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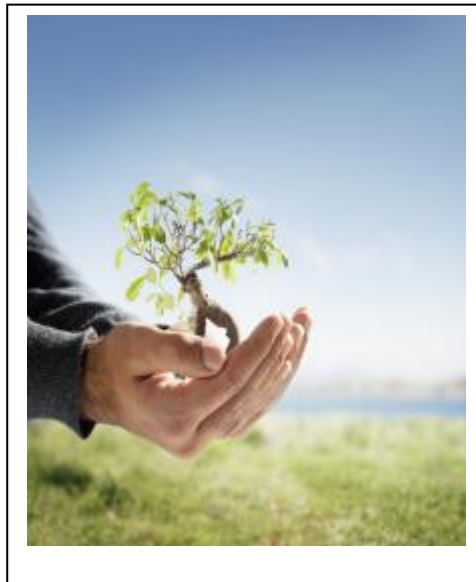
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Enhancing Dignity through Caring Conversations

Draft Final Report for Queen's Nursing Institute Scotland

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About the Authors

Dr. Belinda Dewar

Belinda is a nurse, educator and researcher and has been working with staff in older people care settings over the last 20 years. She has expertise in user involvement, caring, creative ways of helping to hear the voices of all stakeholders and action learning and has been asked to contribute to this body of knowledge both nationally and internationally. She is committed not only to improving care services for service users but also to supporting staff in the health and social care sector to enhance their working lives.

She held a position of nurse consultant and worked with the Scottish Government and other key stakeholders to promote a positive care culture across care homes in Scotland. She is currently Professor of Practice Improvement at the University of the West of Scotland and Director of the My Home Life programme in Scotland. This programme aims to enhance the quality of life of those living, working and visiting care homes. She recently completed her doctoral studies where she developed a model for compassionate caring which has at its heart the 7 c's of caring conversations. She is committed to approaches to research that empower others to be critical of their practice and develop change in partnership with patients and their families.

Tamsin MacBride

Tamsin is a Lecturer in Adult Health at the University of the West of Scotland (UWS). She has extensive clinical nursing experience including a practice education role which focussed on staff development within a clinical speciality area. She has worked at UWS for five years and is widely involved in teaching, learning, assessment and module coordination on the BSc Adult Nursing Programme. She joined the Institute of Care and Practice Improvement in 2013 and was appointed to work with Professor Dewar on the project detailed in this report.

Acknowledgements

We would like to thank the Queen's Nursing Institute Scotland and The Burdett Trust for Nursing for funding and providing ongoing support and encouragement to complete this work. We are also indebted to all of the staff, residents and families who shared with us their experiences of caring and their dreams of how things could develop in the future.

Executive Summary

Evidence is strong about the centrality of human interaction and relationships to delivering compassionate and dignified care. How to promote excellent human interaction in the care home setting is less clear. Further work in this area is required to develop practice in this area.

This report arises from an appreciative inquiry project into enhancing dignity through caring conversations funded by the Queen's Nursing Institute and the Burdett Trust for Nursing. The aim was to celebrate and develop excellent human interaction that promotes dignity between community nurses, residents and families in care homes. We did this through co-designing, implementing and evaluating an educational intervention with and for people in a care home setting. Specific data generation methods involving residents, relatives and staff included; observation of interactions between staff, families and residents to identify when interactions worked well and enhanced the relationship; interviews with staff, residents and families about their experiences of interactions in the home; and a culture questionnaire and analysis of artefacts and documents.

The project took place in one care home - Carnbroe Care Centre - in North Lanarkshire over a period of 10 months. It reports on the experience and learning from that inquiry and sets out an educational approach that could be rolled out across other care homes to enhance conversations that promote dignity.

The inquiry has worked with a range of staff, relatives and residents to explore caring conversations that matter to them. It has generated many positive care practices where people were communicating in a way that was compassionate. The way in which people communicated mapped well to the evidence based framework of the 7 c's of caring conversations identified by Dewar (2011) which are: be courageous, connect emotionally, be curious, consider other perspectives, collaborate, compromise and celebrate. Building on the knowledge of what works well staff developed local small 'tests of change' that enabled these good practices to happen more of the time. For example they implemented strategies to help them to notice and reflect on conversations, and developed their skills in finding out more about the resident as a person.

The approach of appreciative inquiry proved not just a valuable approach to exploring good caring conversations and developing practice but formed the framework for an educational intervention that has been developed and could potentially be rolled out across other care homes in Scotland.

Project Team

Professor Belinda Dewar, University of West of Scotland (Principal Investigator), Tamsin MacBride, Lecturer University of the West of Scotland, Michael Donavon, Carnbroe Care Home, Mary McGookin, unpaid carer (critical friend).

Introduction and Background

Concerns about standards of care for older people have been apparent for decades (Norton, McLaren and Exton-Smith, 1962; Townsend, 1966) and despite considerable efforts to improve the situation (Davies et al., 1999; Health Advisory Service, 2000; DoH, 2006) several recent high profile reports indicate that unacceptable standards of care for older people remain prevalent (Parliamentary and Health Service Ombudsman, 2011; Care Quality Commission, 2011; Mid Staffordshire NHS Foundation Public Inquiry, 2013; Department of Health, 2011; Tadd et al., 2011). This has resulted in a more explicit emphasis in policy about the centrality of compassion and dignity in healthcare.

For example, in the UK, the preface to the National Health Service (NHS) constitution, states that “[*The NHS*] touches our lives at times of most basic human need, when care and compassion are what matter most”. (DoH, 2008, p.1) and identifies compassion (a related term to dignity) as a defining value of the NHS. Values and aspirations put forward by Scottish Government policy in health and social care are to:

- recognise service users as citizens, with dignity and respect
- work with principles of openness and inclusion
- ensure that service users have more choice and control over the care that they receive
- provide integrated care

(Scottish Government, 2011).

In Scotland The *National Person-Centred Health and Care Programme* aims to bring coherence to a range of initiatives and programmes to challenge all parts of the health and care system to ‘put the person at the centre of services’, as part of the NHS Healthcare Quality Strategy (Scottish Government, 2011). This is to be evidenced by 2015 in terms of improvements in the care experience; the staff experience; and co-production.

To address the above, considerable policy and practice attention has been given to promoting dignity and models of practice that are centred around relationships (Bate and Robert, 2006; Darzi, 2008; Goodrich and Cornwell, 2008; Scottish Government, 2011; DOH, 2012; Local Government Association, NHS Confederation and Age UK, 2012; Nolan et al., 2003; Tadd et al., 2011).

Against this backdrop of greater attention to improve the **way** care is delivered, there is growing evidence about what matters to older people receiving care. The Commission on Dignity (Local Government Association, NHS Confederation and Age UK, 2012) highlighted the work of Bridges, Flatley and Meyer (2009) who, through a meta-synthesis of available

evidence, concluded that older people in caring environments value processes that enable staff to:

- See who they are
- Connect with them
- Involve them

Bridges, Flatley and Meyer (2009).

In addition the Commission emphasises the value of Professor Nolan's work where he advocates supporting the development of enriched environments that enable the senses of belonging, security, continuity, purpose, achievement and significance to be achieved for staff, residents and families if excellence in dignified care experiences are to be achieved (Nolan et al., 2006).

The RCN (2008, p.9) put forward a helpful definition of dignity which includes:

In care situations, dignity may be promoted or diminished by: the physical environment; organisational culture; by the attitudes and behaviour of the nursing team and others and by the way in which care activities are carried out.

The dimensions in the definition identified above, and the achievement of the senses identified in the Commission on Dignity (Local Government Association, NHS Confederation and Age UK, 2012) require the development of skilled interpersonal human interactions.

Despite an increase in evidence about the meaning of dignity and compassion, and a constant stream of person centred training programmes, there is concern that communication between the older person, their family carer and staff, that helps to promote policy and practice aspirations, continues to be challenging (Dewar and Nolan, 2013; Dewar, Pullin and Tocher, 2011; Edinburgh Napier University and NHS Lothian, 2012; Sheard, 2007).

So how processes that promote dignity and compassion can be achieved in everyday practice is far from clear. Without greater clarity about how to support practitioners to realise aspirations about dignity in practice, terms such as dignity and compassion will remain little more than a rhetorical and political device which trips easily off the tongue but remains elusive, particularly in a health and social care culture that is dominated by productivity, efficiency and effectiveness, and promotes quick fix solutions to the 'caring problem' (Finfgeld-Connett, 2008; Goodrich and Cornwell, 2008; Youngson, 2008).

The Commission on Dignity (Local Government Association, NHS Confederation and Age UK, 2012, p.3) states that:

We have to work with older people to shape services around their needs, and listen to patients and residents and their families, carers and advocates so we learn from their feedback and continually improve dignity in care.

The interpersonal skills that community nurses require to work with and for older people in a meaningful way include sensitivity, connecting emotionally and showing vulnerability. Innovative examples where practitioners, including nurses, had been supported to develop skilled interpersonal relationships that promoted dignity are being developed (Dewar, 2011; Local Government Association, NHS Confederation and Age UK, (2012); Help the Aged and the National Care Homes Research and Development forum, 2007).

Supporting the development of these skills is not without its challenges. Evidence suggests that dignified and compassionate care can be taught but mechanistic models that focus on behavioural communication skills, such as listening and questioning aimed at problem resolution do not adequately address the relationship that is crucial to delivery of compassionate and dignified care (Doane, 2002). We need education with more emphasis on human relating where there is an acknowledgement of the common bonds of humanity with patients, relatives and colleagues through an appreciation of people's connectedness and an emphasis on being with people rather than doing for them (Dewar, 2011; Doane, 2002). Work based educational models with real time feedback that support people to engage in a way that demonstrates attunement, openness and curiosity, to actively involve people in a way that is comfortable, to manage expectations, be honest about the limitations of support available, tap into strengths and capacity and think creatively about possible solutions that mean something to individuals.

Recent research by Dewar (2011) developed a model for compassionate/dignified care which, has at its heart, caring conversations. This model was developed from observing excellent human interactions between staff, patients and families. The caring conversations have 7 elements which are:

- Be courageous
- Connect emotionally
- Be curious
- Consider other perspectives
- Collaborate
- Compromise
- Celebrate

This model of caring conversations has not yet been tested out in the care home environment. The care home is an important provider of community care and community nursing in the UK. Older people in care homes often have complex needs and the work of

care home staff is critical to supporting residents to enhance their quality of life. This study aimed to test the model in practice and develop education to promote the 7 c's framework of caring conversations.

Aim and Objectives of the Study

Aim

To celebrate and develop excellent human interaction that promotes dignity for community nurses, residents and families in care homes through co- designing, implementing and evaluating an educational intervention in a care home setting.

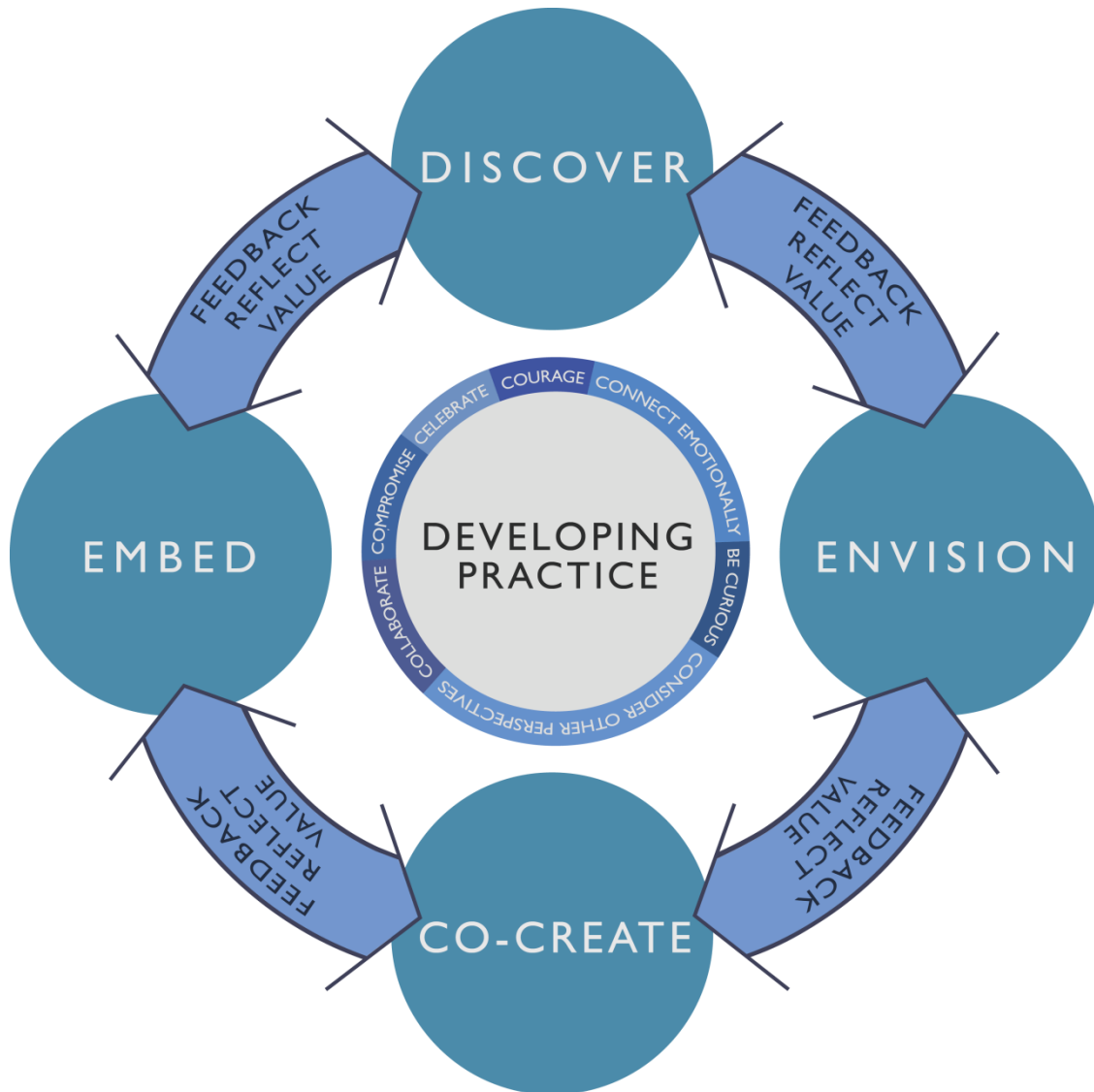
Objectives

- To explore with staff, residents and families their experiences of engaging in caring conversations with each other.
- To map existing examples of excellence in interactions that promote dignity with the evidence based Caring Conversations framework developed by Dewar (2011), and refine this as required.
- To develop, deliver and evaluate, with participants, practice based education based on realtime feedback that supports participants to develop skills in excellent human interaction that promotes dignity.
- To explore and evaluate the involvement of staff, residents and families as collaborators in the inquiry process.

Methodological approach

Appreciative inquiry is the approach used in this study. This has a unique focus on existing organisational strengths, rather than weaknesses, to enhance practices (Cooperrider, Whitney and Stavros, 2008; Dewar and Mackay, 2010; Kavannagh et al., 2008). The appreciative inquiry process has been adapted by Dewar and consists of a 4 phase cycle: Discover (positive elements of practice are illuminated, in this case interpersonal communication that promotes dignity), Envision (an ideal practice environment is envisioned through reflecting on data from discover), Co-create (processes are created that support the ideal, in this case an educational intervention), and Embed (strategies are

implemented and evaluated that strive for the ideal, in this case development of a programme that can be used by other care homes).



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Using an inquiry cycle (Observe, Reflect, Plan and Act) participants devised small cycles of change that responded to their observations and analyses. These were tested out, reviewed and revised according to the effects they created.

Solutions stand the best chance of being devised and implemented effectively if they are developed in collaboration with all the relevant parties. There is a need to combine existing evidence with the experience of staff and residents and their families to both '*build the will*' for development and '*implement developments*' through active support and collaboration.

The project took place in one care home in North Lanarkshire. Carnbroe Care Centre is registered for 72 residents, which is split into 4 separate units. Currently there are two units dedicated to the provision of dementia care and two units providing frail elderly care. The home employs 100 staff inclusive of all ancillary and bank staff. Due to the large size of the care home it was decided that the research team would work with staff from two of the units, this would allow staff to get to know the project and enable a clear focus.

Appreciative inquiry was used with staff, residents and families over a period of 10 months to discover excellent human interaction that promotes dignity and use this to inform an educational intervention that could be tested, refined and then used more widely.

Participants

Staff

Following a number of project meetings (6) that discussed the project aims, and what participation would look like, staff in the 2 units were invited to participate in the programme. A total of 37 staff attended these meetings. All staff were given written information about the project and leaflets were posted on notice boards to summarise the project.

In addition staff were asked before and after any data generation period if they were happy to take part and for the data to be shared more widely. When verbally asked no staff declined to be involved.

Core staff that made of the project team included the care home manager, 2 registered nurses and 3 senior carers /activity co-ordinators. These individuals attended project meetings and played an active role in the project by assisting with data generation, raising awareness of the project to others, and providing ideas for further development.

On a number of occasions, members of the core project team were involved in project work on their days off. Their commitment and enthusiasm for the project was extraordinary.

Towards the end of the project the care home manager left Carnbroe Care Centre to take up another position. In addition one of the support staff involved in the core group also left the care home. There was therefore a period of transition where project activities were on hold.

Relatives

Relatives were invited to participate in specific data generation activities and consent was ascertained at this time. In total 20 relatives were involved in the project.

7 relatives gave feedback during a discussion group exploring their views on what was working well in relation to communication and what could make their experience even better.

10 Relatives engaged in an emotional touchpoint discussion focusing on their feelings about talking to staff in the Carnbroe Care Centre.

3 relatives were involved in individual discussions with the project team.

Residents

In total 18 residents were directly involved in project activities.

2 residents were members of the core project team and attended meetings and gave feedback on emergent data.

3 residents were involved in observation and or filming interactions aimed at finding out more about residents as people.

13 residents were involved in sharing accounts of their experience of communication they were involved in.

Data generation methods

In order to generate data about what was working well during the discover phase a number of data generation activities were used. These included;

- Observation
- Use of Photo-elicitation
- Informal discussions with staff using positive inquiry questions
- Emotional touchpoint stories
- Culture questionnaire

Observation

The project team observed 8 episodes in Carnbroe Care Centre. These included meetings, mealtimes, and interactions in the sitting room. The team adopted the role of participant observers where they observed practices and took part in the activity if appropriate.

During observation the project team noticed specifically interactions that seemed to work well and others that they were curious about. Observations were fed back to the staff to generate discussion about why these particular interactions worked well. This encouraged staff to discuss these interactions, and consider what aspects were important to becoming part of the team's everyday practice. It was often aspects of everyday practice that staff did not necessarily recognise they were doing all the time and therefore this helped to uncover what was working well.

Photo elicitation

Image cards (NHS Education for Scotland, 2012) were used with staff, residents and families to explore the meaning of dignity and their experiences of engaging in caring conversations. The photos used depicted images such as people, landscapes, close ups, abstracts, animals and everyday objects. A number of varied photos were laid out on a table and participants were asked to select an image that summed up what they it felt like to communicate with others in Carnbroe Care Centre. They were then asked to share the reasons for selecting their image.

This was carried out on three separate occasions with different co-participants. This method helped to open up conversations and gain more meaningful information than questioning alone, helping to contextualize individual's experiences and also promote participation with individuals who aren't always able to clearly articulate ideas or express thoughts and feelings. The image seemed to help the individual connect with thoughts they may not have voiced before and articulate them clearly (Harper, 2002; Lorenz and Kolb, 2009; Dewar, 2012).

The outputs from sessions with participants using images were included within written summaries of progress with the project. They were also put on notice boards to enable participants to engage with the key messages and discuss these. Staff, residents and families were happy for these images and their anonymised responses to be displayed round Carnbroe Care Centre home prompting further discussion about what people valued about practices within the care home.

Positive inquiry tool

The positive inquiry tool was used to understand people's experience (Dewar, 2013). This tool poses two questions: 'what is working well for you here' and 'how can your experience be improved'. This tool was used in short informal discussions with staff, residents and relatives. This was carried out with 6 staff, 8 relatives and 5 residents.

Emotional touchpoints

The story method of using emotional touchpoints (ET), first developed by Bate and Robert (2006), focuses on emotion by asking participants to think about key points in their 'journey'/experience (touchpoints) and to select from a range of emotional words; those that best describe how they felt about an experience (Bate and Robert, 2006). The method helps the interviewer and interviewee to directly focus on the emotion related to the different points (touchpoints) in the experience. Using emotional touchpoints can help us to learn about the experiences of residents, relatives and staff. We can learn about those things that worked well for them and those that caused concern. The touchpoints help the storyteller to share their experience in a structured way. The information gleaned from the story can be used to identify small improvements that can have a huge impact on how care is provided and people's sense of well-being. For a fuller account of this method please see Dewar et al. (2010).

Touchpoints were used as the framework for a relatives meeting to explore what it felt like to talk to staff in Carnbroe Care Centre. The touchpoint was 'talking to staff' and relatives were asked to select emotional words to sum up what this felt like and then to go on to discuss why they felt this way.

In addition they were used at a number of staff meetings to explore what people felt about specific experiences e.g. recent inspection report, care of people with a dementia and relatives meetings.

Culture Questionnaire

A culture questionnaire developed by Patterson et al. (2010) was used to assess the culture of care. This tool is based on the extent to which the SENSES (identified by Nolan et al. (2006) and cited in the Commission on Dignity (Local Government Association, NHS Confederation and Age UK, 2012) of security, belonging, continuity, purpose, achievement and significance are met (see appendix 1). All staff were invited to complete the questionnaire (n= 90) with 22 members of staff completing this.

Table 1 illustrates methods used during each phase of the project.

Table 1 - Overview of Phases and Data Generation Activities

Phase	Activity/Data Generation
<p>Phase 1 -Setting the scene and establishing relationships</p>	<ul style="list-style-type: none"> • Field work including informal observation and informal discussions • Informal interviews with staff to explore their views about the project and caring conversations in the workplace (n=48)
<p>Phase 2 – Discover – what is working well?</p>	<ul style="list-style-type: none"> • Structured participant observations (n=8 events) • Staff discussions (n=10) • Photo elicitation (staff n=6, residents n=6, families n=1) to explore both the ‘meaning of dignity’ and ‘conversations that work well’ • Relative discussions using positive inquiry tool (n=8) • Resident discussions using positive inquiry tool (n=5) • Field work including informal observation and informal discussions • Culture questionnaire with staff (n= 22)
<p>Phase 3 – Envision – What would like to see happening more of the time?</p>	<ul style="list-style-type: none"> • Feedback sessions to staff (n =5 sessions attended by 32 staff) • Field work including informal observation and informal discussions
<p>Phase 4 – Co-create – What do we have to do to achieve our vision? Test this out and evaluate the activity.</p>	<ul style="list-style-type: none"> • Group discussions with staff to generate provocative statements • Field work using informal discussions to monitor impact of any development activity
<p>Phase 5 – Embed – What has worked well and how can people be supported to develop further?</p>	<ul style="list-style-type: none"> • One to one exit interviews with staff (n= 5 staff) • Photo elicitation (carried out at time of exit interview n=5 staff) • Development and refinement with staff of an educational programme for enhancing compassion through caring conversations.

Ethical Approval

Submission of ethics approval request for the project was made in May 2013. Ethical approval was granted from the University Research Ethics Committee at the University of West of Scotland in August 2013.

Principles of informed consent, avoidance of personal harm and confidentiality were adhered to in this project. Several meetings were held at the beginning of the project to explain the aims of the project and what participation might look like.

The act of gaining consent from participants was a continuous process rather than a one off event. Consent was checked out at the start and end of any data generation activity. The steps in the process included giving of verbal and written information, the explanation of risks and benefits and having repeated discussions with those involved at appropriate moments in time to ascertain that individuals continued to be content to participate.

For those participants who specifically appear in any photographs or video footage which is part of the educational intervention – they were shown the educational resource, and discussions took place about where the resource could be accessed, and who might use this resource. Further consent was gained from residents' families when a resident appeared in the educational resource.

Results and Interpretation of findings

The results section will be presented and discussed in relation to the different phases of appreciative inquiry. These phases were not necessarily strictly followed in a linear way, indeed often the nature of the project work resulted in movement back and forward and between the phases. Nonetheless it provides a useful way to present the results and findings (Dewar and MacKay, 2010).

Discover

The aim of the discover phase was to explore with staff, residents and families their experiences of engaging in caring conversations with each other. During this phase it was important to spend time building relationships with staff and discussing the aims of the project and their participation. Using a variety of methods within the discover phase helped to highlight and uncover understanding of what was working well within the care home in relation to caring conversations in order to inform future phases of the project.

A range of evidence was generated by specific data generation methods.

Review of Care Centre documents

A review of Carnbroe Care Centre documents was carried out including the information leaflet for Carnbroe Care Centre, the statement of purpose, recent care inspectorate reports and complaints received and the management of these. The aim of this review was to gain an insight into Carnbroe Care Centre and its background. In particular, the focus was to identify positive aspects of documents, particularly those designed for prospective residents and their families, and identify areas that could be further improved to welcome people to Carnbroe Care Centre. Examples of the positive aspects of the documentation include the emphasis on a personalised approach to care and the use of language that was welcoming. It was also identified that there were characteristics of this language that could be enhanced further for the information provided to be even more welcoming to prospective residents and their families. For example the brochure states 'our staff are flexible enough to respond to suggestions' - it is suggested that this could be even more welcoming by saying 'our staff look forward to working with you and any suggestions you may have'. In the statement of purpose it talks about care being delivered 'flexibly within the limitations of the care home environment'. It is suggested that this could be rephrased to appear more positive to prospective residents and relatives as the word 'limitations' may appear less welcoming. It is envisioned that feeding back this information to staff at Carnbroe Care Centre at the end of the project where they are now in a place to embed practices that matter to them and that they value will allow them to collectively develop these documents further.

Culture questionnaire

Overall there was a low response rate to this questionnaire with only 24% of staff completing this. Reasons for non-completion included concern that the data provided would not be anonymous. Despite the low response rate, analysis of the responses provided some interesting data that fed into the discover phase and development of the educational intervention. Positive aspects of the culture of working in Carnbroe Care Centre were highlighted as well as identification of some areas that could be improved to happen more of the time. In relation to positive aspects of the culture within Carnbroe Care Centre, the majority of participants responded 'usually' or 'always' to the following questions:

- In the last month, were you able to make the residents you care for comfortable?
- In the last month I have shown genuine concern and courtesy toward residents, even in the most trying situations.
- In the last month I have made sure I always make visitors feel welcome.
- In the last month when a resident or relative has views that contrast with my own, I have tried to understand why they think as they do.
- In the last month I have taken time to get to know residents as individuals.

It is of interest to note that there appeared to a correlation between the phrasing of the questions and the responses. For those questions that asked about the individual rather than the representation of the team, there tended to be a more positive response. It is suggested that perhaps this relates to individual staff members being more confident in being able to explain their responses than that of the team.

Another interesting point in relation to the questionnaire responses was that it was not always those aspects of the culture that staff identified as areas that could be improved that were focussed on during the study. For example, one of the positive areas highlighted above 'In the last month I have taken the time to get to know residents as individuals' was an area that was identified through the appreciative inquiry process that was already working well but staff in Carnbroe were keen to work on and develop to improve this aspect of the culture, enabling it to happen more of the time.

In relation to some areas that did not receive as positive responses, i.e. the majority of respondents answered 'sometimes', 'rarely' or 'never' (rather than usually or always) when asked the following questions:

- In the last month, did you have time to reflect on care with the team?
- In the last month, were all staff equally valued?
- In the last month, did other staff openly appreciate your work?
- In the last month, did you feel comfortable to discuss differences in opinion in an open way?

These results have been shared with the staff in the Carnbroe Care Centre to prompt discussion that has gone on to inform other phases of the project for example in the co-design phase – different resources are used at team meetings to try to help people to open up conversations, staff have huddles during a shift to say out loud to each other the things they felt they have done well and to openly appreciate others work.

Staff were not invited to complete the questionnaire at the end of the project due to the initial low response rate making it difficult to make any comparisons. In addition to this there have been a number of staff changes including change in management between the beginning and end of the project which may introduce additional factors relating to the workplace culture that could impact on interpretation of results.

Data generation and the 7 c's of Caring Conversations

Using the data generation methods of observation, photo elicitation, discussions and interviews a range of positive interactions that matter to staff, residents and families were identified. These have been themed under the 7 c's of caring conversations (see diagram 1) as one of the aims of the project was to see if this framework had relevance and meaning in

the context of care homes. It is important to note that the positive interactions identified often fall under more than one 'c' but for the purposes of discussion have been themed under the most applicable 'c' relating to the Caring Conversations Framework.

CARING CONVERSATIONS

BE COURAGEOUS - What matters? What would happen if we gave this a go? What is the worst that could happen if you did this?

CONNECT EMOTIONALLY - How did this make you feel? I feel.....You made a difference to my day because.....

BE CURIOUS - What strikes you about this? Help me to understand what is happening here? What prompted you to act in this way? What helped this to happen? What stopped you acting in the way you would have wanted to?

CONSIDER OTHER PERSPECTIVES - Help me to understand where you are coming from? What do others think? What do you expect to happen? What is real and possible?

COLLABORATE - How can we work together to make this happen? What do you need to help you to make this happen? How would you like to be involved? How would you like me to be involved? What would the desired goal/ success look like for you?

COMPROMISE - What is important to you? What would you like to happen? How can we work together to make this happen? What do you feel you can do to help us to get there? What would you like me to do?

CELEBRATE - What worked well here? Why did it work well? How can we help this to happen more of the time? If we had everything we needed what would be the ideal way to do this? What are our strengths in being able to achieve this? What is currently happening that we can draw on? I like when you.....

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Diagram 1: 7 C's of Caring Conversations Framework

Be courageous

Being courageous relates to willingness to take risks, feeling confident to ask questions, working with uncertainty and an ability to stick up for practices that people believed in without feeling that there would be a negative consequence. Examples of findings from the discover phase that related to being courageous include:

- Staff being able to challenge practice in a calm and confident manner when a staff member's mobile phone went off.
- Staff speaking to relatives to update them on a resident's condition rather than waiting to be approached by relatives.

Connect emotionally

This aspect of caring conversations relates to staff asking others how they feel and sharing how they feel. There was evidence that staff did ask people how they felt and noticed times when residents or relatives were upset and actively approached them in these instances.

For example:

- A staff member noticed when one lady was a bit upset or agitated and quickly responding to her by touch and statements of reassurance.
- Staff picking up cues from residents who may be unhappy or upset and responding to these individuals as a priority.
- Staff asking other staff how they were at the start of a shift.
- Staff asking residents open questions such as 'how are you today?'

There were few examples of staff sharing with residents and families how they felt and many commented that they felt this might appear unprofessional. The case study of a relatives meeting detailed on the following page illustrates a meeting where sharing how staff felt emotionally actually helped to establish stronger relationships.

Case Study – The Relatives Meeting

We invited relatives and friends of residents in Carnbroe to attend a meeting to hear more about the Enhancing Dignity project. An aim of the meeting was to invite relatives and friends to share experiences of when communication has worked well for them in Carnbroe using emotional touchpoints (connecting emotionally). This would allow us to highlight positive aspects of communication and encourage this to happen more of the time (celebrate). As more relatives arrived to the meeting, it was challenging to ensure everyone understood the aim of the meeting and the use of the emotional touchpoints. While the use of emotional touchpoints (connecting emotionally) helped people to open up, the meeting became challenging for the facilitator as it lost focus on exploring communication within the Carnbroe Care Centre. Relatives expressed increasing frustration with aspects of care within Carnbroe such as issues relating to missing laundry.

It was interesting that one relative felt increasing frustration when the manager had asked her to come and see the laundry to look for the missing items of their relative. An interesting point to reflect on is that some people may want this but it is important to be curious and ask (being curious, consider other perspectives, collaborate).

During the meeting, staff from Carnbroe found it hard to communicate with relatives when they were expressing frustration. At the end of the meeting the facilitator shared with the group that she found it difficult and challenging to manage the discussion (connecting emotionally). This then led to relatives asking the staff how they felt when speaking to relatives (curious). One staff member said she felt scared (courageous, connecting emotionally).

Following the meeting the facilitators reflected with the care home staff (curious). Some learning taken from this experience included that it would be beneficial to discuss agreed ways of working prior to the meeting commencing and highlight themes that will frame the meeting, such as one speaker at a time. Staff found it hard when relatives were talking about negative issues. We discussed if they would have felt brave enough to share how they were feeling to the relatives about the conversation (connecting emotionally) and they were unsure about this.



The case study highlighted a number of areas including:

- The value of using the 7 c's of caring conversations in variety of settings including managing challenging situations.
- Managing a situation such as this can be challenging for the experienced facilitator so it is important to consider how difficult this can be for less experienced facilitators and explore how the use of the 7 c's can help this.
- How connecting emotionally can open up a conversation and identify emotion in a balanced way.

The creation of an environment where people felt safe to express how they feel and were actively encouraged to do so was something that staff had not necessarily considered appropriate. There was evidence that they were beginning to recognise that if they shared their emotions that this could enhance relationships.

Photo-elicitation also highlighted the emotional aspect of caring conversations and particularly the importance in developing relationships:

(All images courtesy of NHS Education for Scotland (2012)/
<http://nes.scot.nhs.uk/education-and-training/by-discipline/nursing-and-midwifery/resources/publications/valuing-feedback-envision-cards.aspx>)

Image	Quotation
	<p>I liked this image because it reminds me of family, it is important to care for your family because they do everything for you.</p> <p>(Resident)</p>
	<p>This image made me think of a helping hand, comfort at the end of life. All staff support each other through this difficult time. Staff see the residents as family and feel emotion when they pass away. This can be difficult to contain at times but relatives understand and appreciate that staff have this connection with the residents.</p> <p>(Staff member)</p>

Be curious

This aspect of caring conversations relates to questions that genuinely seek to find out something – to wonder and be curious. It is about trying to open up conversations and suspend preconceived ideas and assumptions one might have. This involves asking questions about the feelings and experiences of others as a means of challenging existing assumptions and finding alternative approaches. The case study, ‘The Laundry’ illustrated

below explores this 'c' amongst others where being curious can help us to explore new possibilities.

Case Study – The Missing Laundry

Missing laundry is a key area of concern for some relatives. We learned from one relative that when her mother was in another home the laundry system had worked really well, but she was not sure why.

We shared this information with staff to explore with them the possibility of contacting the other home to find out what helped to make things work well in relation to the laundry issue (Celebrate).

It was interesting because when we shared this with one group of staff they smiled. When I asked them why they were smiling (Be courageous and curious) they said that they would not contact the other home – their smile was related to thinking the idea of calling another home to learn about their good practice was ridiculous.

I asked them how they would feel about calling the home (connect emotionally) and they said they would feel a bit silly and also that they were letting themselves down as this would be admitting that they were not able to tackle the issue of the laundry/admitting failure.

They believed that care homes are in competition and would not willingly give this type of information. They also felt apprehensive about how the other care home would respond to their request.

I asked them what would be the worst thing that could happen if they made this call (be courageous and curious) – having the other care home laugh at them and put the phone down was one of the responses.

We explored how they might feel if another home contacted them to ask them advice and they said they would feel quite proud. We explored whether there might be a slim chance that this is how the care home that did the laundry well might feel. They thought this was possible and felt they may feel confident enough to give the other care home a call.

This case study illustrates a number of things which include:

- The importance of exploring beliefs and attitudes underpinning action and to understand/appreciate the context in which people work. We could have just suggested that they call the home and then wondered why it had not been done.
- The need to create safe places to have meaningful dialogue about practice.
- The value of the 7 c's of caring conversations in helping people to challenge their assumptions and explore new possibilities.

Other examples of positive caring practices that related to being curious that were noticed during the discover phase included:

- Staff asking residents questions about what they like and dislike.
- Staff being humble and stating when they feel they do not carry out best practice and asking questions about how to make things better.
- Staff asking questions to find out more about the resident as a person, such as what did you used to do when you were working? What did you like about that?
- Staff taking the time to ask questions to find out how the relative and family members are.
- Student commenting on how easy it was to ask questions of staff without feeling silly.

The use of photo-elicitation also highlighted some aspects of practice that were related to the 'c' of be curious:

Image	Quotation
	<p>This image reminded me of what it felt like to be new to a care home when you are unsure of residents' likes and dislikes. It is important to know the small details that would enhance the residents' experience. When new staff members start it is important to take them under your wing, introduce them to residents and explain about what makes each resident an individual.</p> <p>(Staff member)</p>
	<p>This image reminds me of how sometimes the environment can be busy and I feel I don't have enough time to spend with residents. I would like there to be dedicated time where I can prioritise working with residents in developing memory boxes and scrap books of the residents' life. It would be nice to add to this during the residents' time in the care home as their life continues.</p> <p>(Staff member)</p>

Consider other perspectives

This involves exploring another's point of view, acknowledging that they may not hold the same beliefs as you and feeling comfortable to discuss any differences in an open way. A number of interactions were noticed that aimed to consider other perspectives:

- Staff asking relatives for their expertise to understand their perspective on what might help a resident to remain more calm.
- Staff valuing residents' needs, for example asking the resident what they took in their tea rather than asking the relative.
- Staff having open discussions about their thoughts about a recent inspection report.

The following quotation yielded from a participant using photo-elicitation also demonstrates how staff worked hard to find out about the person and consider their perspectives on what mattered to them:

Image	Quotation
	<p>This image makes me think of hope for the future for my friend (resident). It is easy to approach staff here, some things that make the staff approachable is the fact they know about the residents for example – xxxxx (name of resident) likes John Wayne films and she sometimes stays up later if a John Wayne film is on. I also like it when staff have a 'banter' with the residents.</p> <p>(Friend of resident)</p>

Collaborate

This involves talking together, involving people in decisions, bringing others on board, and developing a shared responsibility.

- Staff talking to each other when sitting at the same table during mealtimes but not excluding residents.
- Staff encouraging residents to do things for themselves by gently asking questions such as 'what would you like to do to help to get ready this morning?'

- Staff checking out with each other how they were getting on with their work and seeing if they needed a hand.
- Staff asking residents if they wanted to help them with specific tasks such as helping out in the café.

Again by using photo-elicitation, collaboration was highlighted as an aspect of conversations that work well within the Carnbroe Care Centre:


Image	Quotation
	<p>The care home is like a family, everyone looks out for each other, they are supportive and work closely together, for example the residents will let staff know if another resident isn't well – staff appreciate this.</p> <p>(Staff member)</p>

Compromise

Compromise is about striving for consensus through discussion and reflection, and involves being prepared to 'give and take':

- Staff allowing residents to eat the food in a way that they want to. One lady poured her tea onto her toast and scrambled egg and proceeded to eat this. No adverse comment was made.
- Staff responding to immediate requests for help by being realistic about when they will be able to do this. For example saying 'I will help your mum to go back to bed as soon as I can - I just have to finish giving xxx his medication'.
- Staff giving residents options. If they did not want to come to the dining room they tried to ask them a little later and if the resident still did not want to come they offered alternatives to eat breakfast elsewhere or even while on the move!
- Staff offering choices to people by being realistic if this could not be achieved at that time and negotiating how this might be achieved in the future. For example asking a resident where they would like to sit at mealtimes and after the person said they would like to sit at the window and realising there were no seats left, negotiating that they would make sure they got to the dining room early tomorrow so the resident could sit at the window.

Photo-elicitation highlighted that compromise was an important aspect of conversations within Carnbroe Care Centre:

Image	Quotation
	<p>I picked this image of a sunset but I am not sure why... I like the fact that staff don't boss me about, have a nice approach, use my first name and you can 'bargain' with them.</p> <p>(Resident)</p>

Celebrate

This involves making a conscious effort to explore what works well and why, and to let people know that their contribution is valued:

- Staff introducing a visitor to residents and saying something about them – this is xxxxx and she was an artist.
- Staff engaging in banter and humour with residents when appropriate .
- Staff giving specific feedback to one another - one staff member was able to give feedback about the thing she valued about working with another member of staff saying that he was good to work with because he knew his stuff, he was approachable, and always nice with the residents.
- Making a point to try to remember family members' names and to use these when talking to families. One relative valued the fact that staff knew the names of her children. It made her feel they mattered.
- Taking the time to capture special moments of interaction, for example through photographs and sharing these with family when they visit. Appendix 2 'Talking with Martha' is a documented example of an interaction with a resident.

The use of photo-elicitation also highlighted the importance of valuing and celebrating what works well:

Image	Quotation
	<p>This reminded me of happy times I have spent with my family – family are important to me. Some residents do not have family so staff and other residents are like family to them. You tend to spend more time with residents that don't have visitors and residents value this.</p> <p>(Staff member)</p>

Use of person centred language

The caring conversations framework does not explicitly ask us to consider person centred language – it is implicit in the framework rather than explicit. There is value in specifically noticing when this works well and feeding this back to staff so that they can be more conscious of the language they use. There were examples when staff used person centred language:

- Staff referring to a garment to protect clothing during mealtimes as a napkin rather than bib, which denotes childlike language.
- Staff referring to a person who 'wanders' around as the lady who likes to be on the move a lot of the time. The case study of 'The Wanderer' in Appendix 3 discusses how this particular example of person centred language was celebrated and informed future developments within the Carnbroe Care Centre e.g. the language poster described in Co-create phase (page 35).

Additional 'C'

It was interesting when looking across the data there were many positive care practices that related to greeting a person and giving information. They were statements rather than questions but nevertheless were valued by all participants as part of a caring conversation. An addition to the framework of caring conversations may be 'being courteous'. Examples of this from the data include:

- Staff welcoming visitors to the home warmly by saying 'Hello, how are you and can I help you?'
- Staff using the person's name when talking to residents.

- Staff giving clear explanations to residents about what was going to happen, for example when supporting a resident to be moved in a hoist.

From the observations there was also something about the way in which people communicated that was important. Whilst this particular aspect, the non-verbal behaviour, of how conversations were carried out was not necessarily captured by the Caring Conversations Framework, it appeared an important feature of life within Carnbroe Care Centre. The promotion of a calm atmosphere was often noted during data collection in the discover phase. For example:

- Staff very calm and not rushing when getting people ready for breakfast.
- Staff sitting at tables during mealtimes with the radio on at a very low level and careful selection of an appropriate channel, some talking but generally a very calm and peaceful atmosphere.

The data mapped well to the 7 c's of caring conversations. Through analysis of the data and discussions with staff an additional 'c' of be courteous was proposed. Some felt that this was already implicit in the caring conversations and others felt that this could be made more explicit. It is interesting that the 7 c's in the framework all relate to enabling deep and meaningful conversations and it could be argued that other interactions that promote social interaction and that may be more superficial are also valuable in helping to connect and promote positive relationships.

Further discussions with others using this framework in care homes will be carried out in the near future to establish whether it is important to include the 'c' of being courteous in the framework.

Envision

During this phase of the project the data from the discover phase was presented back to the participants via discussions, and displays on notice boards. We used questions to enable collective analysis of the material gathered in the discover phase. These included:

- 1) How do you feel about the data?
- 2) What has energised or excited you?
- 3) What are you noticing?
- 4) What surprises you?
- 5) What do you think was taken for granted?
- 6) What does it show about what matters to you and others?
- 7) What are you now thinking about?
- 8) What possibilities for action do you see (however small)?
- 9) What would it take to get from here to what we'd want instead?
- 10) Is there anything you could do tomorrow that would be different?

Following on from these discussions, positive caring practice statements about caring conversations were developed. These statements represented a shared vision of what participants valued and would like to see happening more of the time.

The statements have particular characteristics which are that they:

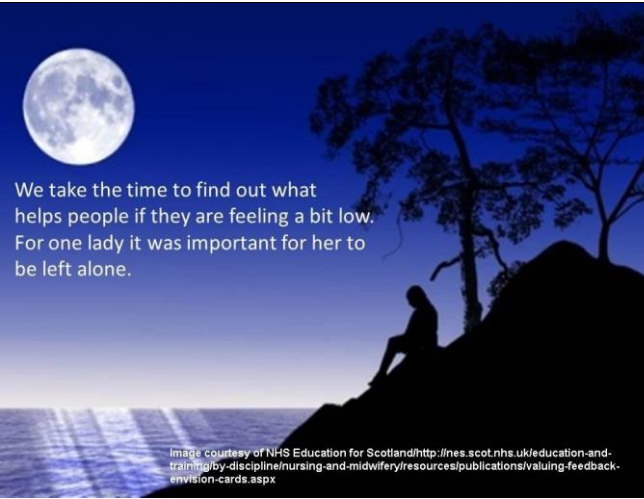
- Challenge or interrupt the current day to day reality
- Are grounded in past examples
- Are what everyone really wants
- Are bold and in the present tense as if it is happening right now

Some examples of positive caring practice statements about caring conversations from the project and their link to the 7 c’s framework (Dewar, 2011) are presented in table 2.

Positive Caring Practice Statements
<ul style="list-style-type: none"> • We make a point of approaching relatives to update them about how their loved one has been on a regular basis rather than relatives coming to find staff to ask. [Collaborate] • We enjoy having a joke and banter with residents when we feel this is appropriate. For example when residents themselves initiate a bit of fun or a joking attitude to something we respond to this with humour [Connecting emotionally] • We always try to encourage residents to do things for themselves in a gentle way and give positive feedback to indicate progress. [Celebrate] • It is important to us that residents eat food in a way that they want to. For example one lady likes to pour her tea onto her toast and scrambled egg before eating it and we make a point of not commenting on this. [Consider other perspectives and celebrate] • We value knowing about the person. For example when introducing new staff to residents we make a point of saying something about them – this is xxxxx and she was an artist. [Celebrate] • It is important to us that we hear the residents’ voice. For example we make a point of asking the resident what they take in their tea rather than asking their relative who is sitting nearby.[Curious]


Table 2: Positive Caring Practice Statements

The statements were discussed with staff and matched to images that were then displayed around the home. Harper (2002) suggests using images can stimulate different and more emotive responses than words alone and therefore this activity encouraged further discussion and co-analysis of data. An example of some of these images and statements can be found in Table 3.



We take the time to find out what helps people if they are feeling a bit low. For one lady it was important for her to be left alone.

Image courtesy of NHS Education for Scotland/<http://nes.scot.nhs.uk/education-and-training/by-discipline/nursing-and-midwifery/resources/publications/valuing-feedback-envision-cards.aspx>



We try to be courageous if we find communication challenging. We have found that sharing our feelings can help to open up conversation and point it in a new direction.

Image courtesy of NHS Education for Scotland/<http://nes.scot.nhs.uk/education-and-training/by-discipline/nursing-and-midwifery/resources/publications/valuing-feedback-envision-cards.aspx>



We always try to make a point of using person centred language. For example we refer to one resident as 'the lady who likes to be on the move a lot of the time' instead of the 'wanderer'.

Image courtesy of NHS Education for Scotland/<http://nes.scot.nhs.uk/education-and-training/by-discipline/nursing-and-midwifery/resources/publications/valuing-feedback-envision-cards.aspx>




Asking and sharing how we are feeling helps us to connect. If we do this we can encourage others to communicate in this way. We asked one relative how she felt about communicating with staff. She shared with us how she felt and asked us how we felt about talking to relatives.

Image courtesy of NHS Education for Scotland/<http://nes.scot.nhs.uk/education-and-training/by-discipline/nursing-and-midwifery/resources/publications/valuing-feedback-envision-cards.aspx>



We make sure we knock on residents doors. If they don't answer we make sure we open the door slowly and call their name out to see if it is okay to enter.

photo credit: <https://www.flickr.com/photos/periwinkled/2728259685/> via <http://photopin.com> <http://creativecommons.org/licenses/by-nc/2.0/>



We take time to find out something about the person and use this to help us connect with them and inform the care we give.

For one man we knew he loved swimming and we took him to the local baths.

For another gentleman we know he loves Scottish songs so we make time to sing these together.

Image courtesy of NHS Education for Scotland/<http://nes.scot.nhs.uk/education-and-training/by-discipline/nursing-and-midwifery/resources/publications/valuing-feedback-envision-cards.aspx>

Table 3: Images and statements

To encourage meaningful discussion of these statements that helped practitioners to reflect on practice and consider further action, we used a set of questions to support discussions. These were:

- How does the statement make you feel?
- Does it happen most of the time?
- What helps it to happen?
- How can it happen more of the time?
- What action do we need to take?
- How will we know if we are doing this more of the time?

Staff enjoyed seeing practises that they already do well celebrated in this visual way. Some staff talked about how they did not always interact in this way that was described in the statements but that now they realised that it was recognised as 'good practice' they would experiment with this way of communicating in future. A number of possible actions were discussed to help positive caring practice happen more of the time and these were further debated and developed in the co-create phase of the project.

Co-create

The outcome of the discussions held during the envision phase led to a number of developments or cycles of improvement taking place in Carnbroe Care Centre. It should be noted however that the very act of noticing what worked well and developing positive caring practice statements about caring conversations in itself was an action that resulted in enhanced awareness of these interpersonal processes. For many staff this awareness led to staff consciously engaging in this 'new way' more of the time.

For example when staff learnt that relatives valued being approached pro-actively when they visited Carnbroe, rather than finding staff to speak to them about how their relative was doing, this prompted more staff to do this.

Specific planned actions that were taken forward to enhance caring conversations in the workplace included;

1. Developing caring conversations to help to get to know the person.
2. Developing language that is person centred.
3. Developing caring conversations that help to open up dialogue with staff during supervision and team meetings.
4. Continuing to reflect and develop caring conversations in the workplace (filming).
5. Caring conversations that open up and balance discussions when relatives are concerned about issues.

Developing caring conversations to help to get to know the person.

Data from the discover phase highlighted that everyone valued getting to know the person as an individual. Staff were aware of the 'this is me' tool developed by the Alzheimer Society that aimed to help people to learn more about the person who has a dementia and decided that this may be a useful framework to systematically learn about residents as people. The manager of Carnbroe organised an action cycle where all staff were asked to use this framework of questions to engage in conversations with 2 residents who they had most contact with.

What happened during this trial was that staff had a number of concerns in using this tool. These included:

- Concern that using the question sheet resulted in a rather stilted conversation that felt like a tick box exercise.
- Feelings of uncertainty when asking some of the questions as they resulted in deep and often emotional responses that staff did not always feel comfortable to respond to.

Previous work by Dewar and Mackay (2010) highlighted similar concerns. Staff felt they would like to develop their skills of asking these questions by first trialing the tool with each other. Many of the questions would help them to learn more about each other as people.

It was interesting that staff asked us if they would be 'allowed' to experiment using the tool with each other as doing this would delay the desired outcome which was that all residents would have a 'this is me' form completed by the end of an 8 week period. They were supported by the project team to develop a strong argument for progressing with their project plan in the way that supported their own learning and development and that resulted in more meaningful conversations.

Following 'practice' of these questions with staff, staff felt that there were too many questions and that it could feel like an interrogation. Following discussions with relatives and residents it was decided to ask 2 key questions:

- Tell me a bit about the things that are important to you in your day to day life?
- How can we support you to have a good experience?

Progress with this work is ongoing.

Developing language that is person centred

In the process of observation we noticed a number of instances when people used person centred language that promoted dignity and compassion. An example of this was when a carer came into a meeting and apologised that she was late because she was helping a resident who liked to be on the move a lot of the time. We discussed this with staff and

many staff said that they had not thought of using this language and had often in the past referred to such residents as 'wanderers'.

As a result of this we developed a language poster (diagram 2) in Carnbroe where staff were actively encouraged to notice the language that was used and reflect on whether this was person centred or not. Discussions focused around celebrating language that was person centred and developing other language to make it more person centred.

An example of the developing language poster is shown below.

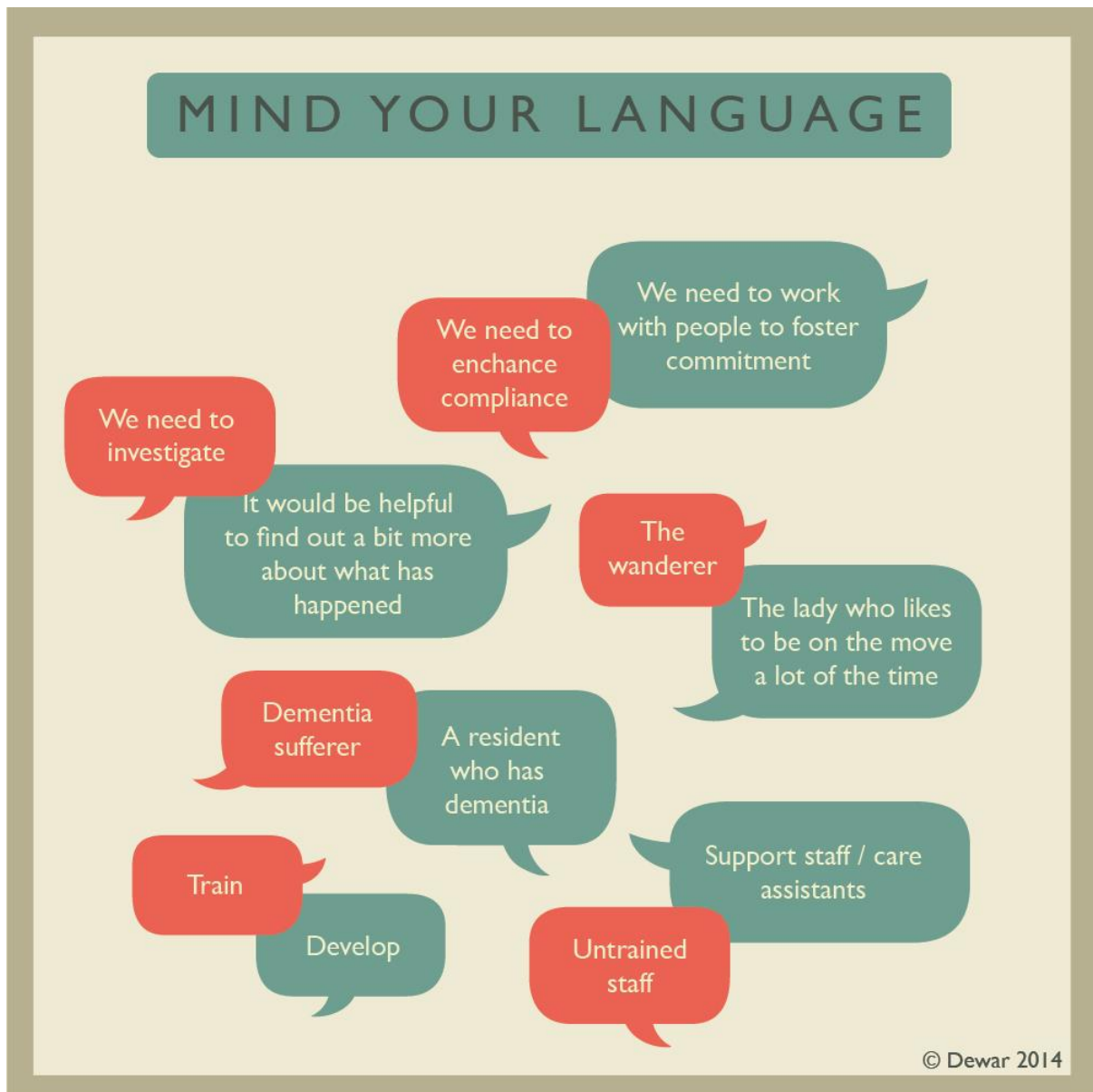


Diagram 2: Mind your language poster

Staff displayed their language poster for all to see and learn from. This in itself was a courageous act as it was openly stating to staff, relatives and residents where they had maybe not got the language they used 'right' in the past.

Through this process of noticing language staff began to critique the language that was used on notices. See the example in diagram 3 that focused on protective mealtimes.

Poster before project commenced Poster following development with staff, residents and families



Diagram 3: Protected mealtimes poster

Developing caring conversations that help to open up dialogue with staff during supervision and team meetings

The manager of Carnbroe had been a participant on the My Home Life Programme, a programme that specifically looks at developing relationships in the care home that enhance the experiences of those who live, die, work and visit the home (www.myhomelife.co.uk). Through this programme he had developed a sophisticated understanding of the caring conversations framework. During the course of the project he had begun to use images and emotional words to open up dialogue during staff supervision and at team meetings. Staff had enjoyed using the resources and felt that quieter staff contributed to meetings for the first time. They also felt that conflict was minimised in meetings as the resources helped to give conversations structure and focused on helping people to consider possibilities rather than dwelling on the negative.

Continuing to reflect and develop caring conversations in the workplace (filming)

A key part of the project was developing skills of actively noticing caring conversations and reflecting on these. The research team had modelled this through the observation process and had also used iPads to film short interactions so that staff and the researchers could view this immediately afterwards and reflect on these conversations. The reflection session

looked at which of the 7 c's from the caring conversations were evident and which could be 'notched' up.

Staff in the core project team began to use this filming method in the workplace. Although they had fun filming the interactions they often had little time to then play this back and reflect on the specific interaction. This method needs more thought if it is to be beneficial to promote reflection on practice in the future.

Reflection on caring conversations happened during shifts where staff got together to talk about what they felt had gone well that day. Thus there was more reflection on conversations happening in the workplace. This dimension of reflecting on practice had been highlighted through the culture questionnaire in the discover phase as something that could happen more of the time.

Caring conversations that open up and balance discussions when relatives are concerned about issues.

Having the confidence to engage in caring conversations, when relatives were concerned or upset about an experience, was something that staff talked about a lot. They felt that this worked well when they knew relatives and had a positive relationship with them. However, they often felt 'out of their depth' in responding to concerns in a way that did not feel defensive.

We had a number of discussions with staff about how they felt when the interaction did not work well. Staff said they felt nervous, sometimes angry if they had taken personally what the relative had said, worried that they would not know the answers and anxious that they may say the wrong thing.

The project team led a relatives meeting using emotional touchpoints to generate discussions about how relatives felt about talking to staff. The write up of this case study can be seen in the Discover phase. What was significant about this meeting was that staff encouraged relatives to engage emotionally. This in turn resulted in one of the relatives mirroring this way of interacting and asking the staff what it felt like to talk to relatives. The staff were able to share how they felt for the first time. One member of staff used the word scared. It took a great deal of courage for the staff member to share openly how she felt but this resulted in a much stronger relationship with the relative.

Embed

The embed phase of appreciative inquiry focuses on considering what we have done in the project, what have we learnt, what do we value and what further support do we need to continue to grow and develop.

As part of this phase key members of the core team were asked a series of questions to assess the above and establish whether the project could be viewed as good participatory research using the authenticity criteria refined by Nolan et al. (2003) and adapted for use in this project with more user friendly language.

The criteria are:

- **Knowing more about me:** new insights into how I tend to see things, what I take for granted and how I typically act.
- **Knowing more about others:** new insights about and amongst others on how they tend to see things, what they take for granted and how they typically act.
- **Ideas for what might change round here:** ideas for areas for positive change that each of us can do for ourselves and with each other.
- **Real change in the way we do things round here:** New ways of working for ourselves and with each other that enhance significance, purpose, achievement, belonging, continuity and security in the home.
- **Fairness and balance:** inclusion of the views of all parties to reach fair and balanced conclusions based on evidence that is convincing to us and includes any surprising or unexpected changes.

The criteria were used to develop specific questions that were asked and can be seen in Appendix 4. A group of 5 staff who had played a key role in the project took part in discussions at the end of the project.

Knowing more about me

Staff spoke of how they had learnt more about themselves as people.

I didn't realise that I don't like to ask questions. I feel uncomfortable doing this because I feel I am putting people on the spot – it's a bit of an interrogation and I don't want to do this. I have learnt how to ask questions that feel comfortable.

I feel a bit scared to share my emotions with others – I'm not there yet but am getting there.

Knowing more about others

Core staff on the project in particular talked about feeling more confident, better able to ask questions that really heard the perspective of another, being less defensive particularly if they were talking to relatives, being more curious rather than assuming their perspective was right, and better at taking the time to explore things with people rather than trying to solve problems. They also felt they made a more conscious effort to praise people and notice the good things that happen.

The project has encouraged me to listen more to residents and colleagues. I consider their point of view rather than my own.

I am still a bit nervous when approaching relatives who are not happy but I press a pause button in my head now and give myself time so I don't come across nervous and they feel that I am listening to them.

I do try to notice the things people are doing well and tell them – relatives and residents take it better from me than other staff. Other staff kind of look at me...

I have learnt things about others that I did not know.

Real change in the way we do things around here

Staff felt that those who had been more involved with the project had much new learning and had changed the way they did things. They were however not wholly confident that they could influence others. In order to do this they would need continued support from management with a shared vision of the value of caring conversations in the workplace together with a commitment to embed some of the processes into routine practice.

Three staff completed the caring conversations questionnaire that had been developed as an outcome of the project. One of the aspects that continues to be rated 'low' is the opportunity to reflect on care through discussions. With this in mind the staff thought that a good starting point to try to embed this further into daily practice was:

- Use of a diary where staff write down things that are working well and then putting positive practices on the notice board to share more widely
- Feeding back positive practices during team meetings (monthly)
- Embedding 'what's worked well' as part of a daily routine
- Sharing their poem (see page 41) as part of promoting the way we do things around here to others e.g. the induction process

Fairness and balance

Staff were uncertain and a bit nervous at the start of the project as they were not sure what the project would entail. Feedback indicated that they were able to express their views.

I felt welcomed into the project, people were friendly and didn't make me feel nervous or thick; I felt comfortable and was not anxious.

We all helped each other during the project, lending a hand. If you weren't sure about things you could ask someone for help.

For residents and families we also have some evidence that the creative methods used in the project helped them to engage.

For example at a project meeting where a resident was unable to express his views on what dignity meant to him he was invited to select an image that summed up what dignity felt like. He selected 2 images and was clearly able to convey what dignity felt like for him.

Another resident who was happy to take part in the project meetings but did not want to be in any of the films – we asked and she felt comfortable to say due to the relationship that we had built up during the course of the project.

Due to time constraints within the care home setting and staff availability it was not possible to engage with a wide number of staff to explore their learning from the project. However much of this learning was documented throughout the project and can be seen in the positive caring practices identified as well as the specific learning from some of the developments they took forward. The learning from the project was gathered throughout and was put together as a poem illustrated below.

A poem about developing caring conversations in our care centre – I used to but now I

Noticing when I am upset and being there for me in a way that is comfortable, taking the time to look me in the eye and ask me how I am, shaking my hand oh what a welcome, not bossing me about, giving me options and working together on these, knowing the things that are important to me. What is a dignified experience- these things are. This is how we define it. How can we make it happen more of the time?

Missing socks, nobody tells me why, not knowing what's going on unless I ask, not knowing what I am doing well unless you tell me, people talking over me and asking my relative things instead of asking me. Good to find out, good to ask, good to talk, good to share. Learning about others experience – the most powerful teacher.

Assumptions, assumptions, assumptions. We all make them. We could check them out.

I didn't realise that she liked to be left alone when she was feeling low
I didn't realise that staff felt uncomfortable to give praise to others
I didn't realise the relative wasn't angry with us
I didn't realise that sharing my feelings could open up conversations

Checking out assumptions. There's an element of surprise. Keeps us on our toes. Stops us thinking about how we want to be cared for and makes us **ask** about how you want to be cared for. Understanding the important things that matter to you. This is a dignified experience; this is how we define it.

Knowing how people are feeling helps us to connect. Feelings can be scary. Exploring feelings can feel like taking a risk, it takes courage. It feels brave to share our feelings
Learning that if a person says they feel proud, belittled, comfortable, sad or privileged, this is real and cannot be disputed.

What matters to you, How do you feel What do you think about that, why do you do that, what are you going to do now, how do you feel about that, what helps you to do that?
Asking questions, listening, sharing. No time to ask questions **make** time to ask questions. Without this we can't reflect and develop.

Where am I now?

I used to call people wanderers I describe these people as those who like to be on the move a lot of the time

I used to hide when relatives came into the care home now I go out and greet them and ask them questions about how **they** are

I used to worry about sitting talking to residents. Now I know it is legitimate. I make time to do this now

I used to tell people what they were not doing well now I commend people for things they are doing well

I used to be afraid of asking questions, I thought it was an interrogation, now I know that asking questions can be positive and it helps people to feel valued and heard
I used to try to fix things if there was a problem – now I ask questions like ‘what do you think would help’ to encourage others to come up with solutions that are often better than mine
Taking the time to have caring conversations turns phrases like engagement, participation and being heard into reality.
It takes courage to ask – be brave – it makes a difference to all of us.

Other initiatives that were taken forward to help to embed and sustain the developments more widely in the organisation

1. Development of an educational programme to enhance developing caring conversation in practice using appreciative inquiry (<http://myhomelife.uws.ac.uk/scotland/positive-caring-practices/>). This educational resource includes video footage generated in the Carnbroe Care Centre to illustrate key methods of engaging in caring conversations. In addition it provides resources such as emotional touchpoints, images and the positive inquiry tool for staff to use to both explore what conversations work well in the care home and to open up dialogue during interactions.
2. Development of a caring conversation profile that could be used by staff in care homes to profile how well people feel interactions happen (see Appendix 5).
3. Creation of a poem (see above) made into a digital story that highlighted staff reflections on the process of the inquiry as well as what they felt they had achieved and their aspirations for continuing to develop their practice. The digital story can be accessed through the educational resource (<http://myhomelife.uws.ac.uk/scotland/embed/>).

Conclusions

The appreciative inquiry enabled the project team to explore the experiences of caring conversations within the care home from a range of different perspectives. There were many examples of positive interactions that mapped well to the caring conversations framework. Social conversations that were statements to either welcome people or for providing explanations were another elements of caring conversations that could be embedded into the framework. The approach of appreciative inquiry helped staff to take a closer look at their conversations and to openly appreciate those that were valued and seemed to have a positive outcome. These practices became identified as positive caring practices that were shared more widely in the home. This helped staff to be more conscious of these positive ways of interacting. A number of methods were used to promote

exploration of caring conversations which in themselves became the methods staff began to use to enable them to develop caring conversations more within the home. The experiences shared by participants, methods tried and outcomes of this project have been developed into an educational resource. Indeed the very approach of appreciative inquiry is what is suggested as an appropriate model for enhancing caring conversations in care homes. Time constraints and change of management did not enable us to fully test out the educational intervention and this would be recommended as a next step.

Caring conversations are crucial to developing relationships within the home that help to promote a dignified and compassionate experience for all. Further development of these conversations requires a commitment to the value of these in the overall vision of the home and the commitment of senior leaders to see this aspect of practice as equal importance to other practices that may be more closely monitored and thus afforded priority. Staff found many aspects of caring conversations challenging and felt that they needed further support to be able to feel truly comfortable with this aspect of their role. The priority caring conversations is given within the home and the educational resource may go some way to supporting staff but further educational opportunities need to be considered in supporting staff with this complex and skilled area of their practice.

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Appendix 1: Culture Questionnaire

CARE Profile (STAFF)

Date: _____

Grade/Band _____

Time in post (*years/months*) _____

As part of the 'Enhancing dignity through caring conversations project' we would like to invite you to complete this questionnaire to enable us to develop a profile of what staff think about the culture of the care home. In other words it is about finding out how people perceive the 'way things are done around here'.

The questionnaire will help us to understand something about the culture of your area. It will highlight aspects that staff feel are working really well and other areas that may need some development.

We will gather and collate this information to enable us to work together to:

- Feedback the results to you, your manager and other key staff within your team with a view to supporting us to consider future developments
- Gain valuable feedback about the responses to the questionnaire prior to and after the project

The questionnaires are anonymous.

In this questionnaire, you are asked to consider how often certain events happen in your area where you work. Please use the five-point scale provided to show how often each event has occurred over the last month. If you think something doesn't apply to you, or if you don't know the answer, please circle **N/A** (not applicable) or **Don't know**.

Please try to answer each statement as honestly as possible based on your actual experiences over the last month. All information gathered is confidential and will therefore not affect your work standing in any way.

Section 1

	Item	Response (Circle)						
1	In the last month, did you have all the information you needed to care for residents?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know
2	In the last month, did staff work together as a team?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know
3	In the last month, were staff friendly to residents and families?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know
4	In the last month, did other staff provide prompt assistance when you needed help?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know
5	In the last month did you have time to reflect on care with the team?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know
6	In the last month have you spent time with others to figure out ways to improve care?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know
7	In the last month, did residents look comfortable after staff had provided care?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know
8	In the last month, were you kept informed about things that affect the care home?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know
9	In the last month, did staff use safe moving and handling techniques?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know
10	In the last month, could you deliver care without being distracted?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know
11	In the last month, did it feel safe to bring up problems or tough issues?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know

	Item	Response (Circle)								
12	In the last month, were suitable clinical supplies available when you needed them ?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
13	In the last month, were you confident about the competence and abilities of other team members?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
14	In the last month, were you able to protect yourself (and your clothes) from body fluids and clinical waste?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
15	In the last month, was the care home fully staffed for each shift?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
16	In the last month, did staff have the skills to provide the care that residents needed?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
17	In the last month, did you feel able to influence the way things happen in the care home?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
18	In the last month, were you able to attend to residents without feeling rushed?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
19	In the last month, were you confident about the competence and abilities of other team members?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
20	In the last month, were you confident about your own competence and abilities?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
21	In the last month, were you self-motivated to learn new things?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
22	In the last month, were all staff equally valued?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		

	Item	Response (Circle)								
23	In the last month were differences of opinion between staff handled well?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
24	In the last month, did you have opportunities to discuss the care of residents with other staff during each shift?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
25	In the last month, were misunderstandings between staff effectively resolved?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
26	In the last month, were colleagues approachable if you needed advice?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
27	In the last month, were you able to talk to your colleagues in confidence?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
28	In the last month were you able to challenge your colleagues about issues without fear of being rejected	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
29	In the last month, were you encouraged to use your initiative at work?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
30	In the last month, were you given sufficient notice of future off-duty commitments?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
31	In the last month, were the staff you were working with familiar to you on each shift?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
32	In the last month, did other staff openly appreciate your work?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
33	In the last month were you able to make the residents you care for comfortable	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		
34	In the last month were you able to really count on others to help out when things were difficult techniques?	Never	Rarely	Sometimes	Usually	Always	N/A	Don't Know		

Now that you have completed section 1 of the questionnaire, think about the questions and answers that stood out for you. It would help us if you could give more information about these. In particular if you were able to share some examples or comment about why you felt this way.

Section 2

These questions concern how you are able to do your job.

	Item	Response					
1	In the last month I have felt comfortable to discuss differences in opinion in an open way	Never	Rarely	Sometimes	Usually	Always	N/A or Don't know
2	In the last month I have consulted residents about changes to their treatment	Never	Rarely	Sometimes	Usually	Always	
3	In the last month I have taken time to get know residents as individuals	Never	Rarely	Sometimes	Usually	Always	
4	In the last month I have regularly discussed residents' progress with them	Never	Rarely	Sometimes	Usually	Always	
5	In the last month I have provided continuity of care for residents	Never	Rarely	Sometimes	Usually	Always	
6	In the last month I have encouraged residents to get to know one another if appropriate	Never	Rarely	Sometimes	Usually	Always	
7	In the last month I have actively asked residents and relatives if they would like to be involved in the resident's care	Never	Rarely	Sometimes	Usually	Always	
8	In the last month I have encouraged residents' to express opinions about their care	Never	Rarely	Sometimes	Usually	Always	
9	In the last month I have encouraged residents to talk about things that might be worrying for them	Never	Rarely	Sometimes	Usually	Always	
10	In the last month I have shown genuine concern and courtesy toward residents, even under the most trying situations	Never	Rarely	Sometimes	Usually	Always	
11	In the last month I have made sure I always make visitors feel welcome	Never	Rarely	Sometimes	Usually	Always	
12	In the last month I have tried hard to see things from the resident's perspective, even if I don't really get on well with them	Never	Rarely	Sometimes	Usually	Always	
13	In the last month when a resident or relative has views that contrast with my own, I have tried to understand why they think as they do	Never	Rarely	Sometimes	Usually	Always	

Now that you have completed section 2 of the questionnaire, think about the questions and answers that stood out for you. It would help us if you could give more information about these. In particular if you were able to share some examples or comment about why you felt this way.

Section 3

The following words describe different feelings and emotions.

Thinking of the past month, how much of the time have you felt each of the following:

Over the last month I have felt...

Item	Response (please circle)				
Relaxed	Never	Rarely	Sometimes	Usually	Always
Miserable	Never	Rarely	Sometimes	Usually	Always
Depressed	Never	Rarely	Sometimes	Usually	Always
Optimistic	Never	Rarely	Sometimes	Usually	Always
Calm	Never	Rarely	Sometimes	Usually	Always
Tense	Never	Rarely	Sometimes	Usually	Always
Worried	Never	Rarely	Sometimes	Usually	Always
Enthusiastic	Never	Rarely	Sometimes	Usually	Always
Anxious	Never	Rarely	Sometimes	Usually	Always
Comfortable	Never	Rarely	Sometimes	Usually	Always

Is there anything you would like to add about the experience of working here?

Now that you have completed section 3 of the questionnaire, think about the way you feel when you are at work. It would help us if you were able to give us more information about the reasons why you felt some of these emotions.

Thank you for taking the time to complete this questionnaire

Section 1 Developed by M. Faulkner & S. Davies, (2004). The University of Sheffield, UK. Adapted by Dewar 2012

Email: m.w.faulkner@sheffield.ac.uk

Section 2 and 3 adapted by Dewar and Cook 2012 from Patterson et al (2010) SDO

Appendix 2: Talking With Martha



I approached Martha and started to talk to her about the birds in the cage. She stopped me and said excuse me I don't know who you are, who are you? I felt a bit embarrassed that I had not introduced myself right away. I said my name was xxxx and she said I could call her Martha.

I asked her the names of the birds –Joey and Bluey she said. She had her hand in the cage, palm upright and Joey was sitting on her hand eating seeds. She said to me 'you look scared'. I said I did feel a bit scared and that I was not sure I would feel able to put my hand in the cage. She said go on I'll help you. She helped me to put some seeds on my hand and held my hand to put it in the cage.

Martha then recited some poetry. I asked her where the poem had come from and she said she had written it. She told me that she had worked in a University teaching English. I asked her if she might write a poem for me and she said what about. I said it would be lovely to have a poem about relationships and caring. She said – not relationships and caring at Carnbroe – and then said only joking and laughed and said it was very good living here.

She went on to talk about other things and we talked about the ward and family. She said she had nobody to visit her now. I asked her where she was from and she said Cove and proceeded to try to explain to me where this was. I could not understand as I don't know places through the West. I asked her if there was an atlas here and she said no. I said I would go and try to get one.

I came back with my iPad and we looked at the map where Cove was, and she talked to me more about Loch Long and how to get there.

I asked her if she would mind if I took her photograph – she seemed pleased about this and posed in front of the birds. She then asked me if she could buy the picture from me – I said I would bring it in for her next week.

I really enjoyed the conversation and felt that Martha gained a sense of purpose in helping me with the birds, a sense of continuity where we were looking back at where she was from, a sense of significance in that her conversation mattered.

We had fun and laughed.

It made me think about the 'every moment counts initiative' and how we can strive in our conversations with people to achieve the senses of belonging, continuity, significance and achievement together.

Appendix 3: Case Study: The 'Wanderer'

Case Study – The 'Wanderer'

The use of language is an area of positive practice we highlighted through our observations at Carnbroe. The term 'the wanderer' is sometimes used in healthcare to describe individuals often who are living with dementia. During one meeting when the project was being introduced, a member of staff arrived a few minutes late. She explained she was assisting a resident who 'liked to be on the move all the time'. This was highlighted to the group as a positive caring practice (celebrate). Some members of staff at the meeting indicated that we did often use the term wanderer (courageous) but this discussion encouraged them to consider use of different terms in future (consider other perspectives). This informed a 'mind your language' poster to highlight positive care practices encouraging people to use person-centred language more of the time.

This also guided future conversations. For example when working with a member of staff one day, they described a resident as a 'wanderer'. We used this example of person centred language used by their colleague (celebrate, courageous) in order to consider different ways you might describe residents thereby encouraging a dignified person centred approach (consider other perspectives). The staff member discussed that this was a nicer way to describe 'the wanderer' (celebrate).

This case study illustrates a number of things which include:

- The importance of adopting an appreciative stance to identify positive areas of practice
- The power of illuminating positive areas of practice to facilitate staff to practice these more of the time
- The value of the 7 c's of caring conversations in helping people to challenge their current practices and explore new possibilities.

Appendix 4: Criteria for assessment

Knowing more about me

New insights into how I tend to see things, what I take for granted and how I typically act

- What have you learnt about yourself?
- How has this learning influenced the way you think/do things now?

Knowing more about others

New insights about and amongst others on how they tend to see things, what they take for granted and how they typically act

- What have you learnt about others?
- How has this learning influenced the way you interact/do things with others?

Ideas for what we might develop round here

Ideas about areas for development that each of us can do for ourselves and with each other.

- What ideas have been stimulated for development with you and your teams?

Real differences in the way we do things round here

New ways of working for ourselves and with each other that enhance the sense of significance, purpose, achievement, belonging, continuity and security for everyone.

- What evidence is there that developments have enhanced the senses/made an impact?

Fairness and balance

Inclusion of the views of all parties to reach fair and balanced conclusions based on evidence that is convincing to us and which includes any surprising or unexpected developments.

- What has it felt like to be involved?
- Can you tell me a bit about a time when you felt that your opinions were listened to and valued in this programme?
- How did you enable the opinions of others to be heard and valued?
- What unexpected or surprising elements did you notice?

Sharp and Dewar 2014 -These are adapted from Guba, E.G., Lincoln, Y.S. (1989) Fourth Generation Evaluation. Newbury Park: Sage, pp245-250 and Hanson, E., Magnusson, L., Nolan, J., and Nolan, M (2006) Developing a model of participatory research involving researchers, practitioners, older people and their family carers: An international collaboration, *Journal of Research in Nursing* Vol 11(4) 325–342 and Devised by Nolan, M.R., Hanson, E., Magnusson, L., Andersson, B. (2003) Gauging quality in constructivist research: the ÄldreVäst Sjuhärad model revisited. *Quality in Ageing — Policy, Practice and Research* 4:2, 22–27.

Appendix 5: Caring Conversations Profile

CARING CONVERSATIONS IN THE WORKPLACE

STAFF QUESTIONNAIRE

Instructions: Please take 10 minutes of your time to complete this questionnaire. Be as honest as you can and put a tick in the square that you think best describes each of the following items in relation to how you believe they represent the caring conversations that happen in your care environment.

	This is a feature of care in this care home			
	Most of the time	Some of the time	Not very often	Don't know
1. Staff openly appreciate my work				
2. I use person centred language, such as the person with dementia rather than dementia sufferer				
3. We regularly have reflective discussions about the experience of caring within the care home				
4. I feel comfortable talking about end of life issues				
5. Colleagues are approachable if you need advice				
6. I can discuss confidential matters with colleagues				
7. I regularly notice what people do well and give praise to them about these things				
9. I do not assume that what I think is right or the best way – I try to consider the				

	This is a feature of care in this care home			
	Most of the time	Some of the time	Not very often	Don't know
perspectives of others				
11. We regularly seek help and advice from other experts when it is required including the a resident's relatives				
12. I collaborate with residents and families to develop the service				
13. I involve residents and families in issues that affect their care				
14. People are actively encouraged to challenge practices within this care home				
16. All are equally valued in this home				
17. People are supported to express their views in the care home				
18.I feel confident to challenge when the vision of person centred care is breached				
20. I find out what really matters to people and share this knowledge with others				
21.I know information about what helps people to feel content				
22.I know information about what helps people if they are feeling low				
27. I regularly ask families how they are feeling and if have they any questions				
28. I feel comfortable to share with others how I feel				
30. I feel able to put forward a case for				

	This is a feature of care in this care home			
	Most of the time	Some of the time	Not very often	Don't know
change based on local knowledge				
31. I check out what people would like to be called				
32.I take time to get to know staff as people				
33. I feel comfortable to discuss differences of opinion in an open way				
34. I consult residents and families about any changes to their care				
36. I ask questions to learn about what matters to family members				
37. I actively ask patients how they would like to be involved in care				
38. I actively ask relatives how they would like to be involved in care				
39.I feel comfortable to encourage residents to talk about things that may be worrying them				
40.I show genuine concern and courtesy toward residents, even under the most trying situations				
44.I make sure I always make visitors feel welcome				
45.When a resident has views that contrast with my own, I try to understand why they think as they do				
46.When a relative has views that contrast with my own, I try to understand why they think as they do				

	This is a feature of care in this care home			
	Most of the time	Some of the time	Not very often	Don't know
47. I recognise and seek support for the emotional demands of my role				
48. I feel able to provide a clear justification for why things are done the way they are				
50. I support people by starting from where they are at, rather than imposing my starting point				
51. Staff in this unit try to see possibilities rather than joining in the negative talk				
52. I feel comfortable to give praise to others				
53. I regularly ask others how they feel about a particular situation				
54. I feel confident to negotiate what is possible when a person's aspirations may not be able to be met				
55. I know what people's strengths are				
56. I am clear about what is valued in the care home				

Now that you have completed the questionnaire, think about the questions and answers that stood out for you. It would help us if you could give more information about these. In particular if you were able to share some examples or comment about why you felt this way.

