Leadership in Compassionate Care

Enhancing patient care by promoting compassionate practice

Second International Conference on Compassionate Care 23-24 June 2011

Programme

Day 1 Thursday, 23rd June

09.30

Coffee and Registration.

10.00

Opening Ceremony & Speeches.

Professor Dame Joan K Stringer DBE,
Principal & Vice Chancellor, Edinburgh Napier University.

10.40 – Keynote presentation 1
Chair: **Professor Morag Prowse,**
Dean, Faculty of Health,
Life & Social Sciences,
Edinburgh Napier University
Question and answer session

Associate Professor Sue Davies,
Winona State University, USA.

Compassionate Care: A letter from America.

11.40 – Symposia session 1
(90 mins)
Chair: **Julie Ross**

1. Celtic Knots: compassion and change in systems and organizations, Adult Network Psychology, Lancashire, England. *Julie Ross*.
2. Big Brother and Service Experience. *Steven Edwards*.
3. Is Compassion the Icing or the Cake?
   Psychological and Neurological Theories of Relationship.
   Julie Ross and Dr. James Hoy.
4 Service Improvement and Crisis Resolution and Home Treatment Teams: An Appreciative Response to feedback.
   Dr. James Hoy and Andrew Jones.
5. Accommodating relationship service users inhabit in the provision of compassionate care. *Liz Baines*.

11.40 – Workshop session 1
(60 mins)

1. A Compassion Footprint for Healthcare. *Mary Prendergast*. St. Patrick's Hospital, Cashel, Co. Tipperary, Ireland.
2. Is compassion a rational or irrational emotion?
   Using rational emotive behavior therapy (REBT) principles to cultivate compassion in healthcare professions.
   Lidia Vosloo. Stellenbosch University, South Africa.
3. Assessment of compassion, Leadership in Compassionate Care Programme Team, Edinburgh Napier University and NHS Lothian, Scotland.

11.40 – Roundtable discussion session 1
(90 mins)

1. Innovations in practice and education in care homes – the dance movement psychotherapy story.
   Edith MacIntosh, Care Commission, Dundee, Scotland.
2. Restoration through Narration: the Senses Framework meets Creative Writing.
   Mary Clarke, University of Strathclyde, Scotland.
3. More than just a jag?: The delivery of childhood vaccinations as an interpersonal over a technical skill.
   Dr. Carol Gray, Edinburgh Napier University, Scotland.
4. Creating a compassionate hospital using a method of positive engagement.
   Andy Willcocks, Portland Hospital, London.

Day 1
Thursday, 23rd June

11.40 – Poster presentation	1. Improving the stroke care pathway post discharge – development of an online Community Stroke Resource. *Tracy Walker*, NHS Blackburn with Darwen 2. Enhancing practice in lymphoedema – community link nurse programme one year on. *Jan Shepherd*, NHS Blackburn with Darwen. 3. Determining need for compassionate care/methods, measurements and outcomes. *Gail Robertson*, NHS Dumfries and Galloway. 4. Implementation of the Whooley screening tool: improving detection of depression and access to treatments for clients with long term conditions. *Trea Simpson*, NHS Blackburn with Darwen, England. 5. Leading into the future, what student nurses need in clinical practice. Vivienne Shaw, NHS Lothian, Scotland.
13.20 – Lunch	Student reflections on compassionate care: 1340-1400.
14.00 – Symposia session 2 (90 mins)	Relationship Centred Care: Evidence based frameworks in practice. *Professor Mike Nolan*, Sheffield University, England.
14.00 – Workshop session 2 (60 mins)	1. Rescuer or victim? Is compassion fatigue a manifestation of the Karpman drama triangle between nurse and patient? *Lidia Vosloo*. Stellenbosch University, South Africa. 2. A new perspective in digital storytelling: Students' insights into compassionate care, *Karen Barrie, Jenny Eames, Jackie Phillips,* NHS Healthcare Improvement Scotland & Edinburgh Napier University, Scotland. 3. How to use Talking Mats to capture the experiences of people with learning disabilities who have cancer? *Scott Taylor* and *Siobhan Mack*, NHS Lothian, Scotland.
14.00 – Roundtable discussion session 2 (90 mins)	1. Use of emotional touchpoints in relation to district nurse community patients, assessing delivery of care and patient experiences. *Nichola Wraight*. NHS Lothian, Scotland. 2. Communicating Compassion: communication support needs and access to primary care. *Sharon Symon*, NHS Greater Glasgow and Clyde, Scotland. 3. Use of emotional touchpoint and emotional words to understand difficulties encountered by nursing students with the process of portfolio construction. *Maria Pilcher*, NHS Lothian, Scotland. 4. ASIST-ing Nursing practice; enhancing awareness and skills of immediate suicide intervention. *Orla McAlindon*, Queen's University, Belfast. 5. Does Providing a Restorative Space for Nurse Educators working in a Higher Education Institute in a School of Nursing, Midwifery and Social Sciences impact on their Experience of Teaching and Learning. *Mandy Gentleman*, Edinburgh Napier University, Scotland.

15.30 – Coffee

15.45 – Keynote presentation 2
Chair: **Dr. Jack Watters,**
Vice President for External Medical Affairs, Pfizer Pharmaceuticals
Question and answer session

Dr. Jason Leitch,
National Clinical Lead for Quality,
the Scottish Government, Scotland.
Can we design compassion into the system?
Lessons from improvement science.

16.45 – Close of Day

19.30 – Gala Event Edinburgh Corn Exchange

Collage workshop

Throughout the conference you will be able to participate in a collage workshop where we will endeavour to make a collage which would take the form of a 'Quilt' where we would encourage you to particpate in making your individual square for the collage, thinking about 'Compassionate Care Working Well'.

Programme

Day 2 Friday, 24th June

09.30	Coffee and Registration
10.00 – Welcome address **Opening speech**	**Melanie Hornett,** Executive Nurse Director, NHS Lothian. **Ros Moore,** Chief Nursing Officer for Scotland.
10.40 – Keynote presentation 3 Chair: **Melanie Hornett,** Executive Nurse Director, NHS Lothian Question and answer session	**Lillemor Lindwall,** Associate Professor, Karlstad University, Sweden. Considerations of human dignity in nursing.
11.10 – Symposia session 3 (90 mins) Chair: **Professor Lawrie Elliott**	1. A consideration of issues surrounding the reality of developing compassionate care as a cultural norm in clinical environments. *Dorothy Horsburgh* and *Janis Moody*. Edinburgh Napier University, Scotland. 2. Embedding compassionate caring elements into acute illness module. *Liz Adamson*, Edinburgh Napier University, Scotland. 3. Using compassionate care stories in the curriculum: sharing students' experiences. *Anne Waugh, Karen Barrie, Aileen McPartlin, Jessica Midgely-Smith*, Edinburgh Napier University, Scotland. 4. An evaluation of student and lecturer experience and understanding of the PDT role in terms of compassionate care. *Janis Moody, Paddy Perry, Kev Head*, Edinburgh Napier University, Scotland.
11.10 – Workshop session 3 (60 mins)	1. Compassionate Care Cold-spots: 'warming up' mental health inpatient services. *Paul Davenport*, Royal Preston Hospital, England. 2. Making Connections: using technology to enhance practice by learning about the head, heart and hand. *Dr. Maggie Hutchings* and *Dr. Caroline Ellis-Hill*, School of Health and Social Care, Bournemouth, England. 3. Compassion and caring – leading the change. *Claire Chambers* and *Elaine Ryder*, Oxford Brookes University, Oxford.

11.10 – Roundtable discussion session 3
(90 mins)

1. Drama as an active teaching and learning tool in healthcare education.
   Orla McAlindon, Queen's University, Belfast.
2. Ways of working with the people who care.
   Susan Hood, NHS Lothian, Scotland.
3. An education programme to enable compassionate care and optimal re-ablement with service users through the development of health and social care support workers: promoting self management, enablement and rehabilitation at home.
   Wendy Thomson, NHS Dumfries and Galloway, Scotland.
4. Working with managers to bring about sustainable improvement in quality.
   Jenny Kalorkoti, NHS Lothian, Scotland.
5. Perspectives on person-centred care; A comparison between Edinburgh Napier University Scotland and Hanze University of Applied Sciences Holland.
   Roos van der Steen & Eva Steenbergen, Holland.

12.40 – Lunch Student reflections on compassionate care: 1310 -1330.

13.30 – Creative activity Tree of Knowledge

14.00 – Symposia session 4
(90 mins)
Chair: Professor **Catriona Kennedy**

1. Dignity and respect for dignity – from the nurse's perspective.
   Katarina Bredenhof Heijkenskjold.
2. Nurses learn caring theory by listening to each other.
   Lena Boussaid.
3. Maintaining patient's dignity in forensic care: The challenge of maintaining patient's dignity in clinical caring situations.
   Lena-Karin Gustafsson.

14.00 – Workshop session 4
(60 mins)

1. Reflection of three leaders of compassionate care: it's about confidence, determination and relationships.
   Juliet MacArthur, Johnathan McClennan, Michele Yeaman, and *Helen Ogilvie*, NHS Lothian, Scotland.
2. The conversation is the relationship. The art of compassionate communication. *Michael Brophy*, Dublin.
3. Smells, bells and dolls – compassionate connecting using three modalities in Dementia Care.
   Fiona Robertson, Fiona Cartmell and *Carole Clarke*, NHS Lothian.

Day 2
Friday, 24th June

14.00 – Roundtable discussion session 4
(90 mins)

1. A strategically compassionate response to Living and Dying Well with Dementia.
   Jenny Henderson, Alzheimer Scotland, Stephen Smith, Edinburgh Napier University, Scotland. Mark Hazelhurst, Scottish Partnership for Palliative Care.
2. From reaction to reflection, refocusing on compassionate care.
   Karen Bowman, Lancashire Foundation Trust, England.
3. Compassionate care… nutritional care.
   Joy Farquharson and *Michele Miller*, NHS Healthcare Improvement Scotland.
4. Compassionate Caring Conversations: Experience in practice.
   Liz Adamson, Josie Pearson and *Joyce Malone*, Edinburgh Napier University and NHS Lothian.
5. The role of nurses in leading the global fight against the spread of non-communicable diseases, compassion in action.
   Paula DeColla, External Medical Affairs International at Pfizer Pharmaceuticals, United States of America.

15.30 – Keynote presentation 4
Chair: **Dr Jayne Donaldson,**
Head of School, School of Nursing Midwifery and Social Care,
Edinburgh Napier University

Question and answer session

Claire Forbes,
Director of Communications,
Office of the Parliamentary & Health Service Ombudsman,
London.

Care and Compassion?

16.20 – Closing session

Iain McIntosh,
Deputy Dean,
Faculty of Health Life and Social Sciences,
Edinburgh Napier University.

Day 1
Thursday, 23rd June

Keynote Presentaion 1

Presenter:
Sue Davies, Associate Professor, PhD, MSc, BSc, RGN, RN, RHV,
Winona State University.

SDavies@winona.edu

Biography

Sue Davies worked as a health visitor and as a senior nurse within a unit providing services for older people in London before moving into higher education in 1990. Following positions at Kings College in London and the University of Manchester, Sue spent twelve years in Sheffield working with Professor Mike Nolan, and completed her PhD on relatives' experiences of nursing home entry. She has an extensive record of publication and grant capture, predominantly in the field of long-term care for older adults. In 2002 she was awarded a Department of Health post-doctoral fellowship to support a programme of research on quality of life in care homes. She was a co-founder of the National Care Homes Research and Development Forum in the UK and made an important contribution to the My Home Life campaign, championed by the charity Help the Aged. A move to the US in 2005 provided opportunities to revisit earlier career aspirations as a nurse educator and she is currently employed as an Associate Professor, contributing to an undergraduate program in nursing. Sue continues to explore research interests in the field of gerontological nursing while also exploring the many delights that Minnesota has to offer.

Compassionate care: A letter from America.

In 2005 I started a 'new life' in the American Midwest, allowing me to compare opportunities for compassionate care within two very different healthcare systems. This keynote presentation will take the form of an illustrated 'letter from America' in which some of the differences between healthcare practice and healthcare education in these two countries will be considered, with a focus on how policy and cultural issues influence opportunities for compassionate care. Following a brief overview of the main differences between the UK and US health systems, the following areas will provide a focus for the presentation:

- **the culture of philanthropy in the American mid-west** – in particular, the contribution of volunteers to compassionate care in a range of settings will be highlighted;
- **the preparation of nursing students to deliver compassionate care** – here I will focus upon support for students during practicum experiences, and the reciprocal nature of relationships between faculty, students and service users;
- **organisational structures that enable and support compassionate care** – using the Mayo Clinic in Rochester, Minnesota as an exemplar, I will describe some of the macro- and micro- processes that enable and support compassionate care within this world-famous healthcare organisation.

Initiatives consistent with compassionate and relationship-centred care will be described, with the emphasis on practices that could be translated into different health care and education systems. Simultaneously, opportunities for those working in the US to learn from practice in the UK will be highlighted. My goal is to illuminate some of the facilitators and barriers to compassionate care that transcend cultural differences, with a view to identifying practices that delegates might try within their own organisations.

Day 1
Thursday, 23rd June

Keynote Presentaion 1

Presenter:
Jason Leitch, National Clinical Lead for Quality,
the Scottish Government, Scotland.
Jason.Leitch@scotland.gsi.gov.uk

Biography

Jason is on secondment from his academic post as an Honorary Consultant in Oral Surgery at the University of Glasgow Dental School in Scotland. He was a 2005-06 Quality Improvement Fellow at the Institute for Healthcare Improvement, in Boston, sponsored by the Health Foundation. Jason is also a trustee of the UK wing of the Indian Rural Evangelical Fellowship which runs orphanages in southeast India.

He has a doctorate from the University of Glasgow, an MPH from Harvard and is a fellow of the Royal College of Surgeons of England, The Royal College of Physicians and Surgeons of Glasgow and the Royal College of Surgeons of Edinburgh. He is also a Fellow of the Higher Education Academy. He chairs the Conduct and Health Committees of the General Dental Council, the regulatory body for dentistry in the UK.

Can we design compassion into the system?
Lessons from improvement science.

Improvement science, however you choose to define it, has gained considerable momentum around the world in the last decade. No one definition is agreeable to all stakeholders but at it's most basic it is about reliably implementing evidence. How do we ensure safe, effective, timely, equitable, efficient and person-centred care for every patient, every time? Not only that, but how do we 'improve' these elements continuously? Scotland has been at the forefront of the quality movement in healthcare. The publication of the Quality Strategy in May 2010 was a unique step for a country-wide healthcare system. We now have examples of implementation and reliable process and outcome improvement to demonstrate shorter waits, less infections and lower mortality to name only a few.

However, is this relevant to compassion? Can we engineer compassion into a complex system? Can we 'make' clinicians nicer? Can we 'make' the system nicer? Experience is at least, or more, important than clinical outcome and yet it doesn't get the same attention.

This session will discuss quality improvement and the science which underpins it. It will then explore the possibilities of applying these techniques to person-centred care.

Day 2
Friday, 24th June

Keynote Presentaion 1

Presenter:
Lillemor Lindwall, Associate Professor
Karlstad University, Sweden

Lillemor.Lindwall@kau.se

Biography

Lillemor Lindwall is Associate Professor of Nursing at Karlstad University, Department of Nursing, in Sweden.

Lillemors experiences are from medical and surgical wards and also from elderly care. Most of her clinical work has been at operating theatre as nurse anesthetists.

In addition she is also a senior lecture and has for many years been working with education of nurses with responsibility for specialist education in operating room nursing at advanced level.

Lillemor's PhD in 2004 is in Caring Science at Åbo Akademi, Finland. The focus of her research is to promote health and wellbeing as well as to alleviate suffering and to maintain dignity in patients at all ages in various contexts. The research reported in her dissertation deals with patients' experiences of their bodies in connection with health and suffering and perioperative nursing care. Her research interests lie in qualitative research by phenomenological and hermeneutical approach.

She also mentors less experienced researchers and supervises three PhD students in topics relating to moral virtues, perioperative nursing and dignity.

Her current research deals with experiences of a compassionate care, the perioperative dialogue and caring culture, its ethos, ethics and dignity as well as how it is carried out in practice.

Considerations of human dignity in nursing.

The caring science tradition on which this presentation is based originates in humanistically oriented caring science, which acknowledges the human right to dignity. Dignity can be defined as a sense of honor or appreciation, something that can be applied to every human being. A human being has two forms of dignity

1) **absolute human dignity contains values like holiness, human worth, freedom of being and acting, and infinite responsibility;** and
2) **relative dignity, as part of a human being's bodily dimension and is influenced by culture and society**.

Between these values there is a movement whose purpose is to let an attainable value appear, whose significance serves as a symbol of human value and creates the feeling of dignity. Human dignity comes out of an ethos of professional nursing care, a basic ethical view. If we exclude human dignity from professional nursing care professional nursing care ceases to be professional.

Human dignity is shown in the way physicians, nurses and other members of staff behave, in the way they are together with and towards the patient. Dignified behavior is experienced as confirmed human dignity and impolite behavior is experienced as violated human dignity. Confirming the patients human dignity leads to a deeper understanding for the patient, whereas violated human dignity gives rise to value conflicts within the nurse.

During the last year we have conducted research that presents studies of human dignity in different nursing settings. A literature review reveals that knowledge exist about what human dignity is and how to both maintain or violate patients dignity in psychiatric, medical and perioperative nursing care.

Keywords: human dignity, professional nursing care

Three critical questions you would like the audience to consider:

'What challenges do nurses experience in promoting dignity?'

Day 2
Friday, 24th June

Keynote Presentaion 1

Presenter:
Claire Forbes, **Director of Communications,**
Office of the Parliamentary and Health Service Ombudsman, London.

Biography

Claire Forbes has been the Director of Communications at the Office of the Parliamentary and Health Service Ombudsman since December 2009.

Claire leads on internal and external communications, including media relations, publications, internal communications, events and all online communications. Claire is also responsible for public affairs and stakeholder engagement work.

Prior to joining the Ombudsman's Office, Claire was the Director of Communications at the Youth Justice Board and the Advertising Standards Authority and so has a wealth of experience in directing communications and marketing strategies to achieve corporate objectives.

Last October Claire oversaw the publication and promotion of the Ombudsman's first report on complaint handling in the NHS in England, *Listening and Learning*, which covered the first full year of the new complaint handling system for the NHS. The report included previously unpublished data about the number of complaints the Ombudsman received in the last year for every trust in England, and the action the Ombudsman took as a result.

In February Claire oversaw the publication and promotion of *Care and Compassion?*, the Ombudsman's report which tells the stories of ten older people who suffered unnecessary pain, indignity and distress while in the care of the NHS. The report has initiated a national debate about the care of older people involving Members of Parliament, NHS leadership, the NHS Confederation, the Royal College of Nursing and many other professional colleges and bodies.

The Health Service Ombudsman's report, *Care and Compassion?* hit the headlines earlier this year with ten stories of the experiences of older people in hospital or under the care of their GP. The stories present a picture of NHS provision in England that is failing to respond to the needs of older people with care and compassion. The report concludes that the NHS is failing to meet even the most basic standards of care for older people. This is the result of an attitude – both personal and institutional– which fails to recognise their humanity and individuality and to respond to them with sensitivity, compassion and professionalism.

In this keynote presentation, Claire Forbes, Director of Communications for the Health Service Ombudsman, will tell the story of the *Care and Compassion?* report, and how and why it was published. Using film to recount some of the stories of patients' experiences, she will outline the lessons it contains for the NHS nationally, regionally and locally. She will highlight the action the Health Service Ombudsman has called for to address the issues raised by the report and will describe the reaction from the public, politicians, the medical profession and the NHS itself. Finally, she will reflect on what the report and its impact might mean for the care of older people in the NHS in the future.

Celtic knots:
Compassion and change in systems and organisations

Presenter: **Julie Ross,** **Consultant Clinical Psychologist**, Professional Lead Psychologist for Acute Mental Health Care, Adult Network, Psychology, Lancashire, England.

julie.ross@lancashirecare.nhs.uk

This series of papers looks at the inter-dependent relationships between service users, carers, staff and organisations. In implementing therapeutic and organisational change it is tempting to seek simple solutions, often with undertones of blame or criticism, that become attached either to an individual or a part of the service.

These papers will demonstrate that no-one person, and no one team is an island, and that meaningful and lasting change can only be achieved by the compassionate recognition of our interdependence. Our lives have meaning in our relationships with others, and compassion and transformation occurs when we honestly attempt to see issues from the point of view of others: paradoxically particularly when those views are different from our own.

It is proposed that the high risk and high expressed emotional presentations of service users in acute mental health care can create significant challenges in relating compassionately. The desperation of service users in mental health crisis leads to presentations with no easy solutions and there is often pressure for services to remove problems with subsequent deepening of the cycle of desperation when this is not possible.

The papers begin with video footage of service user feedback and progress to a theoretical overview of psychological and neurological understanding of relationship and compassion. Two service examples are then described, one at a macro level, and one at a micro level. Using our theoretical understanding, and the trusting relationships we have established within our service, we will demonstrate how dialogues of blame were transcended and transformed into positive therapeutic and organisational change with strong foundations for the future.

In conclusion: compassion is not just the icing on the cake of services: it is a vital ingredient without which there is no cake worth eating.

Three critical questions you would like the audience to consider:

'To what extent do we require compassion for healthy functioning?'

'How can we learn from service user feedback without resorting to blame and over-simplistic solutions?'

'Paradoxically, can our response to divergent perspectives lead to therapeutic change and service improvement?'

References

Tronick E. Z. 'Dyadically Expanded States of Consciousness and the Process of Therapeutic Change'. *Infant Mental Health Journal* vol. 19 (3) pp 290-299 (1998).

Big brother and service experience

Presenter: **Steven Edwards, Head of Service User Experience,**
Sceptre Point.

Objective
To develop a programme for capturing patient and carers experiences in a way which promotes reflective learning and compassionate nursing practice.

Methods
Building on a model developed by the Mental Health Improvement Programme using a diary room similar to that seen on the TV show Big Brother, we held a series of Diary Days across the Trust's Adult Inpatient Units. Five questions, which had been developed by a patient reference group, were used as prompts to enable the participants to record their stories. These were then used to create a video diary which could be shared with frontline staff and service managers in a service improvement workshop. These workshops were used to identify key themes around nursing practice which could form the basis of a local service improvement programme.

Results
Feedback from the staff and service users indicates the video diaries have made a significant contribution to changing attitudes and behaviours towards the patient experience at Lancashire Care. Patients really enjoyed the process of being able to tell their stories and valued the opportunity to share their experiences. Some questioned how the material would be used but were pleased to participate once they were reassured how the material would be used to improve service experience.

For nursing staff the biggest revelation was to see how appreciative patients were about the care they had received and how big a part this had played in their patient's recovery. This began a process of reassessing their practice and how we could build on the positive experiences the patients were relating. Challenges emerged around experiences where staff struggled to see why patients were upset or disappointed by their care. Further work is now being planned to create a second wave of diaries which could address some of these tensions.

Three critical questions you would like the audience to consider:

'How can we ensure all aspects of the patient and carer's stories are heard by staff and managers in a way which promotes appreciative inquiry?'

'How can we ensure that patients and carers feel that their stories are being used to make a meaningful difference to nursing practice?'

'How can we link the video diaries programme to other initiatives designed to assess the quality of service user experience?'

Is compassion the icing or the cake?
Psychological and neurological theories of relationship

Presenter: **Julie Ross, Consultant Lead Psychologist,**
Lancashire Care Foundation. *Julie.ross@lancashirecare.nhs.uk*

Co-author: **Dr James Hoy, Consultant Clinical Psychologist, Professional Lead Psychologist Acute Mental Health Care North Lancashire.** Parkwood, Blackpool.

This paper presents research that demonstrates how performance on a range of tasks declines as arousal, or stress, increases. Furthermore, evidence consistently shows that the single greatest factor in recovery in Mental Health is the quality of the therapeutic relationship, regardless of the nature of the intervention.

Relational patterns formed in childhood have been shown to impact on our ability to regulate emotion, develop healthy relationships, and empathise with, and think about, others. This pattern can also be re-enacted between staff and service users, and between the organisation and its staff, in what has been termed 'parallel process' by psychotherapists.

Neurological evidence demonstrates that the brain systems activated by experiencing shame or criticism are separate from those that are activated by feelings of compassion. So, importantly, the two cannot occur together. This challenges organisations to respond constructively to negative feedback from service users.

We will consider what ingredients make up a successful therapeutic relationship, alongside some of the forces that can work against the achievement of a strong relationship in healthcare. These forces may be personal, or organisational. Individuals, teams, and organisations have their own style of dealing with the stresses, or tensions that arise from challenging working circumstances and these can work either for, or against positive outcomes. In Acute Mental Health Care, working with service users in states of mind of acute and overwhelming distress creates particular challenges for staff.

To conclude, how organisations try to improve and to manage services directly impacts on the relationship with the service user, and consequently on treatment outcome. Facilitating compassion at all levels of the organisation is crucial.

It is argued that compassion is, therefore, not just the icing on the cake of services: it is a vital ingredient without which there is no cake worth eating.

Three critical questions you would like the audience to consider:

'How can we learn from service user feedback without resorting to blame and over-simplistic solutions?'

'How do relationships between the organisation and its staff impact on the relationship between staff and service user?'

'To what extent does the compassionate response impact on treatment outcome'

References

Tronick E. Z. 'Dyadically Expanded States of Consciousness and the Process of Therapeutic Change'. *Infant Mental Health Journal* vol. 19 (3) pp 290-299 (1998).

Service improvement and crisis resolution and home treatment teams:
An appreciative response to feedback

Presenter: **Dr James Hoy, Consultant Clinical Psychologist,**
Professional Lead Psychologist for Acute Mental Health Care, North Lancashire.
james.hoy@lancashirecare.nhs.uk

Co-author: **Mr Andrew Jones,** Integrated Team Manager and Nurse Practitioner,
Crisis Resolution and Home treatment Team. East Barn, Lancaster.

Shift patterns, lack of opportunity for peer support and the demanding challenging work pressures of the acute services place heavy emotional demands on staff working in these environments. Attempts to improve service delivery are frequently driven by complaints, and a 'problem focus'. This makes it difficult for staff to feel compassion leading to a self-fulfilling prophecy.

Feedback from service users and the complaints system had indicated issues in telephone calls, especially late at night, where it was felt that calls to the Crisis Teams were not always received compassionately. There was a service directive to try to improve Crisis Team's performance in this area.

Compliments to these teams far out-weighed complaints, yet the teams were unaware of this. They were left feeling demoralised and misunderstood. Given this context, the challenge was to assess what intervention would be helpful.

The training team designed training to address these issues while also attempting to break the cycle of a negative/problem focus compounding the blocks to feeling empathy and compassion. An appreciative approach was taken to the training. This asks staff to focus on and describe what they do well and to have conversations with each other about how they can expand and extend this positive practice. Shifting the focus from problems and celebrating strengths makes the reflective/training process an affirming and supporting experience that generates enthusiasm and energy which is more likely to be transformed into positive changes, and increased care and compassion in practice.

Training was also delivered to other teams responsible for writing Relapse Prevention and Crisis Contingency Plans so that Crisis practitioners speaking to a Service User in distress that they do not know are more able to tailor their interventions, and feel better equipped to respond. Finally, strategic work is attempting to address high expectations of these teams.

Three critical questions you would like the audience to consider:

'How can an appreciative approach contribute to service improvement?'

'How can we learn from service user feedback without resorting to blame and over-simplistic solutions?'

'Paradoxically, can our response to divergent perspectives lead to therapeutic change and service improvement?'

References

Srivatva, Suresh, Cooperrider, David. *Appreciative Management and Leadership: The Power of Positive Thought and Action in Organization*. Jossey-Bass, 1990.

Accommodating relationship service users inhabit in the provision of compassionate care

Presenter: **Liz Baines, Practice Development Nurse,**
Ridge Lea Hospital Lancaster.

If compassionate care is to be achieved within in-patient services the relationships which service users inhabit need to be accommodated as the inner lived experience of the individual is not solely existing within a singular space but has meaning through interdependence with others. As parent we know that our offspring's pain and suffering causes some of our own and emotions are interconnected. Surely then mental health support services may be prudent in developing supportive services to carers and their respective service users which cater for this duality.

One such initiative which is being developed at Lancaster in-patients is an emotionally supportive group wherein past in-patients and their carers attempt to provide compassion and understanding to current users of the service. It is hoped in this way that the needs of carers is seen as of equal importance to that of the service user and that it also engenders a spirit of optimism and hope that an admission to an Acute Inpatient unit can be endured and indeed overcome.

Three critical questions you would like the audience to consider:

'In what other ways might Mental Health Services more accommodate the interdependence between carers and service users?'

'Can understanding and compassion to Carers increase staffs' compassion to one another in caring relationships?'

'Would interventions which could include this duality be a step forward in providing more compassionate sensitive care which more closely matches the lived experience of carers and service users?'

A compassion footprint for healthcare

Presenter: **Mary Prendergast, Director of Nursing,**
St Patrick's Hospital, Cashel, Co Tipperary, Ireland.

mary.prendergast2@hse.ie

This paper is concerned with the art of medicine, the application of wisdom in healing patients, that complements the progress in the science of medicine as evidenced in ever more effective drugs and treatment modalities. In order for complete healing to occur, individuals caring for others must practice the art of healing with compassion This paper helps explore some of these important dimensions as they relate to a person, a community and social values. The core of this art of medicine is the value of compassion a theory for healing a sick person as a whole individual- body, mind and spirit. Health care professionals who wish to live the value of compassion need to acquire and develop the capabilities or competencies of compassion. They can then express those capabilities through routine behaviours that may be modelled, learned and practiced while treating sick persons, helping them to minimise their own suffering and to become agents of their own healing whenever possible.

The paper discusses ten capabilities-understanding, empathy, caring integrity, inculcation of hope, mutual respect, knowledge, kindness, appreciation, acceptance and thoughtfulness. Each capability is briefly described and referenced to a source document. This allows readers to elaborate their understanding of the cluster of capabilities, the related behaviours and the contexts in which they may be used with sick persons. Taken together the cluster of capabilities are conceptualised as a 'Compassionate Footprint' the mark of the healing experience left by the Health Care Professional as he or she walks the journey of suffering with the sick person.

The 'Compassionate Footprint' is offered as a model for Health Care Professionals to apply as a 'lithmus test' of their understanding of what it takes to practice the art of medicine and as a benchmark to measure their increasing competence in facilitating the healing of sick persons.

Three critical questions you would like the audience to consider:

'Is there an understanding of how important compassion in healthcare is to our patients and ourselves, whether your analysis is based on compassion received or in compassion lacking from a healthcare professional, or whether learned internally from one's own experience in health care. Can you now consider what is required to develop a model for compassionate care in your health care setting?'

'How can healthcare professionals develop and promote education resources including training courses, written material and electronic media to foster compassion in healthcare by doing so foster and develop a humanistic and holistic approach to healthcare that includes consideration of emotional, psychological, social, spiritual and cultural needs of people.'

'What can you do in your areas of professionalism in healthcare To raise the profile of compassion in healthcare and to recognise, by whatever means, examples of compassion in healthcare.'

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Is compassion a rational or irrational emotion?

Using Albert Ellis's Rational Emotive Behaviour Therapy (REBT) principles to cultivate compassion in healthcare

Presenter: **Lidia Vosloo,**
Stellenbosch University, South Africa. *lidia@psyselect.co.za*

Rationality is a concept that is normally applied to a person's beliefs (also known as self-talk). Albert Ellis (1962 and thereafter) argues that cognition plays a pivotal role in psychological interactionism i.e. that cognition (in this case referred to as self-talk), emotion and behaviour are seen as an interactive system and not as separate systems. Therefore, since emotions, behaviour and self-talk interact and influence the other, it follows that if a person's belief system (self-talk) is changed, it will have an effect on behaviour as well as emotion. Rationality and irrationality are concepts that are seen as core to 'self-helpful' and 'self-defeating' emotions and behaviour.

The workshop will explore which irrational beliefs may hinder healthcare professionals from feeling compassion towards others and therefore prevent them from acting in a compassionate way towards patients; while on the other hand also explore which rational beliefs should be inculcated in students and nurses to ensure visible and sustained compassionate behaviour in caring for patients. Insight into the rationale of Rational Emotive Behaviour Therapy and its applicability to compassion training will be provided. Group discussion will centre on how the principles of REBT can be incorporated as a teaching tool to cultivate compassion in nursing staff.

A model of compassionate interpersonal skills between nurse and patient will be presented and demonstrated, followed by group discussions on its value in the training and coaching of students. There will also be an opportunity for participants to practise the skills via simulation activities.

Three critical questions you would like the audience to consider:

'Is compassion rational or irrational?'

'What are the irrational beliefs that hinder healthcare workers from being compassionate?'

'Is REBT applicable as a training tool to cultivate compassion?'

References

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Assessment of compassion

Presenter: **Dr Stephen Smith, Lead Nurse,** Leadership in Compassionate Care Programme, Edinburgh Napier University/NHS Lothian.
Ste.smith@napier.ac.uk

Co-authors: **Belinda Dewar, Jenny Kalorkoti, Mandy Gentleman, Ria Tocher, Simon Pullin,** all Senior Nurses, Leadership in Compassionate Care Programme, Edinburgh Napier University, Edinburgh Napier University/NHS Lothian.

Multiple examples of poor care have been highlighted by the government, media and patient care organisations. The 2011 Parliamentary and Health Service Ombudsman for England report entitled 'Care and Compassion?' highlighted failings in basic elements of care, across the NHS. Although these examples could be regarded as extreme, they highlight areas of concern which are reflected in policy. The Scottish Government's 2010 Quality Strategy for NHS Scotland emphasises the need for more caring environments which supports clinical excellence and this central message appears in other UK policies. Professional bodies explicitly identify and require practitioners to provide care with compassion and respect.

Research has identified a growing awareness that staff, patients and families want to provide and receive care, based on individual needs and in the context of caring relationships. Further, *Von Dietze* and *Orb* (2000) argue that compassion is not just an emotional connection between nurse and patient but requires a moral dimension that directs nurses' decisions and practice.

A number of research programmes have sought to address these issues. Of note are those which focus on person centred care, relationship centred care and enriched care environments (*McCormack*, 2004; *Nolan* et al, 2006). Others include the King's Fund, Point of Care Programme (*Firth Cozens and Cornwell*, 2009). The Leadership in Compassionate Care Programme LCCP (*Smith* et al, 2010) has developed a model for compassionate caring within in-patient settings, for example a key component of the model includes a focus on conversations about care that includes perspectives of patients, relatives and staff. This workshop will focus on the assessment of compassion drawing on research in this area and progress to date of the LCCP approach to assessment. Participants in the workshop will undertake compassionate care assessment processes and discuss their thoughts and experiences in regard to this.

Three critical questions you would like the audience to consider:

'What is the purpose of assessing compassion?'

'What are the key factors associated with assessing compassion?'

'How will assessing compassion make an impact on care?'

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Innovations in practice and education in care homes – the dance movement psychotherapy story

Presenter: **Edith Macintosh,**
Social Care and Social Work Improvement Scotland.

edith.macintosh@SCSWIS.com

As current demographics and policy shifts care towards the community the skills required for those providing care need to change (Scottish Government, 2009, 2010). This has implications for training and development needs of all staff including those in a care home setting.

Allied Health Professionals (AHPs) practice placements are an essential part of the learning experience (*Health Professions Council* 2004) and although there are opportunities for these in many settings within Health and Social Care, traditionally these have not been within care homes.

Developing practice placements for AHPs in care homes gives opportunities to contribute to:

- the development of a learning environment to support
- the quality of life for people living in care homes
- Promoting personalisation, enablement and meaningful activity
- building capacity and capability, in specific areas of identified need e.g. prevention of falls through focused and targeted placements
- the development of leadership skills and through collaborative working to a greater understanding of roles
- the development of an AHP workforce that can recognise and respond appropriately to needs of a frailer, older population
- preventing inappropriate admissions to another care environment through advice, education and enablement
- raising the profile and validity of practice learning in a care home.

Over the past months 3 dance movement psychotherapy students from Queen Margaret University (QMU) have been on practice placement in care homes in Edinburgh. This small innovative pilot supports a national work in exploring care homes as a place of learning for AHP students. This has proved a fascinating journey where communication, education, understanding and partnership working have been keys to success. The benefits to both people in care homes and in understanding of partner roles has been realised and further supported the quality to care. This project is being fully evaluated through stories that will form the poster presentation.

Three critical questions you would like the audience to consider:

'How can you ensure the communication systems in this partnership are robust to support the success of this work?'

'What are your experiences of non traditional practice placements?'

'Supervisory aspects of this have to be innovative for example long arm supervision. What models have you used and the pros and cons?'

References

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Restoration through narration:
the SENSES framework meets creative writing

Presenter: **Mary Clarke,**
University of Strathclyde.

mary.clark@strath.ac.uk

As a Speech and Language Therapist working in East and Midlothian, I heard 'lost stories' about mining life from people with neurologic damage who were dissociated, metaphorically, linguistically, and in memory, from their past selves. Recovery of language led to storytelling; people sought to understand their dislocation. Losing language had the same impact on their lives that losing their occupations had: 'I just didnae ken what tae dae. I was underfoot in th' house, I wasnae mysel' ony mear'. All of the 'lost stories' illustrate starkly and beautifully the emotional impact of the loss of self; all evidence the need for therapeutic work to be grounded in the SENSES, as a means of helping people and the communities they live in to connect past to present.

My PhD project will entail research in practice writing poetry and fiction inspired by the excavation that underlies therapy, supplementing this with 'found language' from historical records about mining, first person accounts, and my responses to these. A consent form is in development, and any participants can choose to contribute anonymously, though the ultimate aim of the project is to produce a multimedia event at the Scottish Mining Museum highlighting these 'lost stories' and the little-known archives. The project will be supported by Creative Writing, Journalism, and Scottish Oral History Centre staff at the University of Strathclyde. Linguistic theory, Discourse theory, Oral History Theory, and therapeutic approaches will assist in developing a frame for the work, which will be grounded in an exploration of the ways in which the loss of the senses, particularly those of purpose, belonging, and achievement, has impacted on older people in small communities. I hope to show that having stories heard, and told, can restore some of the 'senses'.

Three critical questions you would like the audience to consider:

'What impact does the concept of place identity have on/for patients/clients?'

'What can clinicians do when individual memories are at odds with collective or familial memories? How can a clinician respect and 'hold' these memories?'

'What impact has the loss of language, and with it identity, had on your clients/patients?'

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More than just a jag?:
The delivery of childhood vaccinations as an interpersonal over a technical skill

Presenter: **Dr Carol Gray, Senior Lecturer,**
School of Nursing, Midwifery & Social Care, Edinburgh Napier University.
c.gray2@napier.ac.uk

Co-authors: **Professor Catriona Kennedy,** Professor of Nursing, School Director for Research and Knowledge Transfer, School of Nursing, Midwifery & Social Care, Edinburgh Napier University; and **Patricia McIntosh,** Clinical Nurse Manager, NHS Lothian, Astley Ainslie Hospital, Edinburgh.

Background
This paper reports findings from a qualitative study which explored the role of the health professional in the delivery of childhood vaccinations, particularly previously controversial vaccines and newly introduced vaccines. 'Emotional labour' in nursing involves the inducing or suppressing of emotions in order to deliver aspects of care but these aspects have been shown to be largely obscured or unarticulated, designated as an extension of 'women's work'. A range of professionals may be involved in the delivery of childhood vaccinations involving community nurses such as school nurses, community staff nurses, practice nurses and health visitors. Previously, the importance of the nurse to cue emotions was highlighted in vaccination encounters.

Methods
Qualitative methods comprising individual interviews and focus group discussions were used in order to explore the role of the healthcare professional from parents (n=11), young people (n=8) and health staff (n=30).

Findings
Professional competence was highlighted in the delivery of vaccinations, but the ability to manage the emotional components of vaccinations was also important across a range of vaccines. Management of the emotional components of delivery may have been previously undervalued for the role of community nurses in the face of the complexities of vaccinations and issues to do with perceptions of risks, trust and responsibilities reported in this study.

Discussion
The management of emotions was important in the delivery of a range of childhood vaccinations which highlights the role of the health professional as that of a broker for government and public health interventions. In the face of complexities of vaccination delivery, increasing recognition of the interpersonal aspects over the technical aspects of vaccination are called for and further articulation of these components should be explored where nurses are ideally placed to respond and yet where the articulation of such practices have been underreported in the literature.

Three critical questions you would like the audience to consider:

'How do health professionals such as community nurses work to manage emotions in vaccination contexts?'

'What strategies work well for short ten-minute interactions and busy clinics?'

'What aspects do patients/clients value the most from such encounters and what is the impact for future encounters?'

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Creating a compassionate hospital using a method of positive engagement

Presenter: **Andy Willcocks, Clinical Nurse Specialist,**
Portland Hospital, London.

Andrew_willcocks@sky.com

Service Excellence within healthcare stems from the compassion demonstrated by staff. They must care for the wellbeing of those around them, patients and colleagues alike.

Care must be an active process, which starts with a thought, rather than a task. A lack of compassion often stems from a passive lack of awareness of the needs of the other – a form of insidious negative bias.

We have demonstrated how focusing on developing active, positive approaches from staff can counter this negativity and increase compassionate care.

This poster/presentation presents the way that we have used a 'What's in it for me' approach to tackle negative behaviours and effectively promote wider compassion and engagement in positive behaviour. Staff draw upon their increased awareness of how individual interactions can positively influence their own working days and are therefore more willing to engage in change.

A clearly defined set of steps, facilitated in small groups, encourages staff to highlight the nature of positive and negative interactions. The content of these sessions is then used to direct changes in communication and behaviour across the organisation.

By adopting a universal 'Care Ethic', every interaction becomes more significant and ultimately more caring.

Andy Willcocks has spent 18 years nursing both adults and children in the both the NHS and Private sector. He has led the change towards an active, compassionate culture across several organisations.

Three critical questions you would like the audience to consider:

'How can you motivate staff to engage more actively in care?'

'To what extent must an organisation reflect a 'care ethic'?'

'What thoughts do we need to encourage consistent compassion?'

References

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Poster
Presentation

Improving the stroke care pathway post discharge – development of an online community stroke resource

Presenter: **Tracy Walker, Clinical Specialist Occupational Therapist/Clinical Associate,**
NHS Stroke Improvement Programme, NHS Blackburn with Darwen.

Tracy.walker@bwdpct.nhs.uk

Introduction

Stroke can have a devastating affect on the lives of people and families, 20-30% will die within a month and third of stroke survivors are left with long term disability. The NHS Stroke Improvement Programme have been working with various stakeholders along the stroke care pathway to highlight gaps in service provision, barriers to meeting the National Stroke Strategy's quality markers, and to identify and share innovations or good practice in community stroke care nationally. The online 'Community Stroke Resource' was developed to support the achievement of quality marker 10 of the National Stroke Strategy 'High Quality Specialist Rehabilitation'. The resource contains a wealth of information and clinical documentation, highlighting examples of how clinicians and services are developing innovative models of stroke care provision which improve patient experience and outcomes post hospital discharge, including innovations in nursing practice.

Design

The resource consists of 11 sections, including information on commissioning, tariff, life after stroke, clinical documentation, education, patient and public engagement, reviews, rehabilitation service models, measuring outcomes and guidelines.

Outcomes

The resource was launched on the *Stroke Improvement website* in February 2011 and evaluation so far indicates the following:

- Resource is being used by a wide range of health and social care professional including commissioners, matrons, nurse stroke coordinators, allied health professionals and network leads.
- Access to clinical resources has enabled sharing of good practice and reduction in clinical time searching and 'reinventing the wheel'.
- The information relating to examples of effective models and outcomes has enabled clinicians and network leads to present evidence to commissioners to support stroke developments.
- Peer support, information and innovation sharing for other newer developing services nationally.
- The collation of service models has enabled a snap shot view of models of stroke rehabilitation being developed nationally, the progress and inequalities in service provision.

References

National Stroke Strategy, Department of Health, December 2007

Poster
Presentation

Enhancing practice in lymphoedema –
Community link nurse programme one year on

Presenter: **Jan Shepherd**, **Clinical Lead Tissue Viability and Lymphoedema**,
NHS Blackburn with Darwen *Janine.shepherd@bwd.nhs.uk*

Currently, there is variable provision for patients with lymphoedema across the United Kingdom; it is often inadequate with gaps in service provision (*Board and Harlow*, 2002). Many patients have body image issues, low self esteem and need psychosocial support. A large part of lymphoedema care is being compassionate, providing emotional support not just clinical treatments. Health education and risk reduction strategies reduce unnecessary admissions to hospital, improving quality of life and outcomes for patients. Development of a community lymphoedema link nurse programme providing care and support to patients with lymphoedema has helped to bridge these gaps.

During 2011 to 2014 the NHS is expected to make twenty billion pounds of savings, meanwhile, the focus is on delivering efficiencies, quality, safety and value for money (*NHS Employers* 2009). The impact of making cost savings whilst ensuring quality, safety and efficiency means utilising resources already available.

The author recognised the need to support the community lymphoedema service to aid provision of early recognition, appropriate treatment and ongoing person centred care with access to specialists, irrespective of the cause of lymphoedema. Community nurses needed to take a proactive role in managing and supporting patients with mild uncomplicated lymphoedema.

The practice enhancement involved educating 10 community nurses using a structured programme including a Lymphoedema theory book and competency workbook, with bi-monthly practical education sessions. Communicating with patients to elicit what their priorities are rather than what the health professional thinks is the priority, is the key to quality lymphoedema care. The need for sensitivity to patients who are experiencing body image issues, loss of identity, cancer diagnosis and its treatment.

The poster presentation or round table discussion would involve –

- Explanation and visual demonstration of sections from the lymphoedema theory book and workbook
- Photographs of the link group in action
- Raising awareness and early recognition of the poorly recognised and little understood condition of Lymphoedema
- Discuss provision of community lymphoedema service in a neutral non clinical health and social care setting. This represents a shift away from the clinical environment towards a warm welcoming social environment. Patients who have had endless appointments within hospital and hospice environments are very receptive to this.
- Discuss the benefits of the link nurse programme for housebound patients, who are socially isolated due to body image issues caused by their condition.

Three critical questions you would like the audience to consider:

'Could a similar initiative work in your area?'

'Suggest strategies to influence NICE guidance for Lymphoedema management?'

References

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Poster
Presentation

Determining need for compassionate care/ methods, measurement and outcomes

Presenter: **Gail Robertson, Discharge Manager,**
Dumfries and Galloway Royal Infirmary.

gailrobertson@nhs.net

Background

Following the publication of The Carers Strategy for Scotland 2010–2015, *Caring Together* which sets out the 10 headline action points by Scottish Government, NHS Dumfries and Galloway in partnership, have implemented the following to improve outcomes for Carers.

Aim

- Ongoing education for all NHS Staff to identify and involve Carers in a compassionate and caring way
- To promote empathy and recognition of the Carers perspective and respond to their particular needs.
- Actively promote the opportunity for Carers assessment, advice, support and referral to other appropriate organisations
- To measure outcomes for Carers and implement change.

Actions implemented

Carers Training for all NHS Dumfries and Galloway staff

Sessions were delivered at department/ward level to all members of staff. The aim of these sessions was to equip staff with the knowledge and skills to Recognise, Record and Refer Carers in a compassionate manner. A pocket size leaflet was developed for individual staff members to act as an aide memoir. Sessions are included at the mandatory induction programme.

Carers Information Leaflet

A concise booklet was produced jointly between Health and the Local Authority. This booklet contains quality information including useful contacts and web addresses. This booklet is given to all admissions and discharges.

Identification

Significant additions were made to the Nursing Admission/Assessment documentation. These additional questions allow immediate identification of the patient as a Carer or cared for by another, and directs nursing staff to options for referral e.g. Carers assessment, other agencies. The initial documentation then becomes the referral form.

Measuring Outcomes

Formal audit takes place twice per year. Case notes are randomly selected to:

- Identify appropriate completion of documentation
- Identify referrals
- Follow through the referral with the appropriate agencies
- Ascertain the outcome for the Carer.

In addition a programme is now in place to contact Carers post discharge through a structured face to face/ telephone interview to ascertain were their needs met and how can our response to Carers be improved.

Three critical questions you would like the audience to consider:

'How do we sustain compassionate care and understanding of the Carers perspective?'

'How do we promote self identification by Carers?'

'How do we continuously measure outcomes ensuring a caring and compassionate approach?'

References

Scottish Government (2010). The Healthcare Quality Strategy for Scotland.

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Poster
Presentation

Implementation of the Whooley screening tool: improving detection of depression and access to treatments for clients with long term conditions

Presenter: **Trea Simpson, Psychological Support & Long Term Conditions Lead,**
NHS Blackburn with Darwen.

Trea.simpson@bwdpct.nhs.uk

Rationale

It is estimated that over 15 million people in the UK live with long-term conditions (LTC) (*DH*, 2008). This group have a 20% risk of developing depression (*Egede*, 2007) which, if left untreated, leads to substantial distress, reduced quality of life and adversely affects the management of LTCs. The Community Matron (CM) role was introduced to case-manage the needs of this client group (*DH*, 2005) with the provision of and access to psychological treatments enhanced (*NICE*, 2009).

Issue

An audit conducted by the Psychological Support & Long Term Conditions Lead (PS&LTC) of the CMs documentation highlighted that screening for depression was not integral to their routine practice and the current screening tool for detecting depression, the PHQ-9 (*Kroenke* et al, 2001), was not being completed consistently. A SWOT analysis (*Ansoff*, 1965) revealed the PHQ-9 to be too lengthy, time consuming and complex. In addition the CMs lack of psychological orientation and knowledge of what actions to take were perceived as barriers. However detection is a crucial first step in the more effective management of depression and in this the CMs have a crucial role.

Evidence

A literature review of the evidence for the use of screening tools to detect depression in this client group identified two relevant meta-analysis and a systematic review. However the best evidence at this time were clinical guidelines issued by *NICE* (2009) in which the *Whooley* (*Whooley* et al, 1997) was identified as a suitable screening tool.

Aim

To evaluate if the introduction of the Whooley by a Team of CMs (April-September 2010) will increase the detection of depression, access to mental health assessment and *NICE* (2009) approved treatments for clients with LTCs.

Outcomes

Positive outcomes include increased detection rates for depression, increased referrals to mental health services, increased client access to and choice of *NICE* approved treatments.

References

Anne Barnish, Strategic Manager, Adults & Older Peoples Services, NHS Blackburn with Darwen, *Anne.Barnish@bwd.nhs.uk*

Lynn Harrison, Course Leader, Advanced Practitioner Course, University of Central Lancashire.

Poster
Presentation

Leading into the future,
what student nurses need in clinical practice

Presenter: **Vivienne Shaw, Practice Education Facilitator,**
NHS Lothian.

vivienne.shaw@luht.scot.nhs.uk

This poster aims to highlight proposed future research based on scoping the needs of first year student nurses in their very first clinical placement in medicine of the elderly practice. The poster outlines experiences based on the six senses (*Nolan* et al, 2008). Anecdotal evidence from students is used to highlight how they felt during and on completion of their first practice placement. The poster is being used as a teaching tool for both mentors and students to raise awareness of the necessity to involve students within the nursing team at the outset and treat them as partners in person-centred care to promote best practice. Consent has been obtained from participants photographed

Three critical questions you would like the audience to consider:

'How did you feel in your very first practice placement?'

'Did you think that your higher education institution had prepared you for practice?'

'On reflection, what support do you think first year students need in the future when embarking on clinical practice?'

References

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Relationship centred care:
Evidence based framework in practice

Presenter: **Mike Nolan,**
Sheffield University, England.

m.r.nolan@sheffield.ac.uk

Workshop
Session 2

Rescuer or Victim? Is Compassion Fatigue a Manifestation of the Karpman Drama Triangle between Nurse and Patient

Presenter: **Lidia Vosloo, Clinical Psychologist,**
Stellenbosch University, South Africa.
lidia@psyselect.co.za

The concern that compassion towards a patient is no longer the key value in healthcare, may well lead to minimising *Compassion Fatigue* in healthcare workers. Is this the reason why many dedicated healthcare professionals suppress their compassion – as an act of self preservation?

Steven Karpman's *Drama Triangle* explains the interpersonal dynamics ('games') between individuals, which unconsciously motivate their behaviour towards others. When two or more people interact, they may inadvertently slip into the roles of either Rescuer, Victim or Persecutor. A 'Rescuer' is someone who often puts in more than 50% of the effort: they offer 'help' unasked rather than find out if and how the patient wants to be supported. The Rescuer's efforts often result in feeling 'hard done by' unappreciated and resentful, then 'switching' into the role of Victim. The 'Victim' is someone who feels overwhelmed by their own sense of vulnerability and powerlessness, and seeks a Rescuer to take care of them. At some point the Victim feels let down by their Rescuer, at which stage the Victim will 'switch' to the Persecutor role, and persecute their erstwhile Rescuer. The position of 'Persecutor' is synonymous with being unaware of one's own power; using it negatively or destructively.

The Karpman *Drama Triangle* will be posited and explored as a dynamic between nurse and patient which may lead to a 'compassion trap' as it complicates nurse/patient relationships, causing compassion fatigue. The workshop will explore at what point the caregiver's compassion will lead to Rescuing behavior and what the effect of the switch to Victimhood will have on the caregiver's emotional well-being. Interpersonal skills to avoid the *Drama Triangle* will be demonstrated and guidance will be given on how to apply 'self-compassion' as a remedy for compassion fatigue.

Three critical questions you would like the audience to consider:

'Is compassion suppressed due to compassion fatigue?'

'Is compassion fatigue due to the interpersonal psychodynamics of a 'Karpman Drama Triangle'?'

'How can nurses prevent falling into the trap of becoming a Rescuer or Victim?'

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A new perspective in digital storytelling:
students' insights into compassionate care

Presenter: **Karen Barrie, National Development Manager,**
NHS Healthcare Improvement Scotland.
karen.barrie@nhs.net

Co-authors: **Ms Jenny Eames,** Nursing Student; and
Mrs Jackie Philip, Nurse (Graduated Edinburgh Napier University 2010).

Digital storytelling is a creative process combining audio-recorded personal narrative with carefully selected images and music. It has been applied in health and social care settings throughout Scotland to support patients, carers and staff to find meaning in their experiences and communicate this to others1. This workshop shares the outputs and learning from a short digital storytelling project involving several nursing students from Edinburgh Napier University. The project was initiated after hearing the students share reflective stories on compassion at the Inaugural International Conference on Compassionate Care. Struck by the unique nature of these insights, the project aimed:

1) **To create media artefacts that would allow the student stories to be shared more widely;**
2) **To explore the potential contribution of the digital storytelling process to student learning, presentation and reflection on compassion.**

The power of digital stories, both as product and process, lies in the combination of personal narrative, multimodality and creativity. The use of personal narrative is firmly established in educational contexts, notably in supporting student reflection. Narratives are a basic agency for human empathy and their application in the context of compassionate care teachings is also familiar, as evidenced by the quality of the students' written accounts. The project therefore focused on image choice, storyboard development and the conscious use of metaphor and artistic effects in order to enhance the communicational qualities of the end product and to enrich the learning process.

The workshop provides a brief overview of digital storytelling, and combines the screening of a selection of student stories with discussion on their potential uses. Student reflections on the experience of making digital stories are also shared and future applications of the process in the context of fostering compassionate care are considered. Participants are also encouraged to develop a personal paper storyboard.

Three critical questions you would like the audience to consider:

'As change agents of the future, what role can students play in advancing the commitment to compassionate care and how can their stories be used to support this?'

'How can we better harness the potential of the 'story form', with its possibilities to inspire, engage and transform?'

'How can we use the age-old process of 'storytelling' to maximise the opportunity for reflection and critical thinking about compassion and to explore the enablers and challenges associated with maintaining compassionate practices?'

References

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Spiritual Touchpoints: Making Connections with Spiritual Care. A Collection of Digital Stories. Copies available from: *info@nes.scot.nhs.uk*

How to use Talking Mats
to capture the experiences of people with learning disabilities who have cancer

Presenter: **Scott Taylor, Patient Experience Service Improvement Manager,** NHS Lothian.
scott.taylor@nhslothian.scot.nhs.uk

Co-authors: **Dr Siobhan Mack,** Senior Speech & Language Therapist, and **Grant Ferguson**. NHS Lothian.

The Patient Experience Programme is funded by the Scottish Government to pilot Experienced Based Design service improvement methodology within cancer services. As part of the programme project work is specifically targeted at capturing the experiences of patients who are known to experience health inequalities and whose experiences are generally not captured.

As it is well recognised that people with learning disabilities experience health inequalities and barriers to health services project work is focusing on capturing the experiences of NHS Lothian hospital cancer services of patients with learning disabilities. The principle method of capturing experiences will be Talking Mats which is a symbol based augmentative communication tool. Talking Mats has a strong evidence base and has been used extensively with people with learning disabilities within a variety of settings, but not within hospital or cancer services.

Six staff working with NHS Lothian cancer services have been provided Talking Mats training and are actively capturing the experiences of patients at a variety of points across patient pathways. The experiences of the patient's family and carers, along with NHS Lothian staff will also be captured. Bringing all these experiences together enables patients, families, carers and staff to identify improvement priorities and for improvement actions to be co-designed. These actions are then tested out using small cycles of change (PDSA), which provides rapid feedback on impact and informs further action based on experiences.

Underpinning this project work is strong and visible leadership and sponsorship from within the cancer services, and most importantly with the authority to implement, monitor and measure the improvements actions in place within Quality Improvement Plans. There is an expectation that by the end of the project work a continuous experienced based improvement cycle will evolve, which is supported by the six staff trained and experienced in using Talking Mats.

Three critical questions you would like the audience to consider:

'How can you use Talking Mats?'

'How can you involve people with learning disabilities in experienced based service improvement?'

'How can you develop a continuous cycle of improvement?'

References

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Use of emotional touchpoints in relation to District Nurse community patients, assessing delivery of care and patient experiences

Presenter: **Nicola Wraight, Community Staff Nurse,** NHS Lothian.

Nicola.Wraight@lothian.scot.nhs.uk

Following completion of the Leadership in Compassionate care and Leading into the Future Programme, last year. There was a need for me to continue to use skills developed in this course. Also to use and share knowledge gained within the district nursing locality. Through discussion and reflection with the Nurse Manager and my coach from the programme, we developed ways to expand on my project from the course.

The project was to use emotional touchpoints within the district nurse team for reflection of practice and care delivery. By expanding the use of emotional touchpoints to include patient experiences of care delivery by district nurses. The aim was to gather information on patient's perspectives and feelings in regards to district nurse visits, delivery of care, how they felt during and after the nurses visit and to highlight any concerns or positive feelings they think the service has provided.

Plan

To visit seven individual housebound patients from the district nurse caseload. Time would be allocated outwith normal procedure visits, to use emotional touchpoints. There will be a set of positive and negative words to choose, however there is a choice for the patient to use words that are not available. This would be explained prior to the visit when gaining consent and also at start of session.

Following the session the reviewer would then present the experience back to the patient and collate information to use as patients experiences of the service. Information gained could be used in Releasing Time for Care, which is currently running within the district nurse cluster. Also as a quality measurement for delivery of care. This would incorporate a presentation of information with the Quality Improvement team.

Information would be beneficial for monitoring patient satisfaction and could pin point specific patient experiences that may be need more in depth information and assessment.

Aim

To have evidence of patient feelings or satisfaction in delivery of care within this district nursing team.

To give feedback to the team on patient experiences and reflect on delivery of care.

To highlight positive and negative aspects reflected by patients.

To highlight information to focus on relationship centred approach along with patient centred approach to care.

To share information gathered with the locality group and also into NHS Lothian quality system.

To potentially concentrate on developing human source of information and to relate to decision making in the future and the potential to share with other health care professionals.

Three critical questions you would like the audience to consider:

'Why decide to use patients instead of continuing with staff?'

'Where the patients comfortable using emotional touchpoints?'

'Is this something I could develop into my workplace?'

References

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Communicating compassion:
communication support needs and access to primary care

Presenter: **Sharon Symon, Speech and Language Therapist,**
NHS Greater Glasgow and Clyde.

Sharon.symon@west-dunbarton.gov.uk

Communication Support Needs (CSN) is an umbrella term to cover anyone who needs help to understand language or to communicate. There are a variety of underlying causes, some of which are congenital such as learning disability or cerebral palsy, and some acquired such as stroke. 1-2% of the population needs support with communication. Communication disability can lead to isolation and social exclusion, and to increased difficulty in accessing services.

As access to Primary Care tends to be mediated through language, communication difficulty can exacerbate the health inequalities linked to disability. Identifying and replicating elements of successful communication would help reduce these barriers. Existing research suggested that adjustments such as longer appointments would be likely to prove helpful.

This study worked with a Primary Care practice that has a particular interest in communication. Appreciative Interviews were carried out with a number of practice staff, and using a range of communication supports including Talking Mats, with a number of people with CSN. These interviews showed that whereas some practical adjustments to the appointment system and consultation process were considered helpful and were welcomed, what really enabled patients with CSN to feel that their needs had been met was the delivery of compassionate care. This is experienced as the sense of being known and understood by a healthcare practice with which there is a relationship built up over time. Interestingly, responsibility for the delivery of such care was not limited to health professionals, but was expressed equally by the administrative staff.

The facets of compassionate care that emerged as themes from the interviews were 'being person centred' 'respecting diversity' and 'motivation and leadership'. Recommendations are made for better identification of people with CSN and for increased awareness of the value of compassionate care in reducing the barriers to accessing healthcare experienced by people with communication difficulties and other marginalised groups.

Three critical questions you would like the audience to consider:

'How will we identify people who need support to communicate?'

'How will we provide that support?'

'What would 'being person centred' mean in my workplace?'

References

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Use of emotional touchpoint and emotional words to understand difficulties encountered by nursing students with the process of portfolio construction

Presenter: **Maria Pilcher, Advanced Practitioner,**
Clinical Education, NHS Lothian.

maria.pilcher@luht.scot.nhs.uk

The author's experience as an academic supervisor supporting students undertaking a collaborative NHS/HEI Flying Start™ module has been that constructing a portfolio of evidence can be problematic. Moreover, students often find it difficult to articulate the exact nature of the problems they encounter.

Use of emotional touch points was the method of data collection employed to obtain qualitative data from six students, two from each module cohort.

The intention was that this process could facilitate students to 'get to the heart' of their experience in order to view both the positive and negative aspects. The author was keen to gain an increased understanding of potential reasons for the difficulties they encountered. This approach has been used with patients and relatives and has been associated with strengthening and fostering a compassionate approach to caring (*Dewar* et al 2009).

Freshwater and Stickler (2004) argue that a therapeutic relationship between a teacher and student means that students are more likely to develop a positive attitude towards their patients.

The emotional touch point in this instance was the Flying Start™ Module. Students were asked to select from a range of emotional words that best described their experiences of participating in the module.

Data was initially sorted by assigning the comments of students to the emotional word that prompted the comments on their experiences to emerge, before being assigned into themes and sub-themes through a process of abstract categorisation (*Ritchie and Lewis,* 2003).

The four themes that emerged were associated with both positive and negative aspects of constructing a portfolio and facilitated recommendations to be made to the module team to improve the experience of students on future module cohorts.

Three critical questions you would like the audience to consider:

'Evaluate the student experience after a programme of study has been completed?'

'Elicit the difficulties that may be encountered by students with an assessment whilst undertaking a programme of study?'

'Can use of this technique facilitate students to be more aware of the value of getting to the heart of a patient experience that has been associated with fostering a more compassionate approach to caring?'

References

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ASIST-ing nursing practice:
enhancing compassionate attitudes and skills in 'immediate care' suicide interventions

Presenter: **Orla McAlindon, Nurse/Lecturer,** Queen's University, Belfast.

o.mcalinden@qub.ac.uk

Suicide care, as a public heath phenomomen, may be seen to be at the forefront of a need for compassionate attention in all health and social care settings. Awareness, evidence based skills and knowledge by nurses for their client groups is an expected element in all undergraduate nursing curricula today (DoH 2006 *Modernising Nursing Careers*) According to Youngson (*www.compassioninhealthcare.org*).

We don't expect to become proficient at piano playing, driving a car, or playing golf without regular practice. Compassion is no different. It's why we talk about 'the practice of compassion'. With this in mind the Mental Health Branch of Nursing at Queen's University Belfast N. Ireland have integrated the ASIST programme into the curriculum as an 'added value' component for our developing mental health practitioners. Applied Suicide Intervention Skills Training or ASIST provides the students with opportunities to practice intensively the immediate suicide intervention skills required to keep suicidal individuals safe in the short term.

These skills are learnt, practiced and refined throughout the role plays and facilitate the ASIST-er to become confident and competent in delivering care involving listening, valuing, respecting and the use of what Youngson calls 'non-anxious presence and compassionate silence' Strategic thinking which concentrates on patients' well-being is needed to tackle challenges and shape a more humane and compassionate health care system.

(Donley 2005) and the students involved in this intensive 2 day, highly interactive, practical and practice orientated workshop consistently evaluate the programme as greatly enhancing their abilities to stop, listen, and respond in a compassionate manner respecting the immediate fears and feelings of the suicidal individual. Person centred care requires a reconciliation of the patient/professional agenda by conscious and consistent attention to communication, power and patient autonomy. The ASIST program greatly facilitates this aim thus promoting compassion in care.

Three critical questions you would like the audience to consider:

'Can empathy and compassion be taught or learned?'

'How is the topic of suicide 'covered' in your curriculum or workplace?'

'Is a suicide prevention strategy enough, and how do we know if it is effective?'

References

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Does providing a restorative space for nurse educators working in a higher education institute in a school of nursing, midwifery and social sciences impact on their experience of teaching and learning?

Presenter: **Mandy Gentleman, Senior Nurse,** Leadership and Compassionate Care Programme, Edinburgh Napier University.

m.gentleman@napier.ac.uk

The purpose of this project was to ascertain if there are any benefits to nurse educators in relation to their experience of teaching and learning if they were given the opportunity to reflect on their practice in facilitated reflective groups.

The project arose from work that had previously been carried out as part of the involvement of the Leadership in Compassionate Care work within the UG nursing curriculum within Edinburgh Napier University. A number of nurse educators had been invited to participate in a series of focus groups exploring their beliefs and values about compassionate care. The findings of the focus groups suggested that there was agreement that compassionate care was a complex notion which could be influenced by both the context of care, and the individual(s) involved. However, other themes also emerged which warranted further exploration and one in particular, the importance of the development of supportive relationships with student nurses, especially in relation to the role of Personal Development Tutor (PDT). This was thought to be particularly relevant when teaching about the importance of establishing caring and respectful interactions with patients. Nurse educators said that they felt that there was a sense that they were expected to provide, and nurture the compassionate and caring attributes in student nurses, but in reality, there were limited opportunities where they were able to find the time to reflect and prepare themselves for this challenging work on an on-going basis.

The design of the project was intended to be qualitative and adopted the principles of Action Research. The data was generated through a series of facilitated restorative workshops over a period of four months and collage was chosen as a creative, non-threatening activity that provided an alternative and enjoyable way of representing individual experience(s). The revisiting of the artwork over a period of time supported and recorded the process of the development of key themes.

The round table presentation will discuss the key themes that emerged from this piece of work citing both individual and collective actions that were identified which may influence positive changes within individuals' practice. Participants were also able to reach a consensus as to what actions that they wanted to take collectively take forward and the presentation of the research findings of the project to be conveyed to the Senior Management Team within The School of Nursing, Midwifery and Social Care.

Three critical questions you would like the audience to consider:

'Consider the possible actions which may result in positive change on a strategic level?'

'How can individuals influence be part of, and influence the way that thing are done?'

'What support do you require to feel safe and supported to try new ways of working?'

References

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A consideration of issues surrounding the reality of developing compassionate care
as a cultural norm in clinical environments

Presenter: **Dr Dorothy Horsburgh, Senior Lecturer Research Awards,**
Edinburgh Napier University.
d.horsburgh@napier.ac.uk

Co-author: **Janis Moody**, Lecturer, Edinburgh Napier University.

Evaluation of the Newly-Qualified (NQ) Staff Nurse strand of the Leadership in Compassionate Care Project was carried out by means of questionnaires, focus groups, small group interviews and individual interviews. Questionnaires evaluated the content and approach of study days; the relaxed, supportive atmosphere and the content were considered positive and thought-provoking. Seven focus groups (n= 42), one small group interview (n=2) and individual interviews (n=2) were carried out, using a purposive sample of volunteers on each study day. The aim was to explore NQ Staff Nurses' conceptualisations of compassionate care and factors that facilitate or inhibit its delivery. A constructivist grounded theory approach (*Charmaz* 2006) was adopted, a flexible agenda guiding discussion but ensuring that participants' individual issues remained the focus.

Findings emphasised pressures in transition from student to staff nurse. Support for NQ staff nurses was eclectic rather than systematic with some participants left to 'sink or swim', similar to findings from a systematic review conducted by *Higgins, Spencer and Kane* (2010). Staff in some areas were described as 'in with the bricks' and resistant to even minor changes, resulting in 'institutionalised negativity'. Clinical supervision was perceived as very positive in areas in which it was supported.

Compassionate care was a tautology for most participants ie care would not be 'care' in the absence of compassion. The concept was frequently described by citing situations in which compassion was absent or lacking, highlighting some of the difficulties associated with making compassionate care a reality in day-to-day clinical practice. Nursing was viewed by participants as more than 'just a job' and as an occupation in which 'emotional engagement' is not only desirable but a prerequisite for provision of high quality care. Participants' conceptualisations of compassionate care were not confined to staff/patient relationships, but extended to patient/patient and staff/staff interactions.

Three critical questions you would like the audience to consider:

'Critique findings from the Leadership in Compassionate Care Project's evaluation of its Newly-Qualified Staff Nurse strand.'

'Consider ways in which physical and social environments impact on individuals' ability to deliver competent and compassionate care.'

'Explore feasible measures to facilitate delivery of competent and compassionate care.'

References

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Embedding compassionate caring elements into acute illness module

Presenter: **Liz Adamson, Lecturer Adult Nursing and Teaching Fellow,**
Edinburgh Napier University.

l.adamson@napier.ac.uk

Although compassion is regarded as important in the teaching and training of nurses much of the curricula still adheres to the medical biomedical model (*Firth-Cozens and Cornwell* 2009).

Embedding relationship-centred compassionate nursing practice within the nursing and midwifery programme at Edinburgh Napier University is a priority of The Leadership in Compassionate Care Programme (LCCP). This programme is using action research to take forward developments in education and practice.

Research suggests that listening to the stories of patients enables deeper richer understanding and results in more effective caring interventions (*Haddon* 2009).

Within the Beacon Ward strand of the LCCP, patients, relatives, staff and student nurses were invited to share their experiences of receiving and providing care in a number of care environments. The narratives were then used to inform the facilitation of learning and of assessment within the adult nursing pre registration programme.

Lecturers, students, registered nurses and compassionate care senior nurses met to discuss what matters to patients and families in the acute admission setting and found that the key elements were consistent with those drawn from the LCCP. Data from 8 themes was used to reshape teaching and assessment within a module that uses simulation to teach recognition of acute illness and deterioration, so that compassionate caring attributes were made more explicit and assessed.

The presentation will focus on challenges and outcomes including integrating 'softer' elements into teaching and assessment, preparing the 'actors' for the teaching sessions. The presentation will also share excerpts from online discussions and module evaluations that relate to aspects of compassionate care.

References

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Using compassionate care stories in the curriculum: sharing students' experiences

Presenter: **Anne Waugh, Senior Teaching Fellow and School Director of Academic Quality,** Edinburgh Napier University.

a.waugh@napier.ac.uk

Co-authors: **Karen Barrie,** National Development Manager (Patient Experience), Healthcare Improvement Scotland.
Aileen McPartlin, Student Nurse, School of Nursing, Midwifery and Social Care, Edinburgh Napier University.
Jessica Midgely-Smith, Student Nurse, School of Nursing, Midwifery and Social Care, Edinburgh Napier University.

This discussion will focus on the use of students' compassionate care stories within a group reflection session. The stories were audio recorded; one consisted of a sound track only, another had music added and the remaining two were completed by including both music and still images. Two students from this session will give accounts of their experiences of listening to the stories and how this was useful to their learning. One of the students wrote her story for last year's Leadership in Compassionate Care Conference and will share her experience of the process.

The students listened to and watched stories during one of their regular reflection sessions. Discussion followed each story using a student-led agenda. Feedback was then elicited about what students enjoyed about the stories, their value in learning, their preferences about the format of the stories (audio, audio and music or audio combined with music and images) and other ways in which students considered they might be useful to enhance their learning.

Feedback suggests this is an effective and powerful way of generating discussion about compassionate care and student's experiences in practice learning. Evaluative comments included 'highlights how the small things we might often overlook make a big difference, also makes you feel kind of proud', 'everyone can relate to that story, like how she told the story and was reflective about herself and her participation' and 'shows how daunting nursing can be'. In terms of their use in practice, students commented: '[they are] good for starting reflective discussion/sharing feelings', 'give a good starting point and focus', 'reassures you that other people feel the same' and 'leaving session feeling inspired'.

Three critical questions you would like the audience to consider:

'What did you think about the stories?'

'What ideas do you have about how using this type of story within nursing curricula?'

'How could this type of story be used to support learning and practice in clinical settings?'

References

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An evaluation of student and lecturer experience and understanding of the PDT role in terms of compassionate care

Presenter: **Janis Moody, School of Nursing,**
Midwifery & Social Care, Edinburgh Napier University.
j.moody@napier.ac.uk

Co-authors: **Kevin Head,** Pastoral Support Advisor, Edinburgh Napier University.
Linda King, Lecturer, Edinburgh Napier University.
Patricia Perry, Lecturer, Edinburgh Napier University.
Mandy Gentleman, Senior Nurse, Edinburgh Napier University.

This evaluation study formed part of the Leadership in Compassionate Care Programme being undertaken by Edinburgh Napier University and NHS Lothian and relates to Project Strand 3 which broadly involves consideration of embedding the principles of person-centred compassionate care within the undergraduate curriculum.

The aim of this study was to evaluate the current Personal Development Teacher (PDT) role in terms of the type of support provided and to consider how to include or further enhance compassionate care as a component of a student's personal development planning process.

Currently, the role of the PDT is broadly defined as advising on academic matters; sign-posting relevant sources of support; active engagement in supporting students in the personal development planning process and in working with students to write mutually agreed references (*Lambert & Johnston*, 2010). In terms of this study we wanted to find out what students and staff members who were acting as PDTs deemed to be important with regard to the provision of support for personal students.

Data were generated using the emotional touchpoint technique with 6 students and 5 lecturers. The benefit of this approach are that it allows participants to see in a more balanced way the positive and negative aspects of an experience and helps them take part in a meaningful way in developing provision of the service (*Dewar* et al, 2009).

Students and staff were asked to think about the key times in their experience of personal development support and guidance. We wanted to know how they felt about their experience and the emotional touchpoint technique allowed them to consider aspects of the experience they valued and what aspects they felt could be improved upon.

During this presentation a comparison will be made between what students value in terms of the PDT role and what staff value highlighting the extent compassionate care practiced already as part of the PDT and student relationship. Themes arising from the data will also be discussed and our initial work on applying the data within the context on the Compassionate Care Analysis Framework will be considered.

Three critical questions you would like the audience to consider:

'What do you perceive to be compassionate care in the PDT role?'

'To what extent should compassionate care be an integral part of the PDT role and how can this be measured?'

'Do educators in the healthcare professions have a responsibility to role model desirable professional qualities such as compassion when interacting with students?'

References

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Compassionate care cold-spots:
'warming up' mental health inpatient services

Presenter: **Paul Davenport, Practice Development Nurse,**
Royal Preston Hospital.
paul.davenport@lancashirecare.nhs.uk

Co-authors: **Tony Roberts;**
Dr Graeme Reid, Consultant Clinical Psychologist, Lancashire Care Foundation Trust.
Julie Ross, Consultant Clinical Psychologist, Lancashire Care Foundation Trust.

Themes from complaints, serious incidents and service user feedback indicated pockets of 'cold-spots'. There appeared to be a lack of compassion in some of our mental health inpatient services, for example, during periods of acute patient distress, agitation and anxiety. We challenged ourselves to 'warm up' these cold spots.

Staff in these services work in an extremely demanding environment, where service users are in acute states of distress. Staff work long shifts in this environment, exposed to people experiencing unmanageable states of mind, with little time out for reflective practice. We hypothesised high levels of what has become known as 'compassion fatigue' and 'vicarious traumatisation' and that ward cultures had developed counterproductive ways of coping with stress, with underlying shame and loss of self-esteem.

There is a substantial body of research showing that compassion and caring behaviours are underpinned by specific evolved brain structures and processes. This neuropsychological 'compassion system' is distinct from and fundamentally incompatible with the activation of systems evolved to focus on

a) **threats (including social threats involving criticism and shame) or**

b) **competition for resources/incentives.**

To help people re-learn how to activate their inherent capacity for compassion (for self and others), we needed to help people reflect and shift their awareness in a non-judgemental way so that they can do this for service users. We developed a training package which was supplemented by re-vitalising our culture of reflective practice.

We came together as a group of like-minded people, employed by a Mental Health Trust and a Primary Care Trust, who would be drawing in expertise from a local university and arts charity. We worked together quickly, energetically and effectively, with a minimum of time and resources, by making our approach contagious, and by subverting our respective organisations' immunity against change. This is an experiential workshop: come and find out how we are warming up our inpatient services!

Three critical questions you would like the audience to consider:

'Spreading the meme; how can we make compassion contagious in organisations?'

'What are the distinctions between compassion, caring and being nice? Do these distinctions matter?'

'Do we hide behind techniques, tools and technology?'

References

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Making connections: using technology to enhance practice by learning about the head, heart and hand

Presenters: **Dr Maggie Hutchings, Senior Lecturer in Education,** University of Bournemouth.
mhutchings@bournemouth.ac.uk

Dr Caroline Ellis-Hill, Lecturer in Qualitative Research, University of Bournemouth.
cehill@bournemouth.ac.uk

Co-authors: **Professor Kathleen Galvin,** Professor of Qualitative Research, School of Health and Social Care; **Professor Les Todres,** Professor of Qualitative Research, School of Health and Social Care; **Ms Anne Quinney,** Senior lecturer in Practice Development, School of Health and Social Care; **Mr Andy Pulman,** Web Team leader, School of Health and Social Care, **all** Bournemouth University.

The rise of technology could be seen to distract from compassion in the caring professions (*Todres* et al, 2009). In this workshop we present an educational development at Bournemouth University where technology has been harnessed to support compassion in practice, in a transprofessional undergraduate module taken by 600 second year students in the School of Health and Social Care.

Students from community development, midwifery, nursing branches, occupational therapy, paramedic science, physiotherapy and social work take the Exploring Evidence to Guide Practice Unit facilitated with 17 web-based case studies ranging from experience of the impact of specific diagnoses (such as stroke) to a general experience (such as social isolation). Each case study provides stories and poems, qualitative and quantitative research, policy and practice issues related to each topic. Students attend four weekly research lectures and engage in group work.

Over five weeks groups of 5-9 students work together on a case study initially exploring evidence from poems, stories and qualitative research (heart); then exploring quantitative research and policy (head) and finally considering how the evidence can be integrated with their other studies and own experience to inform their practice (hand). This is supported by podcasts describing research terminology and student managed guided learning activities. Students write weekly individual blogs and a final group blog which is assessed (50%). They also take an online examination (50%).

By building a lifeworld framework which informs and also can incorporate rational 'head' knowledge it is felt students are more likely to develop the confidence to draw on evidence not only from research and policy documents, but also to value the stories of service users and their own human experiences to create the judgment-based care (*Polkinghorne*, 2004) needed in complex caring situations. During the workshop participants will be invited to experience part of this journey.

Three critical questions you would like the audience to consider:

'How would you design a blended learning experience that incorporates the dimensions of head, heart and hand in your programme or institution?'

'How can technology support an enriched humanised learning experience?'

'What are the features of compassionate care that this approach to teaching and learning encompasses?'

References

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Compassion and caring – leading the change

Presenter: **Claire Chambers, Leader** of the Specialist Community Public Health Nursing and Community Specialist Practice programmes, Oxford Brookes University, Oxford.

cachambers@brookes.ac.uk

Co-author: **Elaine Ryder,** Oxford Brookes University, Oxford.

We believe that everyone in the care environment should be able to take a lead on enhancing compassionate care. We are passionate about the need to challenge the potential barriers to compassionate care in practice today. Our first book on 'Compassion and caring in nursing' (*Chambers and Ryder*, 2009) discussed the different elements of compassionate care and we completed our discussion by raising three potential barriers to this patient and client focused care. These were resourcing, the culture of the practice environment and individual nurse attitude. In our current book, which we have almost completed, 'Excellence in compassionate nursing care: leading the change' we are facing these challenges head on and suggesting ways to challenge these potential barriers in practice.

Staff are the most valued resource in any environment, particularly in caring environments. If staff are not being treated with empathy, feel listened to, given choices where appropriate, empowered and helped to develop cultural competence, a compassionate environment and culture will not exist. Individuals who want to be compassionate will find themselves compromised. Therefore nursing leaders, at all levels, need to foster this positive and compassionate care environment.

We found the Inaugural International Conference on Compassionate Care such a stimulating place to be. We presented last year thoughts from our first book. We have moved on to address the role of the leader, at all levels of the organisation, in our second book... We have made many references to your work and the conference in our writing.

Three critical questions you would like the audience to consider:

'How can we continue to take a lead on compassionate care in the resource driven environment of health and social care today?'

'How do we influence the practice culture of where we work so that compassion remains central to care?'

'How can we use our own personal values, beliefs and attributes to take a lead on compassionate care?'

References

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Gilbert P. (2010). *The Compassionate Mind*, London, Constable and Robinson.

Drama as an active teaching and learning tool in healthcare education

Presenter: **Orla McAlindon, Nurse/Lecturer,** Queen's University, Belfast.

o.mcalinden@qub.ac.uk

According to Merton (*Trappist Monk* 1915-1968) 'the whole idea of compassion is based on a keen awareness of the interdependence of all these living beings, which are all part of one another, and all involved in one another'.

Cultural barriers to compassionate care can be presented from two perspectives in healthcare: the patient and the health professional. Content areas include autonomy clashes between the patient and health professional, end-of-life values and preferences, amongst others, and the problem of stereotypical and uncaring behaviours toward people different from ourselves (*Cornelison* 2001) With this in mind teachers at Queen's University Belfast, Northern Ireland, chose to use drama alongside more traditional methods of teaching and learning to increase the awareness, knowledge and learning potential in relation to compassionate care giving in suicide situations, both globally and in our local community.

A short piece of drama delivered as part of the Module 'Ethical & Legal Issues in Nursing', is co- facilitated by Belfast Samaritan volunteers and presented to all four fields of nursing practice students (Adult, Child, Learning Disability and Mental Health).

Evaluations by staff, students and Samaritan volunteers all consistently show that this method of enhancing learning and moving towards an understanding of mental and emotional health is helpful in aiding development of empathy, compassion, reflection and critical thinking. Using this innovative method within the core curriculum helps our students discover their own sensitivity by exposure to different viewpoints and beliefs (*Schantz* 2007) and the importance of provision of 'safe and compassionate care via the channel of the therapeutic relationship'. (*Sun, Long, Boore, Tsao*, 2006).

Three critical questions you would like the audience to consider:

'Can empathy and compassion be taught or learned?'

'How might the topic of suicide intervention be 'followed up' in clinical practice?'

'How can we measure compassion?'

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Ways of working with the people who care

Presenter: **Susan Hood, Senior Charge Nurse,**
Craiglea Ward, Royal Edinburgh Hospital, NHS Lothian.
susan.hood@nhslothian.scot.nhs.uk

Co-author: **Miss Moira Hume,** Occupational Therapist, Craiglea Ward, Royal Edinburgh Hospital.

Craiglea ward in the Royal Edinburgh Hospital has been part of the leadership in compassionate care programme for 2 years. We have embedded a compassionate care approach for patients in our ward. This approach is relationship focussed and has been sustained by a multi-disciplinary team involving nursing, occupational therapy and medical staff with the use of Emotional Touchpoints, providing regular opportunities for discussion, feedback and change. Our ward has undergone many changes in these two years as I'm sure have many other wards.

'What's different here compared with other wards?' was the initial question asked of us during a recent visit from NES and QIS. The answer given was this. Our ward changes have been made by staff, patients and relatives invested in improving their relationships with each other, by patients who feel more confident in decision making on the ward and by relatives taking a leading role in shaping their experience with our ward. We wanted now to find ways to work with the people who care.

How did we achieve this? By encouraging staff and relatives to share their opinions, actively seeking opportunities for them to talk, share and be heard. We continue to work with compassionate care tools such as Beliefs and Values and Emotional Touchpoints.

We would like to share with you the concept that you can highly influence sustainable changes in your own workplace.

Three critical questions you would like the audience to consider:

'How do you successfully initiate change in your team in a way that is meaningful, multidisciplinary and sustainable?'

'How do you receive feedback about your ward and the care you provide?'

'How can staff take a leading role in shaping the culture of your ward?'

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An education programme to enable compassionate care and optimal re-ablement with service users through development of health and social care support workers: promoting self management, enablement and Rehabilitation at Home

Presenter: **Wendy Thomson, Occupational Therapist Development Facilitator,**
Dumfries and Galloway.
wendythomson@nhs.net

Aim

To create quality training 'spring board' for Health and Social Care Support Workers to deliver holistic needs led care and enablement, within a joint, single service provision. Multi-skilled support workers competent within nursing and allied health skills and, working at NHS Career Framework levels 2-4, through demonstration of clinical excellence in self management, enablement and rehabilitation, under the collaborative direction of registered practitioners, to responsively facilitate service user and carer autonomy and enable quality independent community living.

Background & Drivers

- Policy and strategic initiatives in holistic care and re-ablement for service users incorporating the evolving role of support workers
- Geographical challenges – delivering rural services
- Demand to develop scope and flexibility of support roles, within clearly defined parameters, to support compassionate goal orientated practice as devised by regulated practitioners

Development & Implementation of Educational Programme

- 26 week competency based training (4hrs weekly)
- Partnership delivery – Nursing/AHPs Health and Local Authority
- Knowledge and Principles of Practice; Promoting Self Management, Enablement and Rehabilitation; Practice Skills for Enablers (Practical Application)
- Integrated Assessment – communication, evaluation and application of skills project
- Dovetail with KSF dimensions and National Mandatory Standards
- Credit Rateability – SCQF6/180 notional learning hours

Outcomes

- Development and delivery of holistic compassionate care practice
- Equitable, efficient assured delivery to service users and carers
- Contribute towards evidence for regulation and personal development review
- *Awaiting official credit rating and qualification levelling through Scottish Qualification Authority to achieve recognised flexibilityand transferability of support worker training and development*
- Maximising the potential of all available resources
- Impact and improved outcomes will be measured within the Key Performance Indicators of the service

Summary

The education programme contributes towards enabling service users to receive holistic needs led care and optimal re-ablement opportunities through development of clinical excellence which is within the Scottish Qualification Framework to sustain flexible and transferable multi-skilled support staff skills and compassionate care.

Three critical questions you would like the audience to consider:

'What skills do support workers require further educational development in to ensure continuity of care and clinical excellence?'

'Health and Social Care Partnership development is the essence of ongoing quality care delivery but how do we resolve challenges such as differing terms and conditions impacting on continuity of practice?'

'Can service users and carers be further involved in the educational developments to achieve best collaborative practice?'

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Working with managers to bring about sustainable improvement in quality

Presenter: **Jenny Kalorkoti, Senior Nurse,** Leadership in Compassionate Care Programme, NHS Lothian.

Perspectives on person-centred care:
a comparison between Edinburgh Napier University and Hanze University of Applied Sciences

Presenters: **Roos van der Steen & Eva Steenbergen, Students,**
Hanze University of Applied Sciences, The Netherlands.

r.van.der.steen@st.hanze.nl 09011289@live.napier.ac.uk

The aim of the research project is to find out what the different perspectives are of teaching and learning on person-centred care of students during last practical placement and lecturers based on the curricula in Edinburgh Napier University and the Hanze University of Applied Sciences.

The realisation of this research has originated from the existing research project within Edinburgh Napier University on Compassionate Care and the fact that the Hanze University of Applied Sciences in Groningen in the Netherlands also has an interest in the subject. Because the importance of the understanding of nurses about person centred care is essential, it should have a place in the university curriculum that it deserves (*Leistra*, 2004). Research has shown that the perception of student nurses on nursing and caring changes during the nursing programme (*Watson*, 2002). The kind of theory that is taught and the moment in time in which this teaching is done might influence the use of the theory in practical placements.

The way of data collection for this qualitative research will be face-to-face, semi-structured interviews, and participants will be found through using the snowball method.

The analysing of the interviews will take place when all the interviews have taken place. The outcomes of the interviews will be compared between the two universities that are involved. The interviews are done anonymously and with informed consent.

Because the research has not yet taken place, no outcomes are available yet.

Three critical questions you would like the audience to consider:

'What are the perspectives of lecturers and students at Edinburgh Napier University on person-centred care based on the curricula?'

'What are the perspectives of lecturers and students at the Hanze University of Applied Sciences on person-centred care based on the curricula?'

'What are the differences in perspectives of teaching and learning of students during their last placement and lecturers on person-centred care based on the curricula between the two universities?'

References

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Dignity and respect for dignity – from the nurse's perspective

Presenter: **Katarina Bredenhof Heijkenskjöld,** Mälardalen University, Sweden.

katarina.heijkenskjold@mdh.se

Background
The deepest ethical motive in all caring is to show respect for human dignity and the will to make good. Many patients expect to be met with dignity by nurses who will show them consideration and encourage and help them. The **aim** was to understand how nurses experience patients' dignity in medical units.

Method
Gadamer's hermeneutical approach was used and Flanagan's critical incident technique was availed for data collecting. There were 14 clinical nurses at three mid Swedish medical settings who participated in a research group during 2008. The data were analysed by using hermeneutic text interpretation.

Findings
The findings of the study showed that nurses who wanted to preserve patients dignity by seeing them as fellow beings and protected the patients by stopping other nurses from performing unethical acts. They regarded patients as fellow human beings and unique persons with their own history, and had the ability to see when patients' dignity was violated. Nurses do not have the right to deny patients their dignity or value as human beings. The new understanding was that care in professional nursing must be focused on taking responsibility for and protecting patient's dignity.

Three critical questions you would like the audience to consider:

'What does dignity mean for the patient at medical settings?'

'What is the importance of having participating observer in clinical research?'

'What does it mean being present in a compassionated caring culture?'

References

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Nurses learn caring theory
by listening to each other

Presenters: **Lena Boussaid,** School Of Health, Care And Social Welfare, Mälardalens University, Sweden.

lena.boussaid@mdh.se

Background
This paper describes how nurses from a surgical setting learn a caring theory by being co-researchers in a research group. The participation of the co-researchers means that they take part in research meetings where they are given time to discuss and reflect on their practice and *Eriksson's* (2007) caritative caring theory. **The aim** of this study was to describe the learning process of nurses when they where co-researchers in a research group.

Methodology
The design of the study had a hermeneutical approach. Data were collected through interviews with seven co-researchers from a surgical unit in mid Sweden during 2008. Hermeneutical text interpretation was chosen as a way to interpret the text, as it strives to understand the point of the text, rather than explain who the voice of the text is.

Findings
The results show how nurses learn caring theory by being co-researchers in a research group. Nurses described their learning process in following way, given time to talk to each other, expressing actions in words, sharing thoughts with one other, and being touched by the experiences of other nurses. To learn in research groups can be understood as a learning process, when nurses listen to each other and thereby create an expression and meaning of their experiences through caring theory, while developing their profession at the same time.

Three critical questions you would like the audience to consider:

'Innovative methods – an opportunity to learn caring theory in practice?'

'How can a nurse as co-researchers in a research group learn in practice?'

'To tell each other – is this a possible learning strategy in nurses' learning process?'

References

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Maintaining patient's dignity in forensic care:
the challenge of maintaining patient's dignity in clinical caring situations

Presenter: **Lena-Karin Gustafsson,** School of Health, Care and Social Welfare, Mälardalen University, Sweden.

lena-karin.gustafsson@mdh.

Introduction
Human dignity is one of the basic attributes caring ethics and pushed to its limits in the context of forensic care. We must recognise the importance of increased understanding for maintaining patient's dignity to expand earlier formulated knowledge about caring ethics. Illuminations of this topic can create conditions for changing and develop care and make human's dignity and caregivers preservation of dignity evident. The aim in this study was to illuminate the meaning of maintenance of patient's dignity in forensic care.

Methods
A qualitative explorative design with a hermeneutic narrative approach was used to analyse and interpret focus groups interviews with caregivers in forensic care. Caring theory about dignity as an important concept within caring ethics provided the point of departure for the analysis. The study was approved by an ethical research committee.

Findings
Revealed different themes that gave light to the meaning of the phenomena. In the text the meaning of maintenance of patient's dignity was protection and respect, but also brotherly humanity. The themes protection and respect had an outer and inner form. Protection was shown outwards as cover or screen the patient and to guard against danger. The inner form of protection was described as to protect the patients' needs and to arouse the patients' protection recourses. The theme respect was shown outwards as taking the patient seriously and to show others that patient were someone to count with, inwards as teaching patient create respect and teaching patient to expect respect from others being a worthy person. The meaning of maintenance of dignity was also to meet patient with human brotherhood, to do 'the little extra' and to show human similarity.

Conclusions
Understanding the meaning of maintenance of patient's dignity in forensic care will enable nurses to plan and provide professional care, based on caring science.

Three critical questions you would like the audience to consider:

'If we see dignity as relative, as a result of moral or immoral deeds, how can we develop care for patient's dignity if the patient has committed murder?'

'Can experience of preserved dignity have a difference between genders?'

'Can this illumination of dignity in forensic care serve as an understanding for maintained dignity related to other kinds of clinical settings?'

References
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Reflection of three leaders of compassionate care: it's about confidence, determination and relationships

Presenter: **Juliet MacArthur, Lead Practitioner Research,** NHS Lothian.

Juliet.macarthur@nhs.net

Co-authors: **Johnathan McLennan,** Charge Nurse, IPCU, Royal Edinburgh Hospital.
Michele Yeaman, Charge Nurse, Robert Ferguson Unit, Royal Edinburgh Hospital.
With contribution from **Helen Ogilvie,** Charge Nurse, Loanesk Ward, Midlothian Community Hospital.

Leadership is recognised as being one of the most important factors in ensuring that patients and families receive compassionate care. This workshop will involve three charge nurses who worked in Development Sites participating in the Leadership in Compassionate Care (LCC) Programme in Lothian. They have all participated in a research study based on a realistic evaluation approach (*Pawson and Tilley* 1997) that aimed to examine the impact of the Programme, addressing the questions of *what* worked, for *whom* and in *what* context? During a focus group they reflected on the impact and outcomes of being supported by experienced facilitators and taking forward tools and techniques learned through the LCC Programme.

The workshop will be in two parts: the first half will take the form of a Michael Parkinson-type interview that will invite Jonathan and Michele to reflect on their leadership in initiating, embedding and sustaining the messages and values of the LCC Programme in their wards. The third charge nurse Helen will not be present, but her contributions will be included in the presentation. The three charge nurses came into the Programme from very different starting points: one very experienced, one in their first post but with a clear sense of wanting to implement change and the other appointed as a charge nurse immediately prior to involvement. They will reflect on how the Programme shaped their ways of leading and engaging with their teams. Data from the research study will be introduced into the interview as a means by which to examine key factors that have influenced the charge nurses as individuals, but also played a part in contributing to the success of the programme in three contrasting settings.

The interview will be followed by an interactive discussion with the audience who will be invited to explore ways of introducing and maintaining the type of positive challenge that leads to sustained change.

Three critical questions you would like the audience to consider:

'How do you ensure that the care in your ward is compassionate whether you are there or not?'

'How do you go about building the kinds of relationships that will promote and sustain compassionate care?'

'What would support to take forward the type of compassionate care you've heard about in your own setting look like?'

References

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The conversation is the relationship:
the art of compassionate communication

Presenter: **Michael Brophy,** National Advocacy Programme Alliance, Ireland.

icpe@iol.ie

The argument is made that healthcare in Western Europe has fallen victim to the professionalism movement, with care seen merely as problems to be solved, without taking into account the specific psychological and personal history of the patient. The principle that ***the conversation is the relationship*** is designed to provide a narrative structure that helps to ensure that patients are accompanied through their sickness and cared for by healthcare professionals (someone who gives of their best even when they do not feel like it) who give life to the value of compassion in their practice.

All human beings have the same basic needs; this makes it possible to connect with each other and to find mutual understanding on a deep level. This is the doorway to creating a flow between ourselves and others based on a mutual giving from the heart. The art of compassionate communication is the key to unlocking that door.

The workshop is derived from elements of a values intervention process with Care Assistants/Household staff in nursing homes in Ireland. This process is designed to facilitate staff in reconnecting with their own sense of self worth, by way of giving life to the values of personal excellence and compassion in their practice. The purpose of the workshop, based on the work of ***the Center for Non Violent Communication (Marshall B. Rosenberg, Ph.d. Nonviolent Communication: A Language of Life, Pudddle Dancer Press, 2003)***, is to strengthen the ability of participants to respond compassionately to themselves and to others, especially in situations of conflict and stress. Participants are introduced to the key elements of compassionate communication in a series of practical exercises covering;

- **Listening**
- **Observation without Evaluation**
- **Identification and Expression of Feelings**
- **Expression of Needs**
- **Expression of Requests**
- **Expression of Appreciation**
- **Discussion Prompts**

Three critical questions you would like the audience to consider:

'Why is the conversation the relationship in healthcare?'

'Can compassionate communication be taught?'

'Is it possible to provide a framework which can support compassionate communication on the part of individual healthcare professionals with the persons they care for?'

References

Ian Callanan MB FRCSI MBA.

Mr Greg Price, Director of Advocacy.

Smells, bells and dolls – compassionate connecting using three modalities in dementia care

Presenter: **Fiona Robertson, Occupational Therapist,** NHS Lothian.

fiona.robertson@nhslothian.scot.nhs.uk

Co-authors: **Fiona Cartmell,** Aromatherapist;
Carole Clark, Music Therapist, NHS Lothian.

Continuing Care wards for men with Dementia can be a challenging environment for all. Patients with varying and profound communication difficulties struggle to make sense of the world around them. Relationships may be fractured and unpredictable.

Within this setting key roles of Occupational Therapy (OT) are to support the functional ability of individuals with a clear focus on wellbeing and quality of life. As part of an assessed and planned programme of holistic care, OT has brought three different therapies onto the wards.

- **Music therapy** – much has been written about the positive use of music therapy within dementia care (*Aldridge,* 2000)
- **Aromatherapy** – research has shown the efficacy of using specific oils to help with agitation in dementia care (*Ballard* et al 2002)
- **Doll therapy** – the use of doll therapy in institutional care settings has been well documented over the last number of years (*James* et al 2005).

What this workshop will do is to present a brief experience of these interventions. The aim is to show commonalities of a compassionate approach linking all three therapies and to demonstrate strategies of interaction and engagement with people that are often deemed 'hard to reach'.

Three critical questions you would like the audience to consider:

'How can these therapies promote positive interactions between ward members (whether patients or staff)?'

'How can these therapies help to bring patients' relatives into the arena of compassionate care?'

'How can staff attitudes inform the efficacy of the intervention?'

References

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A strategically compassionate response
to living and dying well with dementia

Presenter: **Jenny Henderson, Development Manager,**
Alzheimer Scotland.
jhenderson@alzscot.org

Co-authors: **Mark Hazelwood,** Director, Scottish Partnership for Palliative Care.
Dr Stephen Smith, Lead Nurse, Leadership in Compassionate Care Programme, Edinburgh Napier University.

Many people with dementia have complex mental or physical health problems which may be life threatening, and experience extreme physical and emotional distress as a result, the impact on family members cannot be underestimated. The authors of this report believe that palliative care offers an approach and specific expertise that can improve the lives of people with dementia and their families, whilst supporting health and social care professionals to provide good care in the face of ethical dilemmas and complex management problems. Alzheimer Scotland, Edinburgh Napier University and the Scottish Partnership for Palliative Care (SPPC) organised a summit titled *Living and Dying Well with Dementia,* which took place on 4 March 2011.

The aims of the summit were to:

- Raise awareness of the issues relating to the palliative care of people with dementia and those who care for them
- Identify challenges, find solutions and showcase examples of best practice
- Capture discussion, debate and key messages from the summit within a report for wider dissemination.

Fifty participants with a strategic or academic role in health, social care and government were invited to take part in the summit. The programme included expert speakers on a range of related topics, and delegates had the opportunity to share challenges, find solutions and showcase examples of best practice. During the summit a case study was presented and became the focus of inquiry, participants were invited to consider the case in terms of: clinical issues, systems of care, caring for the family and ethical considerations. The discussion groups were facilitated, scribed and recorded, and will provide the basis for a future report. Outcomes from the summit focussed on a need to prioritise the process of diagnosing a dementia, advance care planning, general systems of communication, support provided to families and ensuring effective transitions between care settings when people with dementia and their families use different services.

Three critical questions you would like the audience to consider:

'What are the palliative care issues experienced by people with dementia and their families?'

'What strategic developments may enhance experience of support and care?'

References

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From reaction to reflection,
refocusing on compassionate care

Presenter: **Karen Bowman, Professional Nurse Lead,**
Lancashire Foundation Trust. *karen.bowman@lancashirecare.nhs.uk*

Co-authors: **Trish Haines** and **June Cross,** Practice Development Leads, Lancashire Foundation Trust.

It has become apparent to me over the last few years that we seem to have lost sight of the art of nursing in terms of 'care'. Assurance demands have forced clinicians to become lost in the science of evidencing, accounting and reacting. *Wright* (2004) argued that this is perceived as more important than hands on care.

As a lead nurse for an adult mental health network, I arrived at the decision that this approach is costly in terms of the very unique level of engagement that was once recognised as a predominant feature of the nurse patient relationship. The loss of the warm trusting and compassionate relationship with both patients and their carers has become a common theme within complaints and incident investigations.

These processes demand investigation and action within strict deadlines which lose sight of the need for in-depth analysis and reflection on the actual provision of care, thus impacting on the opportunity for improvement.

Findings often show a lack of care in terms of true engagement with our service users and their families and a lack of listening and enquiry. We must always ask the question 'what was the actual caring relationship like between the people involved?', 'What must it have felt like?'

Our organisation has had a change of direction in the last couple of years and clear drive towards embedding the trust values of compassion, integrity, teamwork, respect, accountability and excellence. Underpinned by the adoption of an appreciative leadership model supported the opportunity to foster reflection in order to ensure ongoing development.

Three critical questions you would like the audience to consider:

Service user experience and involvement:
a robust learning and development programme underpinned by service user experience.

Question. 'What should this programme look like?'

Refection and analysis: the important 'time spent' when reviewing care

Question. 'What does this really look like and how can it be achieved?'

Staff support, to care you need to be cared for 'compassion for others begins with kindness to oneself' Koerner (2007).

Question. 'How can we support inpatient staff and ensure they feel cared for?'

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Compassionate care...
nutritional care

Presenter: **Michelle Miller, Programme Manager,**
NHS Healthcare Improvement Scotland. *michelle.miller3@nhs.ne*

Co-author: **Joy Farquharson**

The Better Together In-patient Experience Survey (September 2010) has shown that 40% of respondents said they required help with eating and drinking and 11% of these respondents felt they did not get the help they needed. In assisting to tackle this problem, the Improving Nutritional Care Programme at Healthcare Improvement Scotland, has developed a work stream to focus on improving meal times.

Three critical questions you would like the audience to consider:

'Are there good examples of compassionate care at meal times?'

'How can meal time processes be improved to support compassionate care?'

'Are outcomes too elusive for compassionate nutritional care?'

Compassionate caring conversations:
experience in practice

Presenter: **Liz Adamson, Lecturer,** Teaching Fellow,
Edinburgh Napier University.

l.adamson@napier.ac.uk

Co-authors: **Josie Pearson,** NHS Lothian.
Joyce Malone, Ward, NHS Lothian

For many people entering a hospital ward is a potential source of anxiety or even fear (*Firth-Cozens & Cornwell,* 2009) and therefore the first conversation they engage in may significantly influence their overall experience. Healthcare support workers play an important role in delivering care (*Scottish Government,* 2010) and the ward clerk/ clerkess or clinical support worker may well be the first person a patient or visitor meets. Their communications skills are therefore vitally important.

A project facilitated jointly by Edinburgh Napier University and NHS Lothian, offered a development opportunity for clinical support workers and ward clerks. As part of this the participants were encouraged to reflect on their own experiences of engaging in compassionate caring conversations. In this round table discussion the 2 participants (a ward clerkess and a clinical support worker) will each share one of their personal experiences in practice which will initiate discussion.

In particular the discussion will focus on the role of the clinical support worker and ward clerkess in relation to compassionate care within their area of work.

Three critical questions you would like the audience to consider:

'What are the challenges that support workers face in their role as caring communicators?'

'Do support workers need permission to use their initiative to care compassionately?'

'How important is the first conversation a relative or patient has as they enter a war?'

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The role of nurses in leading the global fight against the spread of non-communicable diseases, compassion in action

Presenter: **Paula De Cola, External Medical Affairs**, International at Pfizer Pharmaceuticals . *paula.decola@pfizer.com*

Every country in the world is affected by the rising tide of non-communicable diseases (NCDs) and the necessity for access to appropriate, affordable care for people with these conditions as well as interventions focused on prevention. Statistics now show that 60% of deaths globally are due to NCDs, with 80% occurring in low and middle income countries. There is an urgent need for nurses to proactively engage with all parts of the community and all sectors, to address this threat to global health and development. Nurses, with their skills, knowledge and closeness to patients, families and communities, are positioned to lead the fight to stem the pandemic. Pfizer and the International Council of Nurses collaborated on a survey of 1,600 nurses in eight countries that show nurses want to lead in the global fight against the further spread of non-communicable diseases (NCDs) but workload and time constraints are holding them back.

Tell us about your experiences or stories

If you would like to comment on any work related to this programme, please contact one of the team:

Stephen Smith
ste.smith@napier.ac.uk

Mandy Gentleman
m.gentleman@napier.ac.uk

Ria Tocher
r.tocher@napier.ac.uk

Belinda Dewar
b.dewar@napier.ac.uk

Jenny Kalorkoti
j.kalorkoti@napier.ac.uk

Simon Pullin
s.pullin@napier.ac.uk

www.napier.ac.uk/fhlss/NMSC/compassionatecare

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