person, and implies that person knowledge is not always appropriate in all settings. The findings from my study suggest that, although person knowledge is best developed over time and does require trust, it has equal value to other types of knowledge and is not context specific. My study provides strong evidence of the value of this knowledge to develop relationships which in turn enhance compassionate relationship-centred care.

Findings add support to the construct of social knowledge in Liaschenko and Fisher's (1999) theory, where they feel this knowledge is necessary to help to move case to patient and patient to person knowledge. There is little empirical work on how to develop and implement this knowledge in practice. The strategies tested out in this study can help practitioners to develop social knowledge to inform the delivery of good care.

There is increasing recognition and focus on staff wellbeing in the context of compassionate caring (Freshwater & Cahill 2010; Maben *et al.* 2006). Much of the concern about staff wellbeing relates to the tensions that occur for staff in being able to deliver care that meets both professional and patient expectations. Theories about emotional containment and emotional management are emphasised in the literature. The findings from this study, whilst recognising the emotional labour inherent in the work of nursing, ask us to consider the value of expression of emotions in the relationship. They provide empirical evidence of its value to the development of the relationship and giving compassionate relationship-centred care. In addition, much of the empirical work that has examined emotion in nursing has not focused on the expression of positive emotions and their value in increasing patients', families' and staffs' sense of achievement, identity and

purpose. The findings from this study therefore add to the theory about emotions in the health care context.

Theorists and researchers who have developed frameworks that focus on caring, emphasise the centrality of relationships in the giving and receiving of good care (Daaleman *et al.* 2008; Bridges, Flatley & Meyer 2009; Hatrick 1997; Nolan et al 2006; Tresolini & Pew-Fetzer Taskforce 1994). One of the criticisms of these frameworks is the lack of guidance on how to achieve the aspirations embedded in them for patients, families and staff. The findings from this study provide a model of key processes that can help these frameworks to be realised for all groups. Using caring conversations to develop knowledge about what matters to people, and how they feel, enables relationships to develop that focus on working together to shape the way things are done. Key attributes of caring conversations, which include having the courage to act boldly which may involve taking risks, connecting emotionally and celebrating knowledge and actions that have worked well, are often missing from existing frameworks. Articulation of these attributes is necessary if we are to adequately support practitioners to deliver compassionate relationship-centred care and accord it value and status. This work adds support for existing conceptual frameworks, and puts forward some important strategies that can work in the context of everyday contemporary health care practice.

The findings from this work also contribute significantly to theories of change, particularly changing cultures. Culture is made up of the daily conversations and negotiations in an organisation. This study has drawn into focus that changing conversations in an organisation can have a significant impact on culture. AI focuses specifically on the way we talk about things (in this case compassionate caring practice). With its emphasis on positive narratives, real time feedback that values individuals, and being genuinely curious about what is happening, it supported staff to adopt this way of working with each other, patients and families which in turn enhanced their capacity to be compassionate in the workplace. What developed was a new language and a new way of talking about things that was positive and empowering. Staff enacted a way of being that was characteristic of learned hopefulness. Theories underpinning organisational change

need to make more explicit the central role of conversations in changing workplace culture. In addition, the explicit framework of the 7'C's provides an important framework to guide conversations to both enhance caring and cultural change. The 7 'C's provide an important theoretical contribution to the role of the facilitator of change, this thesis arguing that the role of the animateur described by Boud and Miller (1997) more aptly describes this role.

An important contribution could also be said to be made to the evidence-based practice movement. What this study did was develop local practice-based theory that had direct meaning to practice, captured 'hearts and minds', and was flexible enough to continue what was working and relinquish that which was not. Thus, my study has provided empirical evidence about how knowledge can be developed in practice using appreciative approaches, and their relationship to knowledge use and translation.

Finally, the findings of this work challenge definitions of compassionate caring – all of which focus on the act of compassion, as responding to people who are suffering. This study argues that compassionate caring can be enacted in any situation where one recognises vulnerability in others and strives to act with them to relieve it.

The outcomes of my study make a unique contribution to the existing knowledge base on compassionate relationship-centred care and changing practice in health care in a number of ways:

- they demonstrate the impact of using appreciative approaches to facilitate change within health care contexts;
- they provide empirical evidence of the effectiveness of strategies that can be delivered in the context of everyday practice by frontline practitioners to enhance compassionate caring;

- they show that supporting people to share emotions, find out what matters to people and develop relationships through caring conversations is crucial to delivering compassionate care; and
- they have led to the development and testing of a practice model that promotes compassionate relationship-centred care.

This study is timely, as there is a pressing need to articulate more fully the knowledge and processes that enable compassionate care-giving. This is even more urgent in a health care world which is committed to measurement and productivity. If compassion is a defining value of the NHS as stated in the NHS Constitution (DoH 2008a, p.1) then this study provides important knowledge about what it means and how to deliver it in practice which may minimise the risk of compassion, like other concepts, becoming just another ‘political slogan’.

Indeed there is a danger that, if we cannot name the knowledge and processes that help us to deliver compassionate relationship-centred care, this important aspect will be lost. The model presented in this study helps practitioners to name it, celebrate it, act on it and defend it.

References

Abma, T.A., & Widdershoven, G.A.M., (2005). Sharing stories, *Evaluation and the Health Professions*. **28** (1), pp.90-109.

Akerjordet, K., & Severinsson, E., (2007). Emotional intelligence: a review of the literature with specific focus on empirical and epistemological perspectives, *Journal of Clinical Nursing*. **16** (8), pp.1405-1416.

Allan, H., (2001). A 'good enough' nurse: supporting patients in a fertility unit, *Nursing Inquiry*. **8** (1), pp. 51-60.

Angrosino, M.V., & Mays de Perez, K.A., (2000). Rethinking observation: from method to context. **In:** Denzin, N.K. and Lincoln, Y.S., (eds). (2000) *Handbook of qualitative research*, 2nd ed. Thousand Oaks: Sage, pp.673-702.

Animarts, (2003). *The art of the animateur. An investigation in the skills and insights required of artists to work effectively in schools and communities*. London: Animarts/Guildhall School of Music and Drama/London International Festival of Theatre.
Available from: <http://www.animarts.org.uk/> [accessed 12th December 2009].

Askham, J., (2008). *Health care and services for older people: overview report of research to support the national service framework for older people*. London: Department of Health.

Attree, M., (2001). Patients' and relatives' experiences and perspectives of 'good' and 'not so good' quality care. *Journal of Advanced Nursing*. **33** (4), pp.456-466.

Baillie, L., (2009). Patient Dignity in an acute hospital setting: a case study, *International Journal of Nursing Studies*. **46** (1), pp.22-37.

Banks, M., (2001). *Visual Methods in Social Research*. London: Sage Publications.

Barker, P., & Barker, P., (2004). More than a feeling, *Nursing Standard*. **19** (11), pp.18-19.

Barnard, D., (1995). The promise of intimacy and the fear of our own undoing, *Journal of Palliative Care*. **11** (4), pp.22-26.

Bassett, C., (2002). Nurses' perceptions of care and caring, *International Journal of Nursing Practice*. **8** (1), pp.8-15.

Bate, P., & Robert, G., (2007). *Bringing user experience to healthcare improvement: the concepts, methods and practices of experience based design*. Oxford: Radcliffe Publishing.

Bate, S., P., Mendel, P. & Robert, G., (2008). *Organizing for quality: the improvement journeys of leading hospitals in Europe and the United States*. Briefing Paper. London: The Nuffield Trust.

Bate, S.P., & Robert, G., (2009). Bringing social movement theory to healthcare practice in the English National Health Service. **In:** Banaszak-Holl, J., Levitsky, S.R., & Zald, M. (eds). (2009) *Social movements and the transformation of American health care*, Oxford:

Oxford University Press, Section12.

Bendall, E., (2006). Learning for reality, *Journal of Advanced Nursing*. 53 (1), pp. 14-17.

Benner, P., (1984). *From Novice to Expert: Uncovering the Knowledge Embedded in Clinical Practice*. Menlo Park, CA: Addison-Wesley.

Benner, P., Tanner, C., & Chesla, C., (1996). *Expertise in nursing practice: caring, clinical judgment, and ethics*. New York: Springer.

Benner, P., & Wrubel, J. (1989). *The Primacy of Caring: Stress and Coping in Health and Illness*. Menlo Park, CA: Addison-Wesley.

Binnie, A., & Titchen, A., (1999). *Freedom to practice nursing*. Edinburgh: Butterworth Heinemann.

Birleson, P., (1998). Learning organisations: a suitable model for improving mental health services, *Australian and New Zealand Journal of Psychiatry*. 32 (2), pp.214-222.

Bolton, S., (2000). Who cares? Offering emotional work as a gift in the nursing labour process, *Journal of Advanced Nursing*. 32 (3), pp.580-586.

Boomer, C., McCormack, B., & Henderson, E., (2006). *Development of leadership and practice development knowledge and skills with ward sisters in surgical settings in the Royal Hospitals and Belfast City Hospital*. Final Report. Belfast: Royal Hospitals Trust.

Borkan, J., (1999). Immersion/crystallization. **In:** Crabtree, B.F. & Miller, W.L., (eds). (1999) *Doing qualitative research*, 2nd ed. Thousand Oaks, CA: Sage, pp.179-194.

Boud. D., & Miller, N., eds. (1997). *Working with experience: animating learning*. London: Routledge.

Bradbury, H., & Lichtenstein, B.M.B., (2000). Relationality in organizational research: exploring the space in between, *Organisational Science*. **11** (5), pp.551-564.

Bradbury, H. & Reason, P., (2001). Conclusion: broadening the bandwidth of validity: issues and choice points for improving the quality of action research. **In:** Reason, P.& Bradbury, H. (eds). (2001) *Handbook of Action research: participative inquiry and practice*. London: Sage, pp. 455-467.

Bridges, J., (2004). *Workforce matters: exploring a new flexible role in health care*. PhD, City University, London.

Bridges, J., Flatley, M., & Meyer, J., (2009). *Best practice for older people in acute care settings (BPOP): Guidance for nurses*. London: RCN/City University.

Bridges, J., Flatley, M., & Meyer, J., (2011). *A systematic review of qualitative research on nurses' experiences of caring in acute hospital settings*. London: City University.

Bridges, J., & Nicholson, C., (2008). Service improvement using patient narratives: engaging with the issues, *International Journal of Older People Nursing*. **3** (3), pp.217-222.

Brooker, D., (2004). What is person-centred care in dementia? *Reviews in Clinical Gerontology*. **13** (3), pp.215-222.

- Brown Wilson, C., (2007). *Exploring relationships in care homes. A constructivist enquiry*. PhD Dissertation, University of Sheffield, Sheffield.
- Brown Wilson, C., (2009). Developing community in care homes through relationship centred approach, *Health and Social Care in the Community*. **17** (2), pp.177-186.
- Brown Wilson, C., Davies, S., & Nolan, M.R., (2009). Developing relationships in care homes - the contribution of staff, residents and families, *Ageing and Society*. **29** (7), pp.1-23.
- Burdett Trust for Nursing, (2006). *Who cares, wins: leadership and the business of caring*. London: The Burdett Trust for Nursing. Available from: http://www.burdettnursingtrust.org.uk/public/documents/who_cares_wins_031006_1.pdf [accessed 25th February 2009].
- Burns, D., (2007). *Systematic Action Research: a strategy for whole system change*. Bristol: Policy Press.
- Burr, V., (2003). *Social constructionism*. 2nd ed. Hove: Routledge.
- Bush, N.J., (2009). Compassion fatigue: are you at risk?, *Oncology Nursing Forum*. **36** (1), pp.24-28.
- Bushe, G., & Kassam, A.F., (2005). When is appreciative inquiry transformational?: a meta case analysis, *The Journal of Applied Behavioural Science*. **41** (2), pp.161-181.
- Bushe, G.R., (2007). Why appreciative inquiry is unlikely to generate research publications, *Appreciative Inquiry Practitioner*. November 2007.

Buster, S., (26th November 2008). *Better Together: Scotland's Patient Experience Programme: Building on the Experiences of NHS Patients and Users*. Available from: <http://www.scotland.gov.uk/Publications/2008/11/20095545/0> [accessed 4th May 2011]

Cady, S.H., & Caster, M. A. (2000). A DIET for action research: An integrated problem and appreciative focused approach to organization development. *Organization Development Journal*, (18) **4**, pp. 79-93.

Canadian Institutes of Health Care Research, (2005). *Knowledge translation*. Available at: <http://www.cihr-irsc.gc.ca/e/8505.html> [accessed 20th June 2009].

Carper, B.A., (1978). Fundamental patterns of knowing in nursing, *Advances in Nursing Science*. **1** (1), pp.13-23.

Carr, W., & Kemmis, S., (1986). *Becoming critical: education, knowledge, and action research*. Lewes: Falmer.

Carter, C., Ruhe, M., Weyer, S., Litaker, D., Fry, R., & Stange, K., (2007). An appreciative inquiry approach to practice improvement and transformative change in health care settings, *Quality Management in Health Care*. **16** (3), pp.194-204.

Carter, L., Nelson, J., Sievers, B., Dukek, S., Pipe, T., & Holland, D., (2008). Exploring a culture of caring, *Nursing Administration Quarterly*. **32** (1), pp.57-63.

Casey, D., (2007). Using action research to change health promoting practice, *Nursing and Health Sciences*. **9** (1), pp.5-13.

Cash, K., (2007). Compassionate strangers, *Nursing Philosophy*. **8** (2), pp.71-72.

- Chambers, C., & Ryder, E., (2009). *Compassion and caring in nursing*. Abingdon: Radcliffe Publishing.
- Chochinov, H.M., (2007). Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care, *British Medical Journal*. **335** (7612), pp.184-187.
- Chochinov, H.M., Hack, T., McClement, S., Kristjanson, L., Harlos, M., (2002). Dignity in the terminally ill: A developing empirical model. *Social Science & Medicine*, **54**, pp. 433-443.
- Christiansen, B., (2008). Good work - how is it recognized by the nurse?, *Journal of Clinical Nursing*. **17** (12), pp.1645-1651.
- Clarke, A., (2000). Using biography to enhance the nursing care of older people, *British Journal of Nursing*. **9** (7), pp.429-433.
- Clarke, A., Hanson, E.J., & Ross, H., (2003). Seeing the person behind the patient: enhancing the care of older people using a biographical approach, *Journal of Clinical Nursing*. **12** (5), pp.697-706.
- Clout, L., (2008). NHS nurses told to smile and show compassion. *The Daily Telegraph*, November 11. Available from: <http://www.telegraph.co.uk/health/2148140/NHS-nurses-told-to-smile-and-show-compassion.html> [accessed 28th January 2009].
- Coghlan, D., & Brannick, T., (2005) *Doing Action Research in your own Organization*. 2nd ed. London: Sage Publications.

Commission for Healthcare Audit and Inspection, (2006). *Living well in later life: a review of progress against the National Service Framework for Older People*. London: Commission for Healthcare Audit and Inspection.

Congressi, L., (2006). Four days in a strange place, *Journal of Health Services Research & Policy*. **11** (2), pp.122-124.

Cooperrider D., & Srivastva, S., (1987). Appreciative inquiry in organizational life. **In:** Pasmore, W.A. & Woodman, R.W., (eds). *Research in organizational change and development*. Greenwich, CT: JAI Press, Volume 1, pp.129-169.

Cooperrider, D., & Whitney, D., (2000). A positive revolution in change: appreciative inquiry. **In:** Cooperrider, D., Sorenson, P.F.J., Whiney, D., & Yaeger, T.F., (eds). *Appreciative Inquiry: Rethinking human organization towards a positive theory of change*. Champaign, IL: Stipes Publishing LCC, pp.3-27.

Cooperrider, D.L., Whitney, D., & Stavros, J.M., (2003). *The appreciative inquiry handbook*. Bedford Heights, OH: Lakeshore Communications.

Corbin, J., (2008). Is caring a lost art in nursing?, *International Journal of Nursing Studies*. **45** (2), pp.163-165.

Coyle, J., & Williams, B., (2001). Valuing people as individuals: development of an instrument through a survey of person-centredness in secondary care, *Journal of Advanced Nursing*. **36** (3), pp.450-459.

Creswell, J.W., (2003). *Research Design: qualitative, quantitative and mixed methods design*, 2nd edition. London: Sage.

Crigger, N.J., Brannigan, M., & Baird, M., (2006). Compassionate nursing professionals as good citizens of the world, *Advances in Nursing Science*. **29** (1), pp.15-26.

Cummings, G.G., MacGregor, T., Davey, M., Lee, H. P., Wong, C., Lo, E., Muise, M., Stafford, E., (2010). Leadership styles and outcome patterns for the nursing workforce and work environment: a systematic review. *International Journal of Nursing Studies*. **47** (3), pp.363-385.

Daaleman, T. P., Usher, B. M., Williams, S. W., Rawlings, J., & Hanson, L. C., (2008) An exploratory study of spiritual care at the end of life, *Annals of Family Medicine*. **6** (5), pp. 406-411.

Darzi, A., (2008). *High quality care for all: NHS next stage review final report*. London: Department of Health.

Davies, S., Atkinson, L., Aveyard, B., Martin, U., McCaffrey, S., & Powell, A., (2007). Changing the culture within care homes for older people. **In:** Nolan, M., Hanson, E., Grant, G., & Keady, J. (eds). *User participation in health and social care research – voices, values and evaluation*. Maidenhead: Open University Press, McGraw-Hill Education, pp.50-68.

Davies, S., Nolan, M.R., Brown, J., & Wilson, F., (1999). *Dignity on the ward: Promoting excellence in the acute hospital care of older people*. Report for Help the Aged/Order of St John's Trust. Sheffield: University of Sheffield's School of Nursing and Midwifery & Help the Aged.

Davis, D., Evans, M., Jadad, A., Perrier, L., Rath, D., & Ryan, D., (2003). The case for knowledge translation: shortening the journey from evidence to effect, *British Medical Journal*. **327**(7405), pp.33-35.

Denzin, N.K., & Lincoln, Y.S., (2005). *The Sage Handbook of Qualitative Research* London: Sage.

Department of Health, (2001). *National Service Framework for Older People*. London: Department of Health.

Department of Health, (2005). *Now I feel tall: what a patient-led NHS feels like*. London: Department of Health.

Department of Health, (2006). *About Dignity in Care* [online]. Available from: <http://www.dh.gov.uk/en/SocialCare/Socialcarereform/Dignityincare/index.htm> [accessed 28th July 2009].

Department of Health, (2008a). *The National Health Service constitution: A draft for consultation July 2008* [online]. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085814 [accessed 27th January 2009].

Department of Health, (2008b). *High quality care for all - NHS next stage review final report*. London: Department of Health.

Department of Health, (2008c). *Confidence in caring: a framework for best practice*. London: Department of Health.

Department of Health, (2009). *Understanding what matters: a guide to using patient feedback to transform services*. London: Department of Health.

Deutsch, S., & Sherwood, G., (2008). Reflection: an educational strategy to develop emotionally-competent nurse leaders, *Journal of Nursing Management*, **16** (8), pp. 946-954.

Dewar, B., (2005). Beyond tokenistic involvement of older people in research: a framework for future development and understanding, *International Journal of Nursing Older People*. **14** (3a), pp.48-53.

Dewar, B., (2007). Promoting positive culture in care homes. **In:** Help the Aged. *My home life: quality of life in care homes, a review of the literature*, pp.148-156. Available from: www.myhomelife.org.uk/resources/mhl.review.pdf [accessed 18th May 2009].

Dewar, B., (2010). Editorial: Appreciative Inquiry, *International Journal of Older People Nursing*. **5** (4), pp.290-291.

Dewar, B., Dickie, H., & Morrison, M., (2003a). Speaking for ourselves, *Nursing Older People*. **15** (6), pp.10-16.

Dewar, B., Tocher, R., & Watson, W., (2003b). Enhancing partnerships with relatives in care settings for older people, *Nursing Standard*. **17** (40), pp.33-39.

Dewar, B., & Mackay, R., (2010). Appreciating compassionate care in acute care setting caring for older people, *International Journal of Older People Nursing*. **5** (4), pp.299-308.

Dewar, B., Mackay, R., Smith, S., Pullin, S., & Tocher, R., (2010). Use of emotional touchpoints as a method of tapping into the experience of receiving compassionate care in a hospital setting, *Journal of Research in Nursing*. **15** (1), pp.29-41.

Dewar, B., & Macleod Clark, J., (1991). The role of the paid non-professional nursing helper: a review of the literature, *Journal of Advanced Nursing*. **17** (1), pp.113-120.

Dewar, B., Pullin, S., & Tocher, R., (2011). Valuing compassion through definition and measurement, *Nursing Management*. **17** (9), pp.30-35.

Dewar, B., & Sharp, C., (2006). Using Evidence: how action learning can support individual and organizational learning through action research, *Educational Action Research*. **14** (2), pp. 153-159.

Dewar, B., & Walker, E., (2001). How do we facilitate carers' involvement in decision making?, *Journal of Advanced Nursing*. **34** (3), pp.329-338.

Dewing, J., (2004). Concerns relating to the application of frameworks to promote person-centredness in nursing older people, *International Journal of Older People Nursing*. **13** (3a), pp.39-44.

Dewing, J., (2007). Participatory research: a method of process consent with persons who have dementia, *International Journal of Social Research and Practice*. **6** (1), pp. 11-25.

Dingman, S., Williams, M., Fosbinder, D., Warnick, M., (1999). Implementing a caring model to improve patient satisfaction, *Journal of Nursing Administration*, **29** (12), pp.30-37.

Dingwall, R. & Allen, D., (2001). The implications of healthcare reforms for the profession of nursing, *Nursing Inquiry*, **8** (2), pp. 64-74.

Doane, G.A.H., (2002). Beyond behavioural skills to human involved processes: relational nursing practice and interpretive pedagogy, *Journal of Nursing Education*. **41** (9), pp.400-404.

Dobbins, M., Ciliska, D., Cockerill, R., Barnsley, J., & DiCenso, A., (2002). A framework for the dissemination and utilization of research for healthcare policy and practice, *Online Journal for Knowledge Synthesis for Nursing*. **9** (2). Available from: [http://30334.vws.magma.ca/kte_docs/A_framework_for_dissemination_\(2002\).pdf](http://30334.vws.magma.ca/kte_docs/A_framework_for_dissemination_(2002).pdf) [accessed March 14th 2011].

Dobrow, M.J., Goel, V., & Upshur, R.E., (2004). Evidence-based health policy: context and utilisation, *Social Science & Medicine*. **58** (1), pp.207-217.

Dopson S., Fitzgerald L., Ferlie E., Gabbay J., & Locock L., (2002). No magic targets! Changing clinical practice to become more evidence based, *Health Care Management Review*. **27** (3), pp.35-47.

Dreaper, J., (2008) *NHS 'fast losing its compassion'*. BBC News. 30th December.
Available from: <http://news.bbc.co.uk/1/hi/health/7797868.stm> [accessed 27th January 2009].

Dutton, J.E., Worline, M.C., Frost, P.J., & Lilius, J., (2006). Explaining compassion organizing, *Administrative Science Quarterly*. **51**, pp.59-96.

Egan, T.M. & Lancaster C.M., (2005). Comparing appreciative inquiry to action research: OD practitioner perspectives, *Organization Development Journal*. **23** (2), pp.29-49.

Emerson, R.M., Fretz, R.I., & Shaw, L.L., (2001). Participant observation and fieldnotes. **In:** Atkinson P., Coffey A., Delamont S., Lofland J. & Lofland L. (eds). *Handbook of Ethnography* London: Sage, pp.352–368.

Eriksson, C. & Saveman, B. I., (2002). Nurses' experiences of abusive/non-abusive caring for demented patients in acute care settings, *Scandinavian Journal of Caring Sciences*, **16** (1), pp. 79-85.

Evans, D., (2002). Database searches for qualitative research, *Journal of the Medical Library Association*. **90** (3), pp.290-293.

Faulkner, M., Davies, S., & Nolan, M.R., (2006). Development of the combined assessment of residential environments (CARE) profiles, *Journal of Advanced Nursing*. **55** (6), pp.664-677.

Finfgeld-Connett, D., (2008). Meta-synthesis of caring in nursing, *Journal of Clinical Nursing*. **17** (2), pp.196-204.

Finlay, L., & Gough, B., (eds.) (2003). *Reflexivity: a practical guide for researchers in health and social science*, Oxford: Blackwell Publishing.

Firth-Cozens, J., & Cornwell, J., (2009). *The Point of Care: enabling compassionate care in acute hospital settings*. London: The Kings Fund.

Forbat, L. & Henderson, J., (2005). Theoretical and practical reflections on sharing transcripts with participants, *Qualitative Health Research*. **15** (8), pp.1114-1128.

Fosbinder, D., (1994). Patient perceptions of nursing care: an emerging theory of interpersonal competence, *Journal of Advanced Nursing*. **20** (6), pp.1085-1093.

Freshwater, D., & Cahill, J., (2010). Care and Compromise: developing a conceptual model for work related stress, *Journal of Research in Nursing*. **15** (2), pp.173-183.

Freshwater, D., & Stickley, T., (2004). The heart of the art: emotional intelligence in nurse education, *Nursing Inquiry*. **11** (2), pp.91-98.

Gabbay, J., & Le May, A., (2004). Evidence based guidelines or collectively constructed “mindlines”? Ethnographic study of knowledge management in primary care, *British Medical Journal*. 329 (7473), pp.1013-1017.

Gallagher, A., (2004). Dignity and respect for dignity -- two key health professional values: implications for nursing practice, *Nursing Ethics*. **11** (6), pp.587-599.

Gallagher, A., Seedhouse, D. (2002). Dignity in care: the views of patients and relatives. *Nursing Times*; **98** (43), 39-40.

Garbett, R., & McCormack, B., (2004). A concept analysis of practice development. **In:** McCormack, B., Manley, K., & Garbett, R. (eds). *Practice Development in Nursing*. Oxford: Blackwell.

Gardner, H., Csikszentmihalyi, M., & Damon, W., (2001). *Good Work: When Excellence and Ethics Meet*. New York: Basic Books.

Gaventa, J., & Cornwell, A., (2001). Power and Knowledge. **In:** Reason, P., & Bradbury, H. *Handbook of Action Research: Participative Inquiry and Practice*. London: Sage Publications, pp.70-80.

Gergen, K.J., (1978). Toward generative theory, *Journal of Personality and Social Psychology*. **36** (11), pp.1344–1360.

Gergen, K.J., (1994a). *Realities and Relationships: soundings in social construction*. Cambridge MA: Harvard University Press.

Gergen, K.J., (1994b) The limits of pure critique. **In:** Simons, H.W., & Billig, M., (eds). *After postmodernism: reconstructing ideological critique*. London: Sage Publications, pp.58-78.

Gergen, K. J., (1999). *An Invitation to Social Construction*. Thousand Oaks, CA: Sage Publications.

Gergen, M., & Gergen, K., (2003). *Social construction: a reader*. London: Sage.

Gerrish, K., (2003). Self and others: the rigour and ethics of insider ethnography. **In:** Latimer, J. (ed). *Advanced Qualitative Research for Nursing*. Blackwell Science: Oxford, pp.77-94.

Gerrish, K., & Lacey, A., eds., (2006). *The Research Process in Nursing*, 5th ed., Oxford: Blackwell Science.

Gibbons, J., Limoges, C., Nowotny, H., Schwartzman, S., Scot P., & Trow M., (1994). *The new production of knowledge: the dynamics of science and research in contemporary societies*. Thousand Oaks, CA: Sage.

Gibson, L., (2008). Why spending five years as a NHS patient made me sick at heart. *Daily Mail*, February 5. Available from: <http://www.dailymail.co.uk/health/article-512374/Why-spending-years-NHS-patient-sick-heart.html> [accessed 11th February 2008].

Glasson, J.B., Chang, E.M.L. and Bidwell, J.W., (2008). The value of participatory action research in clinical nursing practice. *International Journal of Nursing Practice*, **14** (1), pp.34-39.

Goodrich, J., & Cornwell, J., (2008). *Seeing the person in the patient; the Point of Care review paper*. London: King's Fund.

Goodwin, D., Pope, C., Mort, M., & Smith, A., (2003). Ethics and ethnography: an experiential account, *Qualitative Health Research*. **13** (4), pp.567-577.

Gordon, S., & Nelson, S., (2005). An end to angels. Moving away from the virtue script toward a knowledge-based identity for nurses, *American Journal of Nursing*. **105** (5),

pp.62-69.

Graber, D.R., & Mitcham, M.D., (2004). Compassionate clinicians: take patient care beyond the ordinary, *Holistic Nursing Practice*. **18** (2), pp.87-94.

Graham, I.D., Logan, J., Harrison, M.B., Straus, S.E., Tetroe, J., & Caswell, W., (2006). Lost in knowledge translation: time for a map?, *Journal of Continuing Education in the Health Professions*. **26** (1), pp.13-24.

Grant, S., & Humphries, M., (2006). Critical evaluation of appreciative inquiry, *Action Research*. **4** (4), pp.401-418.

Green, A., (2004). Caring behaviors as perceived by nurse practitioners, *Journal of the American Academy of Nurse Practitioners*. **16** (7), pp.283-290.

Greenhalgh, T., (2006). *What seems to be the trouble: stories in health and illness care*. Oxford: Radcliffe Publishing.

Greenhalgh, T., & Hurwitz, B., (1999). Narrative based medicine: Why study narrative? *British Medical Journal*. **318** (7175), pp.48-50.

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O., (2004). Diffusion of innovations in service organisations: systematic review and recommendations. *Milbank Quarterly*, **82** (4), pp.581-629.

Griffiths, P., Jones, S., Maben, J., & Murrells, T., (2008). *State of the art metrics for nursing: a rapid appraisal*. London: National Nursing Research Unit King's College.

Griffiths, P., & Norman, I., (2005). Science and art in reviewing literature, *International Journal of Nursing Studies*. **42** (4), pp.373-376.

Guaspari, J., (1999). The hidden costs of customer satisfaction, *Quality Digest*. **2** pp.45-47.

Guba, E.G., & Lincoln, Y.S., (1989). *Fourth Generation Evaluation*. Newbury Park, CA: Sage.

Gutierrez, K. M., (2005). Critical care nurses' perceptions of and responses to moral distress, *Dimensions of Critical Care Nursing*, **24** (5), pp. 229-241.

Hägström, E., Skovdahl, K., Fläckman, B., Kihlgren, A.L., & Kihlgren, M., (2004). To feel betrayed and to feel that you are betraying the older residents: caregivers' experiences in a newly opened nursing home, *Journal of Clinical Nursing*. **13** (6), pp.687-696.

Hakkennes, S., & Dodd, K. (2008). Guideline implementation in allied health professions: a systematic review of the literature. *Quality and Safety in Health Care* **17** (4), pp.296-300.

Hall, J.E., (2006). Professionalizing action research - a meaningful strategy for modernizing services?, *Journal of Nursing Management*. **14** (3), pp.195-200.

Hammersley, M., (1992). *What's Wrong with Ethnography? – Methodological Explorations*. London: Routledge.

Hammersley, M., & Atkinson, P., (2007). *Ethnography: Principles in Practice*, 3rd ed. London: Routledge.

Hansen-Ketchum, P., & Myrick, F., (2008). Photo-methods for qualitative research in nursing: an ontological and epistemological perspective, *Nursing Philosophy*. **9** (3), pp.205-213.

Harper, D., (2002). Talking about pictures: a case for photo-elicitation, *Visual Studies*. **17** (1), pp.13-26.

Hart, E., & Bond, M., (1995). *Action research for health and social care*. Buckinghamshire: Open University Press.

Hatrick, G.A., (1997). Relational capacity: The foundation for interpersonal nursing practice, *Journal of Advanced Nursing*. **26** (3), pp.523-528.

Harvey, G., Loftus-Hiklls, A., Rycroft-Malone, J., Titchen, A., McCormack, B., & Seers, K., (2002). Getting evidence into practice: the role and function of facilitation, *Journal of Advanced Nursing*. **37** (6), pp.577-588.

Havens, D.S., Wood, S.O., & Leeman, J., (2006). Improving nursing practice and patient care: building capacity with appreciative inquiry, *Journal of Nursing Administration*. **36** (10), pp.463-470.

Healthcare Commission, (2007). *Is anyone listening? A report on complaints handling in the NHS*. London: Commission for Healthcare Audit and Inspection. Available from: http://www.cqc.org.uk/_db/_documents/Is_anyone_listening__A_report_on_complaints_handling_in_the_NHS.pdf [accessed 11th February 2011].

Healthcare Commission, (2008). *Spotlight on complaints*. London: Healthcare Commission.

Hem, M. H., & Heggen, K., (2004). Is compassion essential to nursing practice? *Contemporary Nurse*. **17**, (1-2), pp.19-31.

Heron, J., (1996). *Co-operative inquiry: research into the human condition*. London: Sage.

Heron, J., & Reason, P., (1997). A Participatory Inquiry Paradigm, *Qualitative Inquiry*. **3** (3), pp.274-294.

Heron, J., & Reason, P., (2001). The practice of co-operative inquiry: research with rather than on people. In: Reason, P., & Bradbury, H., (eds). *Handbook of action research: participative inquiry and practice*, London: Sage, pp.179-188.

Hochschild, A., (1983). *The managed heart: the commercialization of human feeling*. New York: Routledge.

Hockley, J., Dewar, B., & Watson, J., (2005). Promoting end of life care in nursing homes using an integrated care pathway for the last days of life, *Journal of Nursing Research*. **10** (2), pp.135-152.

- Holloway, W., & Jefferson, T., (2000). *Doing qualitative research differently: free association narrative and interview method*, London: Sage.
- Holloway, I., & Wheeler, S., (2002). *Qualitative research in nursing*, 2nd ed. Oxford: Blackwell.
- Holman, C., (2006). *Living bereavement: an exploration of healthcare workers' responses to loss and grief in an NHS continuing care ward for older people*. PhD, City University, London.
- Holman, C., Meyer, J., & Davenhill, R., (2006). Psychoanalytically informed research in an NHS continuing care unit for older people: exploring and developing staff's work with complex loss and grief, *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community*. **20** (3), pp.315 – 328.
- Hornstrup, C., & Johansen, T., (2009). From appreciative inquiry to inquiring appreciatively, *Appreciative Practitioner*. **11** (3), pp.7-14.
- Horvath, J. A., (1999). Tacit knowledge in the professions. **In**: Sternberg, R.J., & Horvath, J.A., (eds). *Tacit knowledge in professional practice*, Mahwah, NJ: Lawrence Erlbaum, pp. ix-xiii.
- Hosking, D.M., (1999). Social construction as process: Some new possibilities for research and development, *Concepts and Transformation*. **4** (2), pp.117-132.
- Hosking, D.M., (2002). *Relational constructivism*. Available from: <http://www.relational-constructivism.org/> [accessed 11th February 2011].

- Hsieh, L.J., Fang, Y., Kuo, C. & Turton, M.A., (2004). Patient experiences in the development of a caring code for clinical practice, *International Journal for Human Caring*. **8** (3), pp.21-29.
- Hughes, I., (2006). Action research in healthcare: what is the evidence?, *ALAR Journal*. **11** (2), pp.29-39.
- Hummelvoll, J. K., & Severinsson, E., (2005). Researchers' experience of cooperative inquiry in a mental health setting, *Journal of Advanced Nursing*. **52** (2), pp.184-188.
- Hunter, B., (2005). *Emotion work and boundary maintenance in hospital-based midwifery*. Edinburgh: Churchill Livingstone.
- Hurwitz, B., Greenhalgh, T., & Skultans, V., (2004). *Narrative research in health and illness*. Oxford: BMJ Books & Blackwell Publishing.
- Huynh, T., Alderson, M., & Thompson, M., (2008). Emotional labour underlying caring: an evolutionary concept analysis, *Journal of Advanced Nursing*. **64** (2), pp.195-208.
- Innes, A., Macpherson, S., & McCabe, L., (2006). *Promoting person centred care at the front line*. York: Joseph Rowntree Foundation.
- Isles, V., & Vaughan Smith, J., (2009). *Take it to the limit learning set. Working in health care could be one of the most satisfying jobs in the world – why doesn't it feel like that?* Available from: http://www.reallylearning.com/Current_Projects/Learning_Sets/take-it-to-the-limit-report2.pdf [accessed 11th February 2011].
- Jacelon, C. S., (2003) The dignity of elders in an acute care hospital. *Qualitative Health Research* **13**, pp.543–556.

Johnston, B., & Smith, L.N., (2006). Nurses' and patients' perceptions of expert palliative nursing care, *Journal of Advanced Nursing*. **54** (6), pp.700-709.

Jonsdottir, H., Litchfield, M., & Pharris, M.D., (2004). The relational core of nursing practice as partnership, *Journal of Advanced Nursing*. **47** (3), pp.241-250.

Jormsri, P., Kunaviktikul, W., Ketefian, S., & Chaowalit, A., (2005). Moral competence in nursing practice, *Nursing Ethics*. **12** (6), pp.582-594.

Jull, A., (2001). Compassion: a concept exploration, *Nursing Praxis in New Zealand*. **17** (1), pp.16-23.

Kaiser, K., (2009). Protecting respondent confidentiality in qualitative research, *Qualitative Health Research*. **19** (11), pp.1632-1641.

Kanov, J.M., Maitlis, S., Worline, M.C., Dutton, J.E., Frost, P.J., & Lilius, J.M., (2004). Compassion in organizational life, *American Behavioural Scientist*. **47** (6), pp.808-827.

Karlsson, M., Bergbom, I., Von Post, I., & Berg-Nordenberg, L., (2004). Patient experiences when the nurse cares for and does not care for, *International Journal for Human Caring*. **8** (3), pp.30-36.

Kavanagh, T., Stevens, B., Seers K., Sidami, S., & Watt-Watson, J., (2008). Examining appreciative inquiry as a knowledge translation intervention in pain management, *Canadian Journal of Nursing Research*. **40** (2), pp.40-56.

Kemmis, S., & McTaggart, R., (1988) (eds). *The action research reader*, 3rd ed. Geelong: Deakin University Press.

Kilbride, C., (2007). *Inside the black box: creating excellence in stroke care through a community of practice*. PhD Thesis, City University, London.

Kim, S., & Flaskerud, J.H., (2007). Cultural competence column: cultivating compassion across cultures, *Issues in Mental Health Nursing*. **28** (8), pp.931-934.

Kingdon, C., (2005). Reflexivity: not just a qualitative methodological research tool, *British Journal of Midwifery*. **13** (10), pp.622-627.

Kings Fund, (2009). *Point of Care Programme*. Available from: http://www.kingsfund.org.uk/current_projects/the_point_of_care/ [accessed March 14th 2011].

Kitson, A., Harvey, G., & McCormack, B., (1998). Enabling the implementation of evidence based practice: a conceptual framework, *Quality in Health Care*. **7** (3), pp.149-158.

Kociszewski, C., (2003). A phenomenological pilot study of the nurses' experience of providing spiritual care, *Journal of Holistic Nursing*, **21** (2), pp. 131-148.

Koloroutis, M., (2004). Introduction. In M. Koloroutis (ed). *Relationship-based care: A model for transforming practice*. Minneapolis, MN: Creative Healthcare Management, pp. 1-22.

Kooker, B.M., Shoultz, J., & Codier, E.E., (2007). Identifying emotional intelligence in professional nursing practice, *Journal of Professional Nursing*. **23** (1), pp.30-36.

Kowalski, K., (2008). Appreciative inquiry, *Journal of Continuing Education in Nursing*. **39** (3), p.104.

Kvale, S., (2002). The social construction of validity. **In:** Denzin, N.K. & Lincoln, Y.S., (eds). *The qualitative inquiry reader*. Thousand Oaks, CA: Sage, pp.299-325.

Labonte, R., & Feather, J., (1996). *Handbook on using stories in health promotion practice*. Saskatoon: University of Saskatchewan.

Lax, W., & Galvin, K.T., (2002). Reflections on a community action research project: interprofessional issues and methodological problems, *Journal of Clinical Nursing*. **11** (3), pp.376-386.

Leininger, M.M., (1985). *Qualitative research methods in nursing*. London: Grune and Stratton.

Leininger, M.M., (1991). *The theory of culture care diversity and universality. Culture care diversity and universality: A theory of nursing*. New York: National League for Nursing (redistributed by Jones and Bartlett Publishers, Inc., New York, 2001).

Levenson, R., (2007). *The challenge of dignity in care - upholding the rights of the individual*. London: Help the Aged.

Lewis, J., & Ritchie, J., (2003). Generating for qualitative research. **In:** Ritchie, J., & Lewis, J. *Qualitative research practice: a guide for social science students*. London: Sage, pp. 263-286.

Liaschenko, J. (1997) Knowing the patient. In S.E. Thorne and V.E. Hays (eds) *Nursing Praxis: Knowledge and Action*. Thousand Oaks: Sage.

Liaschenko, J., (2002). Ethics: thoughts on nursing work, *Journal of Nursing Administration*. **32** (2), pp.69-70.

Liaschenko, J., & Fisher, A., (1999). Theorizing the knowledge that nurses use in the conduct of their work, *Scholarly Inquiry for Nursing Practice*. **13** (1), pp.29-41.

Liaschenko, J., Oguz, N.Y., & Brunnquell, D., (2006). Critique of the "tragic case" method in ethics education, *Journal of Medical Ethics*. **32** (11), pp.672-677.

Lincoln, Y.S., & Guba, E.G., (1985). *Naturalistic inquiry*. Newbury Park: Sage.

Lofman, P., Pelkonen, M., & Pietila, A., (2004). Ethical issues in participatory action research, *Scandinavian Journal of Caring Science*. **18** (3), pp.333-340.

Lofland, J., & Lofland, L. H., (1984). *Analysing social settings*, 2nd ed. Belmont: Wadsworth.

Lorenz, L., & Kolb, B., (2009). Involving the public through participative visual research methods, *Health Expectations*. **12** (3), pp.262-274.

Ludema, J.D., Whitney, D., Mohr, B.J., & Griffin, T.J., (2003). *The Appreciative Inquiry Summit. A practitioners guide for leading large group change*. San Francisco, CA: Berrett-Koehler.

Maben, J., (2008a). The art of caring: invisible and subordinated? A response to Juliet Corbin: 'Is caring a lost art in nursing?'. *International Journal of Nursing Studies*. **45** (3), pp.335-338.

Maben, J., (2008b). Patient experience of care and the influence of staff well being. Available from:

<http://www.kcl.ac.uk/content/1/c6/04/11/41/ResearchStudyInformationSheet.pdf>

[accessed 11 February 2011].

Maben, J., Cornwell, J., & Sweeney, K., (2010). In praise of compassion, *Journal of Research in Nursing*, **15** (1), pp. 9-13.

Maben, J., & Griffiths, P., (2008). *Nurses in society: starting the debate*. London: National Nursing Research Unit, King's College London.

Maben, J., Latter, S., & Clark, J.M., (2006). The theory-practice gap: impact of professional-bureaucratic work conflict on newly-qualified nurses, *Journal of Advanced Nursing*. **55** (4), pp.465-477.

Maben, J., Latter, S., & Clark, J. M., (2007). The sustainability of ideals, values and the nursing mandate: evidence from a longitudinal qualitative study, *Nursing Inquiry*, **14** (2), pp. 99-113.

Mackintosh, C., (2007). Protecting the self: a descriptive qualitative exploration of how registered nurses cope with working in surgical areas, *International Journal of Nursing Studies*, **44** (6), pp. 982-990.

Macleod, R., & McPherson, K.M., (2007). Care and compassion: part of person-centred rehabilitation, inappropriate response or a forgotten art?, *Disability & Rehabilitation*. **29** (20-21), pp.1589-1595.

Manley, K., & McCormack, B., (2008). Person-centred care, *Nursing Management*. **15** (8), pp.12-13.

Mantzoukas, S., (2004). Issues of representation in qualitative inquiry, *Qualitative Health Research*. **14** (7), pp.994-1007.

Marincowitz, G.J.O., (2003). How to use participatory action research in primary care, *Family Practice*. **20** (5), pp.595-600.

Marshall, J., (2001), Self-reflective inquiry practices. **In:** Reason, P., & Bradbury, H. (eds). *Handbook of Action Research: Participative Inquiry and Practice*. London: Sage, pp. 433-439.

Mason, J., (2002). *Qualitative researching*. 2nd ed. London: Sage.

Matiti, M.R., & Trorey, G.M., (2008), Patients' expectations of the maintenance of their dignity, *Journal of Clinical Nursing*, **17**, pp. 2709-2717.

Mazhindu, D. M., (2003). Ideal Nurses: the Social Construction of Emotional Labour, *European Journal of Psychotherapy, Counselling & Health*. **6** (3), pp. 242-262.

McCabe, J.L., & Holmes, D., (2009). Reflexivity, critical qualitative research and emancipation: a Foucauldian perspective, *Journal of Advanced Nursing*. **65** (7), pp.1518-1526.

McCance, T.V., McKenna, H.P., & Boore, J.R.P., (2001). Exploring caring using narrative methodology: an analysis of the approach, *Journal of Advanced Nursing*. **33** (3), pp.350-356.

McCormack, B., (2003). A conceptual framework for person centred practice with older people, *International Journal of Nursing Practice*. **9** (3), pp.202-209.

McCormack, B., (2004). Person-centredness in gerontological nursing: an overview of the literature, *International Journal of Older People Nursing* in conjunction with *Journal of Clinical Nursing*. **13** (3a), pp.45-53.

McCormack, B., Dewar, B., Wright, J., Garbett, R., Harvey, G., & Ballantine, K. (2006). *A realist synthesis of evidence relating to practice development*. Edinburgh: NHS Education Scotland.

McCormack, B., Henderson, E., Wilson, V., & Wright, J., (2009). Making practice visible: the workplace culture critical analysis tool (WCCAT), *Practice Development in Health Care*. **8** (1), pp.28-43.

McCormack, B., McCance, T., & Slater, P.F., (2008). Person-centred outcomes and cultural change. **In:** Manley, K., ed. *International Practice Development in Nursing and Healthcare*. Chichester: Blackwell Publishing, pp.189-214.

McCormack, B., Wright, J., Dewar, B., Harvey, G., & Ballantine, K., (2007). A realist synthesis of evidence relating to practice development: recommendations, *Practice Development in Health Care*. **6** (1), pp.76-80.

McGhee, G., Marland, G.R., & Atkinson, A., (2007). Grounded theory research: literature reviewing and reflexivity, *Journal of Advanced Nursing*. **60** (3), pp.334-342.

McGill, I., & Brockbank, A., (2004). *The action learning handbook*. London: Routledge Falmer.

McNamee, S., (2002). Appreciative Inquiry: Social Construction in Practice, *Organisations and People*. **9** (2), pp.35-41.

McNamee, S., (2003). Appreciative evaluation within a conflicted educational context, *New Directions for Evaluation*. **100**, pp.23-40.

McQueen, A., (2000). Nurse-patient relationships and partnership in hospital care, *Journal of Clinical Nursing*. **9** (5), pp.723-731.

Menzies, I.E.P., (2001). A case study of the functioning of social systems as a defence against anxiety. **In:** Rafferty, A., & Traynor, M., (eds). (2001) *Exemplary research for nursing and midwifery*. London: Routledge, pp.111-142.

Menzies Lyth, I., (1959). The functions of social systems as a defence against anxiety: A report on a study of the nursing service of a general hospital, *Human Relations* 13: 95-121; reprinted in *Containing Anxiety in Institutions: Selected Essays, vol. 1*. Free Association Books, 1988, pp.43-88.

Meyer, J., (1999). Using qualitative methods in health related action research. **In:** Pope, C., & Mays, N. (eds). *Qualitative research in health care*, 2nd ed. London: BMJ Books, pp.59-74.

Meyer, J., (2000). Qualitative research in health care: Using qualitative methods in health related action research, *British Medical Journal*. **320** (7228), pp.178-181.

Meyer, J., (2001). *Lay participation in care in an acute hospital setting*. Portsmouth: Nursing Praxis International.

Meyer, J., (2006). Action research. **In:** Gerrish, K., & Lacey, A., (eds). *The research process in nursing*, 5th ed. London: Blackwell Publishing, pp.273-288.

Meyer, J., Ashburner, C., Holman, C., (2006). Becoming connected, being caring, *Educational Action Research*. **14** (4), pp.477-496.

Meyer, J., & Owen, T., (2008). Call for an international dialogue on quality of life in care homes, *International Journal of Older People Nursing*. **3** (4), pp.291-294.

Mills, J., Bonner, A., Francis, K., (2006). Adopting a constructivist approach to grounded theory: implications for research design, *International Journal of Nursing Practice*. **12** (1), pp.8-13.

Milner, J., (2003). Compassionate care nursing with meaning: incorporating holism into nursing practice, *Chart, Journal of Illinois Nursing*. **100** (6), pp.4-6.

Moore, M., (2008). Appreciative inquiry: the why: the what? the how?, *Practice Development in Health Care*. **7** (4), pp.214-220.

Morse, J.M., Swanson, J.M., & Kuzel, A.J., (eds). (2001). *The nature of qualitative evidence*. Thousand Oaks, CA: Sage.

Munn-Giddings, C., McVicar, A., & Smith, L., (2008). Systematic review of the uptake and design of action research in published nursing research 2000-2005, *Journal of Research in Nursing*. **13** (6), pp.465-477.

Murphy, E., & Dingwald, R., (2001). The ethics of ethnography. **In:** Atkinson, P., Coffey, A., Delamont, S., Lofland, J., & Lofland, L. (eds). *Handbook of Ethnography*. London: Sage, pp-339-351.

Murphy, J., Tester, S., Hubbard, G., Downs, M., MacDonald, C., (2005). Enabling frail older people with a communication difficulty to express their views: the use of talking mats as an interview tool, *Health and Social Care in the Community*. **13** (2), pp.95-107.

NCHR&D Forum, (2007). *My home life: quality of life in care homes. Literature Review*. London: Help the Aged.

NHS Centre for Improvement and Innovation, available from: <http://www.institute.nhs.uk> [accessed 14th March 2010].

NHS Lothian, (2006). *The external reference group for older people's service*. Unpublished report. Edinburgh: NHS Lothian.

Newman, T.B., (2003). The power of stories over statistics, *British Medical Journal*. **327** (7429), pp.1424-1427.

Newman, J., & Hughes, M., (2007). *Modernising adult social care: what's working?* London: Department of Health.

Nicholls, L., & Webb, C., (2006). What makes a good midwife? Implications for midwifery practice, *Evidence Based Midwifery*. **4** (2), pp.65-70.

Nicholson, C.J., (2009). *Holding it together: a psycho-social exploration of living with frailty in old age*. PhD, City University London.

Nicholson, C., Flatley, M., Wilkinson, C., Meyer, J., Dale, P., & Wessel, L. (2010) Everybody matters 2: promoting dignity in acute care through effective communication. *Nursing Times*. 106 (21), pp.12-14.

Nieva, V., Murphy, R., Ridley, N., Donaldson, N., Combes, J., Mitchell, P., Kovner, C., Hoy, E., & Carpenter, D., (2005). **In:** Henriksen, K., Battles, J.B., Marks, E.S. (eds). *Advances in patient safety: from research to implementation* (Volume 2: Concepts and Methodology). Rockville (MD): Agency for Healthcare Research and Quality (US); 2005 Feb.

Nolan, M., (1999). Enhancing the quality of care in residential and nursing homes: more than just a professional responsibility, *Journal of Elder Abuse and Neglect*, **10** (1&2),

pp.61-77.

Nolan, M., Brown, J., Davies, S., Nolan, J., & Keady, J., (2006). *The senses framework: improving care for older people through a relationship centred approach*. Getting Research into Practice (GRiP) Report No 2. Project Report. Sheffield: University of Sheffield.

Nolan, M.R., Davies, S., Brown, J., Keady, J., & Nolan, J., (2004). Beyond person centered care: A new vision for gerontological nursing, *International Journal of Older People Nursing*. **13** (3a), pp.45-53.

Nolan, M.R., Davies, S., & Grant, G., (2001). *Working with older people and their families: key issues in policy and practice*. Buckingham: Open University Press.

Nolan, M.R., Hanson, E., Magnusson, L., & Anderson, B., (2003). Gauging quality in constructivist research: the Aldre Vast Sjuharad model revisited, *Quality in Ageing – Policy Practice and Research*. **4** (2), pp.22-27.

Nordam, A., Torjuul, K., & Sorlie, V., (2005). Ethical challenges in the care of older people and risk of being burned out among male nurses, *Journal of Clinical Nursing*, **14** (10), pp. 1248-1256.

Nouwen, H.J., McNeil, D.P., & Morrison, D.A., (1982). *Compassion*. London: Darton, Longman and Todd.

Nutley, S.M., Davies, H.T.O., & Walter, I., (2003). Evidence-based policy and practice: cross-sector lessons from the United Kingdom, *Social Policy Journal of New Zealand*.

20, pp.29-48. Available from:

<http://www.msd.govt.nz/documents/publications/msd/journal/issue20/20-pages29-48.pdf>

[accessed March 14th 2011].

Parahoo, K., (2006). (ed). *Nursing research: principles, processes and issues*.

Basingstoke: Palgrave, 2nd edn.

Parker, V.A., (2002). Connecting relational work and workgroup context in caregiving organizations, *The Journal of Applied Behavioural Science*. **38** (3), pp. 276-297.

Patient Association, (2008). *NHS complaints: who cares? Who can make it better?*

Harrow: Patients Association.

Patterson, M., Nolan, M. Rick, J., Brown, J., Adams, R., & Musson, G., (2011). *From metrics to meaning: culture change and quality in acute hospital care for older people*.

Report from the National Institute for Health Research Service Delivery and Organisation

Programme. Available from: <http://www.sdo.nihr.ac.uk/files/project/93-final-report.pdf>

[accessed 11th February 2011].

Paulson, D.S., (2004). Taking care of patients and caring for patients are not the same,

AORN Journal. **79** (2), pp.359-366.

Pawson, R., (2003). 'Shifting Standards: The quest for quality appraisal in social care knowledge'. ESRC UK Centre for Evidence Based Policy and Practice, Working Paper Series. Available from: www.evidencenetwork.org [accessed 14th March 2010].

Payne, R. L., & Cooper, C. L., (2001). *Emotions at work: theory, research, and applications in management*, Chichester: Wiley.

Pearson, A., (2006). Powerful caring... second article, *Nursing Standard*. **20** (48), pp.20-22.

Peters, M.A., (2005). Reflections on compassion, *International Journal for Human Caring*. **9** (2), pp.71-71.

Peters, M.A., (2006). Compassion: an investigation into the experience of nursing faculty, *International Journal for Human Caring*. **10** (3), pp.38-46.

Petersson, P., Springett, J. & Blomquist, K., (2009). Telling stories from everyday practice, an opportunity to see a bigger picture: a participatory action research project about developing discharge planning, *Health and Social Care in the Community*. **17** (6), pp.548-556.

Pope, C. & Mays, N., (eds). (1999). *Qualitative research in health care*. London: Blackwell Publishing, 2nd edn, pp.1-10.

Post, S.G., (2005). Altruism, happiness and health: it's good to be good, *International Journal of Behavioural Medicine*. **12** (2), pp.66-77.

Powell, A.E., Rushmer, R.K., & Davies, H.T.O., (2009). *A systematic narrative review of quality improvement models in health care*. Edinburgh: NHS Quality Improvement Scotland.

Pratt, C., (2002). Creating unity from competing integrities: A case study in appreciative inquiry methodology. **In:** Fry, R., Barrett, F., Seiling, J., & Whitney, D. (eds). *Appreciative inquiry and organizational transformation. Reports from the field.* Westport, CT: Quorum Books, pp. 99–120.

Prior, M., Guerin, M., & Grimmer-Somers, K., (2008). The effectiveness of clinical guideline implementation strategies – a synthesis of systematic review findings, *Journal of Evaluation in Clinical Practice*. **14** (5), pp.888-897.

Quinn, B., (2003). Exploring nurses' experiences of supporting a cancer patient in their search for meaning, *European Journal of Oncology Nursing*, **7** (3), pp. 164-171.

Reason, P., (2004). *Participation in Human Inquiry*. London: Sage.

Reason, P., & Bradbury, H., (2001). *Handbook of action research: participative inquiry and practice*. London: Sage.

Reason, P., & Torbert, W.R., (2001). Towards a transformational science: a further look at the scientific merits of action research, *Concepts and Transformations*. **6** (1), pp.1-37.

Reed, J., (2005). Using action research in nursing practice with older people: democratizing knowledge, *Journal of Clinical Nursing*. **14** (5), pp.594-600.

Reed, J., (2007). *Appreciative inquiry: research for change*. London: Sage: Thousand Oaks.

Reed, J., (2010). Appreciative Inquiry and older people- finding the literature, *International Journal of Older People Nursing*. **5** (4), pp.292-298.

Reed, J. & Holmberg, L., (eds). (2007). Impact of appreciative inquiry on research: experiences, reflections and thoughts for the future, *Appreciative Inquiry Practitioner*. November, pp.1-55.

Reed, J., & McCormack, B., (2007). The importance of dignity, *International Journal of Older People Nursing*. **2** (3), p.161.

Reed, J., Pearson, P., Douglas, B., Swinburne, S., & Wilding, H., (2002). Going home from hospital – an appreciative inquiry study, *Health and Social Care in the Community*. **10** (1), pp.36-45.

Roach, M.S., (1992). *The human act of caring*. Ottawa, Ontario: Canadian Hospital Association Press.

Roger, P.J., & Fraser, D., (2003). Appreciative inquiry. **In**: Preskill, H., & Coghlan, A.T., (eds). *Using appreciative inquiry in evaluation*. San Francisco, CA: Jossey Bass, pp.75-84.

Rogers, E. M. (2003). *Diffusion of Innovations*. New York: The Free Press, 5th ed.

Rolfe, G., (1996). *Closing the theory practice gap*, Oxford: Butterworth, Heinemann.

Rosenbaum, M., Ferguson, K., & Herwaldt, L., (2005). In their own words: presenting the patient's perspective using research based theatre, *Medical Education*. **39** (6), pp.622-

631.

Ross, F., O'Tuathail, C., & Stubberfield, D., (2005). Towards multidisciplinary assessment of older people: exploring the change process, *Journal of Clinical Nursing*. **14** (4), pp.518-529.

Royal College of Nursing, (2008). *Defending dignity - challenges and opportunities for nursing*. London: Royal College of Nursing.

Sabo, B.M., (2006). Compassion fatigue and nursing work: can we accurately capture the consequences of caring work?, *International Journal of Nursing Practice*. **12** (3), pp.136-142.

Safran, D. G., Miller, W., and Beckman, H., (2006) Organizational dimensions of relationship-centred care: theory, evidence and practice. *Journal of General Internal Medicine* **21** (Suppl 1). S9-15.

Sandelowski, M., (1991). Telling stories: Narrative approaches in qualitative research. *Image: Journal of Nursing Scholarship*. **23** (3), pp.161-166.

Sanghavi, D.M., (2006). What makes for a compassionate patient-caregiver relationship?, *Joint Commission Journal on Quality & Patient Safety*. **32** (5), pp. 283-292.

Schantz, M.L., (2007). Compassion: a concept analysis, *Nursing Forum*. **42** (2), pp. 48-55.

Schmidt, L.A., (2003). Patients perceptions of nursing care in hospital setting, *Journal of Advanced Nursing*. **44** (4), pp.393-399.

Schouten, L.M.T., Hulscher, M.E.J.L., Everdingen, J.J.E., Huijsman, R., & Grol, R.P.T.M., (2008). Evidence for the impact of quality improvement collaboratives: systematic review, *British Medical Journal*. **336** (7659), pp.1491-1494.

Schultz, R., Hebert, R.S., Dew, M.A., Brown, S.L., Scheier, M.F., Beach, S.R., Czaja, S.J., Martire, L.M., Coon, D., Langa, K.M., Gitlin, L.N., Stevens, S. A.B., & Nichols, L., (2007). Patient suffering and caregiver compassion: new opportunities for research, practice, and policy, *Gerontologist*. **47** (1), pp. 4-13.

Schwartz, D., (1989). Visual ethnography: Using photographs in qualitative research, *Qualitative Sociology*. **12** (2), pp.119–154.

Scottish Executive Health Department, (2006a). *Delivering care, enabling health: harnessing the nursing, midwifery and allied health professions' contribution to implementing delivering for health in Scotland*. Edinburgh: Scottish Executive.

Scottish Executive Health Department, (2006b). *Rights, relationships and recovery: The Report of the National Review of Mental Health Nursing in Scotland*. Edinburgh: Scottish Executive.

Scottish Government Health Department, (2007). *Better health, better care*. Edinburgh: Scottish Government.

Seale, C., (1999). Quality in qualitative research, *Qualitative Inquiry*. **5** (4), pp.465-478.

Seligman, M.E.P., (1991). *Learned Optimism*. New York: AA Knope.

Shapiro, J., (2008). Walking a mile in their patient's shoes: empathy and othering in medical student's education, *Philosophy Ethics and Humanities in Medicine* [online] **3**, 10. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2278157/> [accessed 14th March 2010].

Sharp, K., (1998). The case for case studies in nursing research: the problems of generalization, *Journal of Advanced Nursing*. **27** (4), pp.785-789.

Smith, M.K., (1999, 2009). Animateurs, animation and fostering learning and change, *the encyclopaedia of informal education*. Available from: www.infed.org/animate/b-animat.htm [accessed 11 February 2009].

Smith, P., (1992). *The emotional labour of nursing*. London: Macmillan.

Smith, P., (2008). Compassion and smiles: what's the evidence?, *Journal of Research in Nursing*. **13** (5), pp.367-370.

Smith, S., Dewar, B., Pullin, S., and Tocher, R., (2010). Relationship-centred outcomes focused on compassionate care for older people within in-patient care settings, *International Journal of Older People Nursing*. **5** (2), pp.128-137.

Smith, P. & Gray, B., (2001). Emotional labour of nursing revisited: caring and learning 2000, *Nurse Education in Practice*, **1** (1), pp. 42-49.

Smith, J., & Rudd, C., (2010). Implementing the productive ward management programme, *Nursing Standard*. **24** (31), pp.45-48.

Snow, N.E., (1991). Compassion, *American Philosophical Quarterly*. **28** (3), pp. 195-205.

Sparrow, S. & Draper, J., (2010). The (silent) voice of nursing?, *Journal of Clinical Nursing*, **19**, pp. 603-604.

Staden, H., (1998). Alertness to the needs of others: a study of the emotional labour of caring, *Journal of Advanced Nursing*. **27** (1), pp.47-56.

Stange, K.C., Goodwin, M.A., Zyzanski, S.J., & Dietrich, A.J., (2003). Sustainability of a practice-individualized preventive service delivery intervention, *American Journal of Preventive Medicine*. **25** (4), pp.296-300.

Stein-Parbury, J., & Liaschenko, J., (2007). Understanding collaboration between nurses and physicians as knowledge at work, *American Journal of Critical Care*. **16** (5), pp.470-478.

Stickley, T., & Freshwater, D., (2002). The art of loving and the therapeutic relationship, *Nursing Inquiry*. **9** (4), pp.250-256.

Strauss, A. & Corbin, J., (1998). *Basics of qualitative research: techniques and procedures for developing grounded theory*, 2nd ed. Thousand Oaks: CA, USA Sage.

Susman, G.I. & Evered, R.D., (1978). An assessment of the scientific merits of action research, *Administrative Science Quarterly*. **23**, pp.582-603.

Swanson, J.M., & Chenitz, W.C., (1982). Why qualitative research in nursing?, *Nursing Outlook*. April, pp.241-245.

Tarlier, D., (2004). Beyond Caring: the moral and ethical bases of responsive nurse-patient relationships, *Nurse Philosophy*. **5**, pp.230-241.

Theodosius, C., (2006). Recovering emotion from its management, *Sociology*. **40** (5), pp.893-910.

Theodosius, C., (2008). *Emotional Labour in Health Care – the unmanaged heart of nursing*. London: Routledge.

Thomas, H., (2008). Engaging patients to understand and improve their experience of attending hospital, *Journal of Communication in Health Care*. **1** (1), pp.78-87.

Thomas, R.B., & Wilson, J.P., (2004). Issues and controversies in the understanding and diagnosis of compassion fatigue, vicarious traumatization, and secondary traumatic stress disorder, *International Journal of Emergency Mental Health*. **6** (2), pp.81-92.

Thompson, D.S., Estabrooks, C.A., Scott-Findlay, S., Moore, K., & Wallin, L., (2007). Interventions aimed at increasing research use in nursing: a systematic review, *Implementation Science* [online] 2:15. Available from: <http://www.implementationscience.com/content/2/1/15> [accessed 14th March 2010].

Torbert, W. R., (1999). The distinctive questions development action inquiry asks, *Management Learning*. **30** (2), pp.189-206.

Torjuul, K., Elstad, I., & Sorlie, V., (2007). Compassion and responsibility in surgical care, *Nursing Ethics*. **14** (4), pp.522-534.

Tresolini, C.P., & Pew-Fetzer Task Force., (1994). *Health professions education and relationship-centered care: Report of the Pew-Fetzer Task Force on advancing psychosocial education*. San Francisco, CA: Pew Health Professions Commission.

Van der Haar, D., & Hosking, D., (2004). Evaluating appreciative inquiry: a relational constructionist perspective, *Human Relations*. **57** (8), pp.1017-1036.

Van Manen, M., (1997). *Researching lived experience: human science for an action sensitive pedagogy*. London: Althouse Press.

Von Dietze, E., & Orb, A., (2000). Compassionate care: a moral dimension of nursing, *Nursing Inquiry*. **7** (3), pp.166-174.

Walker, E., & Dewar, B.J., (2000). Moving on from interpretivism: an argument for a constructivist approach to inquiry, *Journal of Advanced Nursing*. **32** (3), pp.713-720.

Walsh, K., & Kowanko, I., (2002). Nurses' and patients' perceptions of dignity, *International Journal of Nursing Practice*. **8** (3), pp.143-151.

Walsh, K., Moss, C., Lawless, J., McKelvie, R., & Duncan, L., (2008). Puzzling practice: A strategy for working with clinical practice issues, *International Journal of Nursing Practice*. **14** (2), pp.94–100.

Waterman, H., Tillen, D., Dickson, R., & de Koning, K., (2001). Action research: a systematic review and guidance for assessment, *Health Technology Assessment*. **5** (23). Available from: <http://www.hta.ac.uk/fullmono/mon523.pdf> [Accessed 11 February 2009].

Watkins, J.M., & Mohr, B.J., (2001). *Appreciative Inquiry: change at the speed of imagination*. CA: Josey Bass.

Watson, J., (1997). The theory of human caring. Retrospective and prospective, *Nursing Science Quarterly*. **10** (1), pp.49-52.

Watson, J., (2006) Caring theory as an ethical guide to administrative and clinical practices. *Nursing Administration Quarterly*. **30** (1), pp.48-55.

Webb, C., (1989). Action research: philosophy, methods and personal experiences, *Journal of Advanced Nursing*. **14** (5), pp.403-410.

Webster, J., & Dewing, J., (2007). Growing a practice development strategy for community hospitals, *Practice Development in Healthcare*. **6** (2), pp.97–106.

Weinberg, D. B., (2006). "When little things are big things," in *The complexities of care: nursing reconsidered*, S. Nelson & S. Gordon, eds., ILR Press, Ithaca and London, pp.

30-43.

Wenger, E., (1998). *Communities of practice. Learning, meaning and identity*. Cambridge: Cambridge University Press.

Wenger, E., McDermont, R., Snyder, W.M., (2002). *Cultivating communities of practice*. Boston, MA: Harvard Business School Press.

Wensing, M., Wollersheim, H. & Grol, R. (2006). Organizational interventions to implement improvements in patient care: a structured review of reviews, *Implementation Science* [online] 1: 2. Available from: <http://www.implementationscience.com/content/1/1/2> [accessed 6th May 2009].

Whitehead, J., & Wheeler, H., (2008). Patients' experiences of privacy and dignity. Part 1: a literature review, *British Journal of Nursing*. **17** (6). pp.381-385.

Wilcock, P.M, Brown, G.C.S., Bate, J., Carver, J., & Machin, S., (2003). Using patient stories to inspire quality improvement within the NHS modernization agency collaborative programmes, *Journal of Clinical Nursing*. **12** (3), pp.422-430.

Williams, S., Nolan, M., & Keady, J., (2009). Relational practice as the key to ensuring quality care for frail older people: Discharge: Planning as a case example, *Quality in Ageing*. **10** (3), pp.44-55.

Wilson, G., (2009). Implementation of releasing time to care – the productive ward, *Journal of Nursing Management*. **17** (5), pp.647-654.

Winter, R., (2003). Buddhism and action research: towards an appropriate model of inquiry for the caring professions, *Educational Action Research*. **11** (1), pp.141-160.

Winter, R., & Munn-Giddings, C., (2001). *A handbook for action research in health and social care*. London: Routledge.

Wright, S., (2008). Unthinkable nursing series summary, *Nursing Standard*. **23** (11), pp.20-21.

Youngson, R., (2008). *Compassion in Healthcare: the missing dimension of healthcare reform?* London: NHS Confederation.

Zeldin, T., (1998). *Conversation: How talk can change our lives*. London: Harville Press.

Zimmerman, M.A., (1990). Towards a theory of learned hopefulness: a structural model analysis of participation and empowerment, *Journal of Research in Personality*. **24** (1), pp.71-86.

Appendices

Appendix 1 – Ethical Approval Letter

Email correspondence 19th June 2008

Dear Belinda,

The Research Ethics and Governance Committee grants ethical approval to your project **06/SNMSC/069 -To identify, implement and evaluate strategies that promote compassionate person centred care within hospital wards in NHS Lothian**

There a couple of minor change that the committee would like made:

Please ensure that the independent advisor on the participant information sheet is stated as Iain McIntosh and ensure correct spelling.

On the participant information sheet you should have the same researchers down as in Section 5

A hard copy letter with be with you shortly.

Kind regards

xxxxxxx

Napier University

Canaan Lane Campus

Edinburgh

EH9 2TB

Appendix 2 – Participant Information Sheets



NAPIER UNIVERSITY
EDINBURGH

Leadership in Compassionate
Care Project
School of Nursing and Midwifery & Social Care
Napier University
Canaan Lane Campus
Edinburgh
EH9 2BT
0131 455 5675

Version 3, 2/05/08

Participant Information Sheet - Patient

Leadership in Compassionate Care Project

NHS Lothian and Napier University would like to invite you to take part in a research study taking place from May 2008 to December 2010. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and talk to others about it if you wish.

Part 1 tells you the purpose of this research and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study.

Part 1

What is the Purpose of the research study?

The purpose of this research study is to find out what things affect your experiences of receiving care and what could be done to help to improve and support compassionate,

person centred care across NHS Lothian. “Compassionate care” is often associated with words such as – caring, empathy, person centred care, human touch, and sensitivity. In this study we want to learn more about what it is, what it feels like and how to support people to ensure that it is a core part of all of our work.

Why are we inviting you to take part?

You have been invited to take part in this study because you are a patient in hospital. We are also working with a number of staff and relatives in wards during the project. You will have had experience of receiving care and it is important that we hear your views so that we can learn from this and make the experience of care as person-centred as possible.

Do you have to take part?

It is up to you to decide whether or not you take part in any part of this research, and you would be free to leave the project at any time without giving a reason. This would not affect any services you may receive.

What will happen to you if you take part?

We are asking patients to take part in a number of ways, which may include (it is not anticipated that you will be involved in all of these activities but you will be asked in the consent form to indicate those which you feel happy to participate in):

Being interviewed

You will be asked to take part in two interviews. The interviews will be conducted by our researchers who work for NHS Lothian and/or Napier University. The first interview will last around 40 minutes and we will ask you about your experiences of receiving hospital care. The interviewer will ask questions about

- First realising something was wrong
- Getting to the hospital
- Being in the ward
- Getting better

- Going home

The second interview will take 20 minutes and will involve the researcher feeding back and checking with you, their understanding of what you said. If you are agreeable these interviews will be audio recorded.

These interviews will take place at a time that is convenient for you and does not disrupt your care. The researchers will respect your privacy and conduct an interview wherever possible in private, for example in a separate room in the ward.

Observation of your care

We hope to observe the care you receive from staff whilst in hospital. One of the researchers (also a trained nurse) will work alongside staff when they are providing your care. Observing in this way will ensure minimal disruption to the care given to you and other patients. The researchers will observe for periods of up to one hour. It is anticipated that each period of observation would involve a different group of patients. For example a group of patients may include 6 patients located in one bay of the ward, therefore you would not be observed for the whole one hour period. Whilst observing your care we will respect your right to dignity and privacy.

Expenses and Payments

We will cover any agreed out of pocket expenses which you may incur through taking part in the project, e.g. local travel.

What could be the risks or disadvantages of taking part?

We will be discussing issues about your experiences of receiving care. As part of this we will be discussing your views on what affects care has had on you. Some participants could find that this causes upset or distress. We want to make sure this research works well for everyone taking part and will do our best to support all participants. This could include any assistance or comfort people need or want to help them during our

discussions, as well as someone to talk to afterwards. We will check with you if you need anything to help you to take part and ensure that this support is provided.

What could be the benefits of taking part?

This is a joint study between NHS Lothian and Napier University. We will be working closely with hospital staff, lecturers, and students to make sure we all learn from this project. Whilst we cannot promise that taking part will help you directly, the information we get from this research will be used to enhance care. We have found in other projects that staff and patients have reported that they have learnt a great deal from taking part in project work. This may be an additional benefit.

What happens when the research stops?

At the end of our work we will share the findings and our recommendations, which will be for patients, nurses and university staff. The results of the research will also be published – please see Part 2 for further information. The detailed information (data) from the research will be kept at NHS Lothian and Napier University offices for 5 years. Then all of this information will be confidentially destroyed.

What if there is a problem?

Any complaint about the way you have been dealt with during the research or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the research be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2. The interviews and observations will be taking place in hospital – so others are likely to know you will be taking part, however all information we obtain will be treated in confidence and personal references and identifying information will be removed.

If the information in Part 1 has interested you and you want to take part in the research, please read the additional information in Part 2 before making any decision.

Part 2

What will happen if you don't want to carry on with the study?

You will be able to pull out of the research at any time. This will not affect any services you receive.

What if there is a problem? (Further Information)

If you have a concern about any aspect of this research, please contact the Chief Investigator who will do her best to answer your questions. Please contact Professor Morag Gray by telephone on 0131 455 5687 by post at School of Nursing, Midwifery and Social Care, Napier University, 74 Canaan Lane, Edinburgh, EH9 2TB. If you remain unhappy and wish to complain formally, you can do this through the NHS Lothian Complaints procedure.

You can also contact Stephen Smith Lead Nurse, Leadership in Compassionate Care Project at Napier University, Canaan Lane Campus, Edinburgh, 0131 455 5675.

If at any stage you would like to talk about participating in the research to someone independent of the study then you can contact Iain McIntosh, Head of School of Nursing, Midwifery & Social Care, at Napier University. He can be contacted on 031 455 5368.

This research work is covered by NHS Lothian's Indemnity Insurance policy. In the unlikely event that something goes wrong and you are harmed during the research, and this is due to the research work then you may have grounds for a legal action for compensation against NHS Lothian, but you may have to pay your legal costs. Details

are available upon request from Juliet MacArthur, Lead Practitioner Research, Royal Infirmary of Edinburgh, Little France Crescent, Edinburgh, EH16 4SA, 0131 242 1752.

Will your taking part in the research be kept confidential?

All information collected during this research will be held either in a research office at the Royal Infirmary of Edinburgh or offices at Napier University. A number of staff involved in the project will have access to the information held. (These people are listed on page 6). Professor Morag Gray as the Chief Investigator will act as the custodian of this information and will ensure that it is kept in a confidential and secure way, in accordance with the Data Protection Act, 1998.

Information from audio recordings, and periods of observation will be entered onto a secure (password protected) computer system. All information being entered will be coded; no names and addresses will be entered with this information. Your position will be identified, for example if we use a quote from you we would put the words 'patient' beside this.

If you do give your name and contact details this information will be held in a separate computer file on a secure (password protected) computer system. Written information such as consent forms will be held in locked cabinets at the Royal Infirmary of Edinburgh or Napier University.

You can view copies of any information held on you at any time on request. All information will be kept securely for 5 years then destroyed confidentially.

We will not share any personal information that you have given us with any other organisations **except** in the following very exceptional circumstances. If information is disclosed by you which leads us to believe that someone is at significant risk of harm or abuse, information may be passed to relevant authorities. You would be informed of this.

What will happen to the results of the research?

The results of this research will be published and shared with participants and other individuals and organisations involved with or who have an interest in the research. Participants will not be identified within any reports produced, without their prior consent. The results will also be used to inform future service and educational developments.

Who is organising and funding the research?

The research is being organised by the NHS Lothian and Napier University and is being funded by a private benefactor.

Who has reviewed the research study?

The research has been looked at by an independent group of people, called a Research Ethics Committee. This research has been reviewed and given favourable opinion by the Local Research Ethics Committee.

Further Information

If you require any further information about this research or would like to discuss any aspect of the project, please contact any of the following staff, either at the address given on page 1 or by telephone / email as given below :-

XXXXXXXX



NAPIER UNIVERSITY
EDINBURGH

Leadership in Compassionate
Care Project
School of Nursing and Midwifery &
Social Care
Napier University
Canaan Lane Campus
Edinburgh
EH9 2BT
0131 455 5675

Version 5, 2/05/08

Participant Information Sheet - Relative/Friend

Leadership in Compassionate Care Project

NHS Lothian and Napier University would like to invite you to take part in a research study taking place from May 2008 to December 2010. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and talk to others about it if you wish.

Part 1 tells you the purpose of this research and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study.

Part 1

What is the Purpose of the research study?

The purpose of this research study is to find out from patients and their relatives/friends their experiences of receiving compassionate, person-centred care. Your experience as a relative/friend of someone who is in hospital and what could be done to help to improve and support person centred care across NHS Lothian is important. “Compassionate care”

is often associated with words such as – caring, empathy, human touch, person-centred care and sensitivity. In this study we want to learn more about what it is, what it feels like and how to support people to ensure that it is a core part of all of our work.

Why are we inviting you to take part?

You have been invited to take part in this study because you are a relative/friend of a patient in hospital. We are working with a number of staff, patients and relatives/friends in wards during the project.. You will have had an experience of visiting during their hospital stay. It is important that we hear your views so that we can learn from this and make the experience of care as compassionate as possible.

Do you have to take part?

It is up to you to decide whether or not you take part in any part of this research, and you would be free to leave the project at any time without giving a reason. This would not affect any services you or your relative may receive.

What will happen to you if you take part?

We are asking relatives / friends to take part in interviews. We will also approach relatives where a patient is unable to give consent to the observation of their care.

Being interviewed

You will be asked to take part in two interviews. The interviews will be conducted by our researchers who work for NHS Lothian and/or Napier University. The first interview will last around 40 minutes and we will ask you about your relative's experiences of receiving hospital care. The interviewer will ask questions about

- First realising something was wrong
- Getting to the hospital
- Being in the ward
- Getting better

- Going home

The second interview will take 20 minutes and will involve the researcher feeding back and checking with you, their understanding of what you said. If you are agreeable these interviews will be audio recorded.

These interviews will take place at a time and venue that is convenient for you and does not disrupt your visits to your relative. The researchers will respect your privacy and conduct an interview wherever possible in private, for example in a separate room in the ward or if you prefer in a place away from the ward setting.

Observation of your relative's care

For patients who are able to give consent we would approach them directly to seek their permission.

One of the researchers (a trained nurse) will work alongside staff when they are providing your relative's care. Observing in this way will ensure minimal disruption to the care given to your relative and other patients. The researchers will observe for periods of up to one hour. It is anticipated that each period of observation would involve a different group of patients. For example a group of patients may include 6 patients located in one bay of the ward, therefore your relative would not be observed for the whole one hour period. Whilst observing your relatives care we will respect their right to dignity and privacy.

The purpose of observing care is to give us a fuller picture and assist us in our overall understanding of person centred care. Information from observations of care will be considered alongside interviews with patients, relatives and staff.

Expenses and Payments

We will cover any agreed out of pocket expenses which you may incur through taking part in the project, e.g. local travel.

What could be the risks or disadvantages of taking part?

We will be discussing issues about your experiences. Some participants could find that this causes upset or distress. We want to make sure this research works well for everyone taking part and will do our best to support all participants. This could include any assistance or comfort you need or want to help you during our discussions, as well as someone to talk to afterwards. We will check with you if you need anything to help you to take part and ensure that this support is provided.

What could be the benefits of taking part?

This is a joint study between NHS Lothian and Napier University. We will be working closely with hospital staff, lecturers, and students to make sure we all learn from this project. Whilst we cannot promise that taking part will help you directly, the information we get from this research will help to improve care and enhance the education programmes for student nurses in relation to compassionate care. We have found in other projects that staff and patients have reported that they have learnt a great deal from taking part in project work. This may be an additional benefit.

What happens when the research stops?

At the end of our work we will share the findings and our recommendations, which will be for education organisations, nurses and patients. The results of the research will also be published – please see Part 2 for further information. The detailed information (data) from the research will be kept at NHS Lothian and Napier University offices for 5 years. Then all of this information will be confidentially destroyed.

What if there is a problem?

Any complaint about the way you have been dealt with during the research or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the research be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2. The meetings will be taking place in hospitals or your home – so others are likely to know you will be taking part, however all information we obtain will be treated in confidence and personal references and identifying information will be removed.

If the information in Part 1 has interested you and you want to take part in the research, please read the additional information in Part 2 before making any decision.

Part 2

What will happen if you don't want to carry on with the study?

You will be able to pull out of the research at any time. This will not affect any services you or your relative/friend receives.

What if there is a problem?

If you have a concern about any aspect of this research, please contact the Chief Researcher who will do her best to answer your questions. Please contact Professor Morag Gray by telephone on 0131 455 5687 by post at School of Nursing, Midwifery and Social Care, Napier University, 74 Canaan Lane, Edinburgh, EH9 2TB. If you remain unhappy and wish to complain formally, you can do this through the NHS Lothian Complaints procedure.

You can also contact Stephen Smith Lead Nurse, Leadership in Compassionate Care Project at Napier University, Canaan Lane Campus, Edinburgh, 0131 455 5675.

If at any stage you would like to talk about participating in the research to someone independent of the study then you can contact Iain McIntosh, Head of School of Nursing, Midwifery & Social Care, at Napier University. He can be contacted on 031 455 5368.

This research work is covered by NHS Lothian's Indemnity Insurance policy. In the unlikely event that something goes wrong and you are harmed during the research, and this is due to the research work then you may have grounds for a legal action for compensation against NHS Lothian, but you may have to pay your legal costs. Details are available upon request from Juliet MacArthur, Lead Practitioner Research, Royal Infirmary of Edinburgh, Little France Crescent, Edinburgh, EH16 4SA, 0131 242 1752.

Will your taking part in the research be kept confidential?

All information collected during this research will be held either in a research office at the Royal Infirmary of Edinburgh or offices at Napier University. A number of staff involved in the project will have access to the information held. (These people are listed on page 5). Professor Morag Gray as the Chief Investigator will act as the custodian of this information and will ensure that it is kept in a confidential and secure way, in accordance with the Data Protection Act, 1998.

Information from audio recordings and observations will be entered onto a secure (password protected) computer system. All information being entered will be coded; no names and addresses will be entered with this information. Your position will be identified, for example if we use a quote from you we would put the words 'relative' beside this.

If you do give your name and contact details this information will be held in a separate computer file on a secure (password protected) computer system. Written information such as consent forms will be held in locked cabinets at the Royal Infirmary of Edinburgh or Napier University.

You can view copies of any information held on you at any time on request. All information will be kept securely for 5 years then destroyed confidentially.

We will not share any personal information that you have given us with any other organisations **except** in the following very exceptional circumstances. If information is

disclosed by you which leads us to believe that someone is at significant risk of harm or abuse, information may be passed to relevant authorities. You would be informed of this.

What will happen to the results of the research?

The results of this research will be published and shared with participants and other individuals and organisations involved with or who have an interest in the research. Participants will not be identified within any reports produced, without their prior consent. The results will also be used to inform future service and educational developments.

Who is organising and funding the research?

The research is being organised by the NHS Lothian and Napier University and is being funded by a private benefactor.

Who has reviewed the research study?

The research has been looked at by an independent group of people, called a Research Ethics Committee. This research has been reviewed and given favourable opinion by the Local Research Ethics Committee.

Further Information

If you require any further information about this research or would like to discuss any aspect of the project, please contact any of the following staff, either at the address given on page 1 or by telephone / email as given below :-

XXXXXXXXXX

Leadership in Compassionate Care Project
School of Nursing and Midwifery & Social Care
Napier University
Canaan Lane Campus
Edinburgh
EH9 2BT
0131 455 5675

Version 1 02/5/08

Participant Information Sheet - Staff member

Leadership in Compassionate Care Project

NHS Lothian and Napier University would like to invite you to take part in a research study taking place from May 2008 to December 2010. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and talk to others about it if you wish.

Part 1 tells you the purpose of this research and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study.

Part 1

What is the Purpose of the research study?

The purpose of this research study is to find out from patients and their relatives/friends their experiences of receiving compassionate, person-centred care and from staff the

experiences of giving compassionate person centred care. Your experience as a staff member who is working in hospital and what could be done to help to improve and support person centred care across NHS Lothian is important. “Compassionate care” is often associated with words such as – caring, empathy, human touch, person-centred care and sensitivity. In this study we want to learn more about what it is, what it feels like and how to support people to ensure that it is a core part of all of our work.

Why are we inviting you to take part?

You have been invited to take part in this study because you are a staff member delivering care in hospital. We are working with a number of staff, patients and relatives/friends in wards during the project. You will have had experiences of giving care. It is important that we hear your views so that we can learn from this and make the experience giving and receiving care as compassionate as possible.

Do you have to take part?

It is up to you to decide whether or not you take part in any part of this research, and you would be free to leave the project at any time without giving a reason. This would not affect your working practice in any way.

What will happen to you if you take part?

We are asking staff to take part in interviews and to give consent to the research team observing care giving practices on the ward.

Being interviewed

You will be asked to take part in two interviews. The interviews will be conducted by our researchers who work for NHS Lothian and/or Napier University. The first interview will last around 40 minutes and we will ask you about your thoughts about compassionate person centred care and your experiences of working in the ward and delivering care.

The second interview will take 20 minutes and will involve the researcher feeding back and checking with you, their understanding of what you said. If you are agreeable these interviews will be audio recorded.

These interviews will take place at a time and venue that is convenient for you. The researchers will respect your privacy and conduct an interview wherever possible in private, for example in a separate room in the ward or if you prefer in a place away from the ward setting.

Observation of care

One of the researchers (a trained nurse) will work alongside staff when they are providing care. The researchers will observe for periods of up to one hour. It is anticipated that each period of observation would involve a different group of patients. For example a group of patients may include 6 patients located in one bay of the ward. Whilst observing care we will respect the patient's right to dignity and privacy.

The purpose of observing care is to give us a fuller picture and assist us in our overall understanding of person centred care. Information from observations of care will be considered alongside interviews with patients, relatives and staff.

Expenses and Payments

We will cover any agreed out of pocket expenses which you may incur through taking part in the project, e.g. local travel.

What could be the risks or disadvantages of taking part?

We will be discussing issues about your experiences of giving care. Some participants could find that this causes upset or distress. We want to make sure this research works well for everyone taking part and will do our best to support all participants. This could include any assistance or comfort you need or want to help you during our discussions, as

well as someone to talk to afterwards. We will check with you if you need anything to help you to take part and ensure that this support is provided.

What could be the benefits of taking part?

This is a joint study between NHS Lothian and Napier University. We will be working closely with hospital staff, lecturers, and students to make sure we all learn from this project. Whilst we cannot promise that taking part will help you directly, the information we get from this research will help to improve care and enhance the education programmes for student nurses in relation to compassionate care. We have found in other projects that staff and patients have reported that they have learnt a great deal from taking part in project work. This may be an additional benefit.

What happens when the research stops?

At the end of our work we will share the findings and our recommendations, which will be for education organisations, nurses and patients. The results of the research will also be published – please see Part 2 for further information. The detailed information (data) from the research will be kept at NHS Lothian and Napier University offices for 5 years. Then all of this information will be confidentially destroyed.

What if there is a problem?

Any complaint about the way you have been dealt with during the research or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the research be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2. The meetings will be taking place in the hospital – so others are likely to know you will be taking part, however all information we obtain will be treated in confidence and personal references and identifying information will be removed.

If the information in Part 1 has interested you and you want to take part in the research, please read the additional information in Part 2 before making any decision.

Part 2

What will happen if you don't want to carry on with the study?

You will be able to pull out of the research at any time. This will not affect your working practice.

What if there is a problem?

If you have a concern about any aspect of this research, please contact the Chief Researcher who will do her best to answer your questions. Please contact Professor Morag Gray by telephone on 0131 455 5687 by post at School of Nursing, Midwifery and Social Care, Napier University, 74 Canaan Lane, Edinburgh, EH9 2TB. . If you remain unhappy and wish to complain formally, you can do this through the NHS Lothian Complaints procedure.

You can also contact Stephen Smith Lead Nurse, Leadership in Compassionate Care Project at Napier University, Canaan Lane Campus, Edinburgh, 0131 455 5675.

If at any stage you would like to talk about participating in the research to someone independent of the study then you can contact If at any stage you would like to talk about participating in the research to someone independent of the study then you can contact Iain McIntosh, Head of School of Nursing, Midwifery & Social Care, at Napier University. He can be contacted on 031 455 5368.

This research work is covered by NHS Lothian's Indemnity Insurance policy. In the unlikely event that something goes wrong and you are harmed during the research, and this is due to the research work then you may have grounds for a legal action for compensation against NHS Lothian, but you may have to pay your legal costs. Details

are available upon request from Juliet MacArthur, Lead Practitioner Research, Royal Infirmary of Edinburgh, Little France Crescent, Edinburgh, EH16 4SA, 0131 242 1752.

.

Will your taking part in the research be kept confidential?

All information collected during this research will be held either in a research office at the Royal Infirmary of Edinburgh or offices at Napier University. A number of staff involved in the project will have access to the information held. (These people are listed on page 5). Professor Morag Gray as the Chief Investigator will act as the custodian of this information and will ensure that it is kept in a confidential and secure way, in accordance with the Data Protection Act, 1998.

Information from audio recordings and observations will be entered onto a secure (password protected) computer system. All information being entered will be coded; no names and addresses will be entered with this information. Your position will be identified, for example if we use a quote from you we would put the words 'staff member' beside this.

If you do give your name and contact details this information will be held in a separate computer file on a secure (password protected) computer system. Written information such as consent forms will be held in locked cabinets at the Royal Infirmary of Edinburgh or Napier University.

You can view copies of any information held on you at any time on request. All information will be kept securely for 5 years then destroyed confidentially.

We will not share any personal information that you have given us with any other organisations **except** in the following very exceptional circumstances. If information is disclosed by you which leads us to believe that someone is at significant risk of harm or abuse, information may be passed to relevant authorities. You would be informed of this.

What will happen to the results of the research?

The results of this research will be published and shared with participants and other individuals and organisations involved with or who have an interest in the research. Participants will not be identified within any reports produced, without their prior consent. The results will also be used to inform future service and educational developments.

Who is organising and funding the research?

The research is being organised by the NHS Lothian and Napier University and is being funded by a private benefactor.

Who has reviewed the research study?

The research has been looked at by an independent group of people, called a Research Ethics Committee. This research has been reviewed and given favourable opinion by the Local Research Ethics Committee.

Further Information

If you require any further information about this research or would like to discuss any aspect of the project, please contact any of the following staff, either at the address given on page 1 or by telephone / email as given below :-

Xxxxxx

Appendix 3 – Consent Form



Leadership in Compassionate Care Project
School of Nursing and Midwifery & Social Care
Napier University
Canaan Lane Campus
Edinburgh
EH9 2BT
0131 455 5675

Date : Participant ID number: Version 3 2/05/08

CONSENT FORM PATIENT

Title of Project: **Leadership in Compassionate Care Project**

Please initial
box

Name of Researcher: _____

1. I confirm that I have read and understand the Participant Information Sheet Version 3 dated 02/05/08 for the above research study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my standard of care or legal rights being affected.

3. I agree to interviews being audio recorded.

4. I agree to care being observed

5. I agree to the researchers having access to written information about my care

6. I agree to take part in the above research study.

Name of Participant

Date

Signature

Name of Person taking consent

Date

Signature



Leadership in Compassionate Care Project
School of Nursing and Midwifery & Social Care
Napier University
Canaan Lane Campus
Edinburgh
EH9 2BT
0131 455 5675

 **NAPIER UNIVERSITY**
EDINBURGH

Date : Participant ID number: Version 3, 2/05/08

CONSENT FORM RELATIVE

Title of Project: **Leadership in Compassionate Care Project**

Please initial
box

Name of Researcher: _____

1. I confirm that I have read and understand the Participant Information Sheet Version 5 dated 02/05/08 for the above research study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without the standard of care of my relative/friend or my legal rights being affected.

3. I agree to being interviewed and this will be audio recorded.

4. I agree to my relative's care being observed by the researcher

5. I agree to take part in the above research study.

Name of participant

Date

Signature

Name of person taking consent

Date

Signature



Leadership in
Compassionate Care Project
School of Nursing and Midwifery & Social Care
Napier University
Canaan Lane Campus
Edinburgh
EH9 2BT
0131 455 5675



Date : Participant ID number:

Please initial
box

CONSENT FORM STAFF

Title of Project: **Leadership in Compassionate Care Project**

Name of Researcher: _____

1. I confirm that I have read and understand the Participant Information Sheet Version 1 dated 02/05/08 for the above research study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without the standard of care of my relative/friend or my legal rights being affected.

3. I agree to being interviewed and this will be audio recorded.

4. I agree to delivery of care being observed by the researcher

5. I agree to take part in the above research study.

Name of participant

Date

Signature

Name of person taking consent

Date

Signature

Appendix 4 - Evaluation questions

Looking back over your involvement:

1. What has it felt like to be involved?
2. Can you tell me a bit about a time when you felt that your opinions were listened to and valued in this study?
3. How has this study been different to other improvement projects you have been involved with in the past or are involved in right now? Why has it been different?
4. Can you share with me one good or successful story from the process.....and one not so good, or a disappointment?
5. What areas for change were identified by the study?
6. What improvements have you seen? Can you give examples?
7. What have been the most important parts of the study for you? Why were they important?
8. Tell me a bit about things that you have learnt about yourself through participating in the study?
9. What if anything are you going to do or think about differently as a result of taking part in the study?
10. Is there anything you think we should do differently when we go to the next sites?

11. What do you think will happen now? In what way will things continue?

12. How would you describe what you and others have been doing to someone who did not know about the study?

