Edinburgh Napier UNIVERSITY

Leadership in Compassionate Care

Third International Conference on Compassionate Care

Conference Handbook

June 2012

NHS Lothian

Edinburgh Napier University
and NHS Lothian

Third International Conference on Compassionate Care, Sighthill Campus, Edinburgh Napier University, EH11 4BN

Day 1, Wednesday 27 June 2012

Time	Activity	
0815-0900	Registration and coffee	
0900-1100	**Opening session and keynote presentation** Launch of the Leadership in Compassionate Care Programme Final Report, Dr Stephen Smith, Ria Tocher, Annette Mohadeb, Jacqui Brodie, Gillian Napier, Alison Macdonald Time with the Clown Doctors **Keynote Presentation:** Dr. Susan Frampton, President of The Planetree Foundation, USA. Title of keynote: Connecting a Culture of Compassionate Care to Improved Quality Outcomes	**Chairperson:** Iain McIntosh Dean of the Faculty for Health Life and Social Science, Edinburgh Napier University
11:00-11:30	Tea and coffee	
1130-1300	**Session 1** Workshops **Energising for excellence in compassionate nursing care,** Claire Chambers **Compassion in practice,** Craig Brown	Round table presentations 1. **Compassion in healthcare: views of students and qualified staff,** Dr Mary O'Brien, 2. **Medical education for compassion and service – beyond acquisition of knowledge and skills,** Barbara Hrovatin 3. **Care and Compassion in Healthcare Education – getting the message across to the public,** Ms. S. Elizabeth Robson 4. **The CARE Measure and the CARE Approach: assessing and enhancing the 'human' aspects in healthcare encounters,** Annemieke Bikker 5. **Evaluating caring interventions and finding a reliable, nurse-reported measure of caring behaviour,** Carina Hibberd 6. **Putting the Person in Patient,** Nicola Cotter 7. **Staff feedback in action within a School of Nursing,** Liz Adamson and Linda King 8. **Inspiring hope through a compassionate framework,** Mary Prendergast 9. **Developing a structure of compassionate care to support staff,** Richard Mackay

Time	Activity	
1300-1400	Lunch	
1400-1500	**Session 2** Workshops **Energising for excellence in compassionate nursing care,** Claire Chambers **Compassion in practice,** Craig Brown	Round table presentations 1. **The contribution of Schwartz Center Rounds to a compassionate hospital culture®,** Joanna Goodrich 2. **Keeping compassion alive on the ward,** Annette Mohadeb 3. **They are having a Laugh – Starting a Laughter Yoga club for staff and students – some early thoughts,** Martin Gaughan 4. **Fostering Person-Centred Care – a model for co-creating interactive learning days in NHSScotland Healthboards,** Ewan Kelly 5. **The compassionate organisation – lessons from America,** Dr Belinda Dewar 6. **Working with patients and families to produce a person centred environment: the ward becomes a home,** Gillian Napier
1515-1700	**Keynote presentation** Reflections about compassion, Student Nurses, Edinburgh Napier University Time with the Clown Doctors **Keynote presentation** Alistair Pringle Head of Patient Focus & Equalities Title of keynote: Achievements and ambitions – person centred care	**Chairperson:** Emeritus Professor Morag Gray, Edinburgh Napier University
1930-late	Conference Gala Event	Edinburgh Napier Craiglockhart Campus, Glenlockhart Road, EH14 1DJ

Day 2, Thursday 28 June 2012

Time	Activity	
0815-0900	Registration and coffee	
0900-1100	**Keynote presentation** Reflections about compassion, Student Nurses, Edinburgh Napier University Time with the Clown Doctors **Keynote Presentation:** Dr Robin Youngson, Founder of Hearts in Healthcare, Honorary Senior Lecturer, Department of Psychological Medicine at The University of Auckland, New Zealand. Title of keynote: HEARTS in HEALTHCARE	**Chairperson:** Pat Dawson Associate Director of Nursing, NHS Lothian
11:00-11:30	Tea and coffee	
1130-1300	**Session 3** Workshop Dr Susan Frampton: Planetree International Designation	**Round table presentations** 1. **Embrace people, enjoy what you are doing, work with them without an agenda': Lessons Learned from the Leadership in Compassionate Care Programme**, Juliet MacArthur 2. **Compassionate/Relationship Centred Care delivery in a Primary Care Setting: A Pilot study with community nursing staff**, Dr Janette Pow 3. **Supporting staff wellbeing to enhance patient centred care**, Bev Fitzsimons 4. **Exploring staff experience of providing Compassionate Care through their Audio Diaries**, Steven Edwards 5. **Enhancing compassionate care on the island of Crete, Greece: a report on current initiatives from the University of Crete (UoC)** Sue Shea 6. **Essential Conversations**, Jenny Henderson 7. **Where does our knowledge of compassion come from? Can we learn anything from the modern media about compassion?** Robin Wynyard 8. **Unlocking compassionate creativity to make the best use of organisational resources**, Valerie Iles, 9. **A Visible Outcome for Compassionate Care**, Linda Jane McLean

Time	Activity	
1300-1400	Lunch	1300-1320 Laughter club available
1400-1515	'Goldfish bowl discussion' A discussion, question and answer session A panel will discuss the key themes of the conference. Members of the audience will watch and listen to the goldfish bowl discussion and have the opportunity to ask questions.	
1530-1700	**Keynote presentation** Reflections about compassion, Student Nurses, Edinburgh Napier University Time with the Clown Doctors / Elderflowers **Keynote presentation:** Professor Heather Tierney-Moore, OBE, Chief Executive of Lancashire Care NHS Foundation Trust Title of keynote: "Creating a Compassionate Organisation" – Volume 1	**Chairperson:** Dr Jayne Donaldson Head of School of Nursing, Midwifery and Social Care, Edinburgh Napier University

Dr. Susan Frampton

Keynote Presentation

Dr. Susan Frampton is the President of Planetree and has worked with the organization for over a decade. Planetree is a not-for-profit consultation and membership organization, working with a growing network of hospitals and continuing care communities around the world to implement Planetree's comprehensive patient-/resident-centered model of care, resulting in improvements in both clinical and operational outcomes.

Dr. Frampton has authored numerous publications, the most recent including a series on patient-centered care in the American Journal of Nursing, the International Health Federation Journal, Patient-Centered Care Improvement Guide, a web-based document that has been downloaded over 30,000 times, and the edited collection Putting Patients First, Second Edition (Jossey-Bass Publishing, 2008). The first edition of Putting Patients First (Jossey-Bass Publishing, 2003) won the ACHE Hamilton Book of the Year Award in 2004.

Dr. Frampton is a member of the National Quality Forum's National Priorities Partnership, identifying strategies to improve safety, quality and patient-centered outcomes for the U.S. Healthcare System. She has participated on The Joint Commission's Expert Advisory Panel on culturally competent patient-centered care standards, the National Quality Forum's Care Coordination Steering Team and the Institute of Medicine's review panel for their 2009 publication on integrative medicine.

In addition to speaking internationally on culture change, quality and safety, and the patient experience, she has presented keynotes on designing patient-centered practices in acute care, continuing care, and ambulatory medicine settings for the Healthcare Design Symposium, Veterans Health Administration and the World Health Organization. Additionally, Dr. Frampton was honored in 2009, when she was named one of "20 People who Make Healthcare Better" by Health Leaders Magazine.

Dr. Frampton serves as a faculty member for the Interagency Institute for Federal Health Care Executives (Arlington, VA) each year, and speaks internationally on the connections between patient-centered care, quality and patient safety.

Connecting a Culture of Compassionate Care to Improved Quality Outcomes

Since the Institute of Medicine identified patient-centered care as one of the six aims of a quality healthcare system in 2001, the phrase "patient-centered care" has reverberated around the globe and has become identified as a key strategy to improve the quality and humanity of care delivery. There is a growing awareness of the imperative to better address the human needs of individual patients as well as the communities we serve, and to tie resources to this priority. Moving from concept to reality is a significant challenge however; that challenge begins with creating a foundation for a compassionate organizational culture at all levels. This session will explore the relationship between patient-centered care, organizational culture, quality, and patient experience practices and outcomes. Planetree has worked with hospitals, long-term and ambulatory care settings around the world who have implemented the Planetree philosophy, a comprehensive patient and family centered model of care focused on kindness, caring and respect. International examples of the impact of cultivating compassion in practice will be shared.

Alistair Pringle

Keynote Presentation

Head of Patient Focus & Equalities. Directorate of the Chief Nursing Officer, Patients, Public & Professions.

Alastair has responsibility for the development of national policy on a range of person-centred health and care programmes across NHSScotland, including: implementation of the Patient Rights (Scotland) Act 2011; delivery of NHS inform, Scotland's National Patient Information Service, and; ensuring equality and human rights requirements are met across the health sector.

Alastair joined the Scottish Government in April 2005, following 17 years working in the NHS, working on a range of health improvement and community development initiatives with marginalised and excluded groups.

Achievements and ambitions – person centred care

The Scottish Government have made good progress on the effectiveness, efficiency and timeliness of care and we know that from our recent surveys on Patient Experience across the NHS that most people have a good experience when they use our health services. However, when people have poor experiences it is often to do with poor communication, or not being treated with dignity and respect. Our person-centred ambition is about the best possible quality care and treatment that centres on the needs of patients, not staff rotas or efficiency targets. Person-centred care means that patients are 'people' first and foremost as well as individuals with healthcare needs which require the care and treatment provided by NHS Scotland's professional healthcare and support staff.

To deliver on this ambition the Scottish Government have been working with health, local authority and third sector partners to develop their proposals for the establishment of a National Person-Centred Health & Care Programme. The Programme will provide coherence to the range of initiatives and programmes currently underway and provide a framework to align and add value rather than continuing with a disparate set of initiatives. The aim of this programme is that by 2015 all relevant health and care services are centred around people evidenced through improvements in:

- Care Experience;
- Staff Experience;
- Co-Production.

Dr Robin Youngson

Keynote Presentation

Robin is an anaesthetic specialist in New Zealand who is devoted to strengthening caring and compassion in healthcare. He is the founder of HEARTSinHEALTHCARE.com, a global social movement for health professionals, students, patient activists and all those passionate about re-humanising healthcare.

Robin was a founding member of the national Quality Improvement Committee in New Zealand and was the NZ representative on the WHO International Steering Committee for Patient Safety Solutions. He also helped launch the WHO strategy for "People at the Centre of Healthcare" in 2007. He is an honorary senior lecturer at Auckland University and is the author of the newly published book "**TIME TO CARE – How to love your patients and your job**"

HEARTS in HEALTHCARE

A new global social movement for the re-humanisation of healthcare" Dr Robin Youngson, the Founder of HEARTSinHEALTHCARE.com, shares his vision of a transformed healthcare system, and news of the latest developments in the worldwide social movement that aims to place compassion and caring at the centre of healthcare. Drawing on the latest evidence from neuroscience and positive psychology, Robin explains how reconnecting to the heart of practice is the pathway to happiness, wellbeing and resilience for health professionals, and enhanced outcomes for patients.

Professor Heather Tierney-Moore

OBE, MSc, RGN

Keynote Presentation

Currently Chief Executive, Lancashire Care NHS Foundation Trust, a large health and wellbeing trust employing 7000 staff providing a wide range of community services and specialist mental health across Lancashire. Previously was the Nurse Director for NHS Lothian Board and Chief Operating Officer for Mental Health Services across Edinburgh. Whilst in Lothian she jointly established the Centre for Leadership in Compassionate Care between NHS Lothian and Edinburgh Napier University. Prior to that, she was Chief Nurse at Sheffield Teaching Hospitals NHS Foundation Trust.

She has a distinguished track record at Board and National level in England and Scotland with particular expertise in quality improvement, leadership, governance and culture change.

Visiting Professor at Edinburgh Napier University. Honoured by the Queen for services to nursing in 2001.

"Creating a Compassionate Organisation" – Volume 1

Heather will share the story of her experiences of trying to apply an appreciative and values based approach across a complex and diverse Health and Wellbeing Trust in order to ensure high quality compassionate care a service and individual level. Drawing on a range of evidence and experience including the work within the Centre for Leadership in compassionate Care she will describe and reflect on a journey which still has a long way to go but is making a real difference.

Round table discussion Session 1

Day 1

Leadership in Compassionate Care

Compassion in healthcare: views of students and qualified staff

Author

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Co-authors

Dr Lucy Bray, Senior Research Fellow, Edge Hill University & Alder Hey Children's NHS Foundation Trust.

Kate Zubairu, Senior Lecturer, Edge Hill University

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Background

Compassion is recognised as a core value in nursing and the health service (NMC 2010; DH, 2012). Within the literature various definitions of the concept of compassion exist which require exploration on how these understandings translate into the clinical and educational context.

Methods

This was a mixed methods study, collecting data from a wide range of health professionals using questionnaires and interviews. The study aimed to understand and explore the concept of compassion in health care delivery and education.

Sample

Competed questionnaires were returned by 351 respondents (190 pre-registration health students and 161 qualified healthcare practitioners) recruited through a University in the Northwest of England. Fourteen students and qualified staff were interviewed.

Analysis

Questionnaire survey responses were analysed to produce descriptive statistics; free text responses were subject to content analysis. Qualitative interviews were analysed thematically.

Results

Quantitative phase: Respondents' views of compassion in health care were strikingly similar. Acting with empathy, respecting dignity, being attentive and active listening were seen as the most important characteristics of a compassionate practitioner. Time and the commitment of health care organisations were major factors which influenced the delivery of compassionate care.

Qualitative phase: Compassion was described as '*going beyond*', seeing the patient as an individual not a condition, and doing the '*little things*' that made a difference. Compassion was seen to be inhibited by a '*business model*' approach to health care. Compassion was reported as difficult to teach but positively influenced by good role models within practice.

Conclusion

Providing compassionate care is important, however, there are factors which promote or hinder its delivery. There seemed to be some consensus regarding the nature of compassion in clinical practice. Despite this, the extent to which compassion can be learnt or taught and the use of role models to facilitate this process was debated.

Three critical questions you would like the audience to consider

- What conditions/ factors are required for compassionate care to be developed and maintained in clinical practice?
- How is compassionate care conveyed in clinical practice?
- Can compassionate be taught? If so how?

References

Nursing and Midwifery Council (NMC) (2010) Standards for Pre-Registration Nursing

Department of Health Education (DH) (2012) The NHS Constitution

Medical education for compassion and service – beyond acquisition of knowledge and skills

Author

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As health care professionals struggle to meet increasing, and often conflicting, patient care and health systems demands, there is renewed interest among medical educators for pedagogical methods to strengthen both experienced physicians and physicians-in-training in maintaining personal humanity and professional commitment.

The pressures of contemporary practice may require us to broaden our customary educational objectives and goals, to help students develop the capacity to find lifelong meaning in the same systematic way we now foster the skills to maintain a current knowledge base and technical expertise.

Beyond the acquisition of knowledge and skills, professional identity formation is also central goal in medical education. Professionalism includes technical, intellectual and cognitive competencies as well as deeper issues of humanism and values. The Healer's Art is an elective course in professionalism. It was founded by Rachel Naomi Ramen, MD, at UCSF (1992) on the concept that community of shared values and safety can enable students to discover and strengthen the core values underlying scientific medicine and the profession itself.

The Healer's Art is an innovative medical elective, a process-based curriculum, which enables the formation of a community of inquiry between students and faculty, exploring core values and meaning underlying scientific medicine. These two mutually supportive learning communities; medical students, and practicing physicians, join in a discovery model that encourages honest and mutually respectful sharing of experience, beliefs and personal truths, enabling both groups to perceive and reawaken the personal and universal meaning in their daily experience of medicine.

Currently offered to preclinical medical students at 64 Medical Universities in the USA, Canada, Israel, Taiwan and Slovenia, the Healer's Art course has demonstrated similar outcomes at schools of very diverse regional cultures.

Generally outstanding evaluations show the importance of filling a curricular gap with the opportunity to explore the human dimensions of the practice of medicine and participating in an authentic community. I would like to share the Slovenian experience in leading the Healer's Art course in Slovenia and discuss numerous questions, emerging around teaching humanism in medicine, teaching values, meaning and compassion in medical curricula.

Three critical questions you would like the audience to consider

- According to your experiences, what is the state of medical education in relation to compassion in medical practice today?
- Is it possible to teach values in medical education (like compassion, service, beneficence, caring, humility, presence ...) – if yes, how?
- Are humanistic contents necessary and valid in professional formation of health care professionals (declared vs real)?
- Is it possible for innovative educational courses and learning new skills to be placed inside the same frame of medical thought?

Care and Compassion in Healthcare Education – getting the message across to the public

Author

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Lack of care and compassion has received national and local attention with sensational examples of bad care over-shadowing accounts of good care. Locally a wave of nostalgia surrounding the closure of the old school of nursing coincided with the move of nursing to an all graduate profession. Anecdotal evidence suggested that the public associate intelligence in nurses with being uncaring and vice versa.

An initiative commenced to ensure staff and students were addressing care and compassion, and to also involve the public. Initially a nursing idea, this became a cross-faculty initiative which achieved quantifiable successes.

This commenced with national "Dignity Day" on 1st February using a specially designated website, followed by two conferences run primarily for practitioners and voluntary organisations. Whilst not open to the public the public could access relevant information and watch video presentations.

An intense week of activities then occurred between international midwives day and nurses' day, to which the public were invited. There were five keynote lectures from national figures, four other activities using skills labs, graffiti walls, a discussion on faith and care in the chapel, plentiful refreshments, attendance certificates. All were free of charge apart from a cake sale which raised funds for local charities.

4,800 e-invitations were sent, and 450 members of the public, voluntary organisations, NHS Trust staff, other placement providers, lecturers, and students attended the nine events. The public could see the emphasis on care and compassion being given to staff and students, and then to converse with them later. The voluntary organisations were pivotal in this process, as they represent patients/clients and their families.

The website www.dmu.ac.uk/compassion had 3,200 hits indicating the public were still participating if not attending in person.

The presentation will outline the tactics used to generate this initiative, the challenges and successes to date.

Three critical questions you would like the audience to consider

- Is care and compassion wholly the remit of nursing?
- Is it possible to quantity care and compassion in a curriculum in a way that the public can understand?
- How could your institution engage with the public?

Specific Roles

- School Lead for community and public liaison
- Nursing and Midwifery Lead Admissions Tutor
- Module Leader – medical disorders module
- Link lecturer for a high risk pregnancy ward and a community team.

Professional Background

After staff nurse experience on medical and gynaecological wards Liz trained as a midwife and practised in where she attained a sister's post. Here she developed a teaching aid and won The Jack Kerr Memorial Award for Trent Regional Health Authority.

Her advanced diploma was attained in Bristol, educational qualifications from Nottingham, then an MSc in research methods from Loughborough University. She has been teaching student midwives continuously for twenty five years in Leicester, and was external examiner at the University of Wolverhampton.

She presented nationally and has published a number of articles and is currently editing the second edition of her textbook "Medical Disorders of Pregnancy: a manual for midwives."

Having been midwifery admissions tutor Liz became the school lead for recruitment, and after successes in this area she recently took on the role of Public Engagement Lead for the School of Nursing and Midwifery entailing initiatives such as the Square Mile Project. She recently led a faculty initiative on Care and Compassion, which will continue for the foreseeable future.

The CARE Measure and the CARE Approach: assessing and enhancing the 'human' aspects in healthcare encounters

Author

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The CARE Measure

The Consultation and Relational Empathy (CARE) Measure is an extensively validated, widely used, patient-rated experience measure of perceived empathy and person-centeredness of healthcare practitioners in the clinical encounter. It is based on a broad definition of empathy in context of a therapeutic relationship within the interaction.

The CARE Measure is included in the Quality Strategy for Healthcare in Scotland (that prioritises caring and compassionate staff and services) as a tool suitable for patient feedback for all healthcare professionals in the NHS in Scotland.

This inclusion led to further validation of the CARE Measure in more professional groups and recently, we embarked on a study investigating the validity in primary care healthcare encounters delivered by practice nurses. Also, it increased the need for resources for healthcare practitioners to learn how to facilitate and optimise the necessary skills in encounters with patients.

The CARE Approach

The CARE Approach is a multi-disciplinary learning tool that aims to foster the achievement of empathic, patient-centred interaction in healthcare encounters. It is mapped on the CARE Measure and developed for NHS healthcare staff, as part of the Quality Strategy. The tool is based on research of health and communication literature, drawn on experience of teaching communication skills and discussions with practitioners.

The CARE Approach consists of four interacting components that form an integrated cyclical process: Connecting, Assessing, Responding and Empowering. They are at the core of the CARE Approach learning tool that consists of an on-line manual with six modules. Each contains learning outcomes, examples, exercises and clips of healthcare interactions.

The CARE Approach was launched last August. Currently, six healthcare practices are piloting the CARE Approach. Based on the findings we aim to refine the manual.

Three critical questions you would like the audience to consider

A summary with examples of the CARE Measure & CARE Approach will be presented.

- Measures, like the CARE Measure, aim to assess the amount of empathy that service users feel they have received during a healthcare encounter.

Q: In what ways are the results of these measurements helpful to healthcare practitioners, especially when they have a low score?

- Learning resources, like the CARE Approach, aim to enhance practitioners' interaction with service users in terms of empathy and compassion. However, it could be claimed that in busy healthcare settings time spend on learning about interpersonal effectiveness would be at the expense of technical effectiveness or accessibility of the service.

Q: In what ways do learning resources on the 'human' aspects of care fit in the overall picture of the quality of care?

- In what ways can it be prevented that measures and learning resources on interacting with patients in a caring and compassionate manner are perceived as threatening by healthcare practitioners?

References

Mercer SW, Maxwell M, Heaney D and Watt GC (2004) The consultation and relational empathy (CARE) measure: development and preliminary validation and reliability of an empathy-based consultation process measure. Family Practice 21(6):699-705.

The CARE Approach (2011) http://www.gla.ac.uk/departments/generalpracticeprimarycare/careapproach/

Evaluating caring interventions and finding a reliable, nurse-reported measure of caring behaviour

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Heather Strachan, National Clinical Lead Care Governance Informatics at The Scottish Government

14. Prof. Brian Williams (Unit Director), CSO NMAHP Research Unit, University of Stirling;

There are now significant local and national strategies aimed at improving the quality of compassionate care. This follows an increase in public awareness and a developing understanding that good care can enhance clinical and psychosocial patient outcomes. The Scottish Person centred Interventions Collaboration (ScoPIC) (with academic and clinical members) is currently developing a programme of work within acute, in-patient services:

- evaluating complex interventions aimed at improving patient care
- Releasing Time to Care ™ plus (NHS Tayside)
- Caring Behaviours Assurance System
- developing quality improvement tools and
- Furthering the understanding of person centred care and patient experience.

We are planning parallel, complimentary studies which will explore patient, nursing team, management and contextual perspectives and contributions. However, we face the challenge of a lack of robust, well-validated scales which enable nurses to rate their own caring behaviours and which can contribute to effectiveness evaluations. Earlier evaluations have found positive effects upon caring behaviours, but have had to use methods using routinely collected data which are subject to sampling and reporting bias(1).

A recent study(2) showed a link between caring environment factors (e.g. shared philosophy of care and good leadership) and patient and carer experience, but nurse reported caring behaviours showed a positive bias and were not used in the analysis. This reflects the experience of our research team.

Some argue that caring behaviours cannot be measured, but are only open to qualitative methods. There is also concern that measuring compassionate behaviour will expose it to targets, costings, and a reductionist mindset; perhaps inadvertently destroying the thing we aim to measure. Measuring by observation is resource intensive.

If measuring caring behaviours is valid and useful, do we need new tools or is it just that nurses would benefit from training in the personal reflection skills necessary?

Three critical questions you would like the audience to consider

- What would be the benefits, if any, of quantifying compassionate caring behaviours?
- What are the best approaches to evaluating compassionate caring behaviours?
- Are nurses automatically able to evaluate their own caring behaviours or could training improve reflective ability?

References

Aiken L. H. et al. (2012). Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. BMJ. 344, p. e1717

Patterson M. et al. (2011). From metrics to meaning: Culture change and quality of acute hospital care for older people. NIHR SDO (08/1501/93)

Putting the Person in Patient

Author

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Chest Heart & Stroke Scotland improves the quality of life for people in Scotland affected by chest, heart and stroke illness, through medical research, influencing public policy, advice and information and support in the community.

The Healthcare Quality Strategy re-emphasised the need for the NHS to be 'putting people at the heart of the NHS' and providing 'the best possible care compassionately and reliably'

How can practitioners understand and analyse the experience of care and use what they learn to enhance their compassionate caring practices for service users and their families?

At Chest Heart & Stroke Scotland, we have been using the Voices Scotland Programme for some time to establish what is important to patients and carers living with these long term conditions. We also have over 200 support groups for patients and carers therefore have a vast amount of knowledge through the people we connect with on a day to day basis.

What patients and carers think is important often differs from what the practitioners feel are the priorities for delivering person-centred care and this session will give you a chance to find out that they think. The Voices Scotland team will deliver a fun and interactive session, encouraging you to reflect on what you think are the top 3 issues important to patients and carers. We will then share issues from the Voices Scotland database, broken down into geographical area, showing you how patients and carers themselves have developed a 'Case for Change' to influence the design and development of services in their area, based on their experience of care. Through the sharing and analysis of this information, we will challenge you to consider the impact that supporting patients to self manage will have on their perceptions of whether compassionate, person-centred care is being delivered.

Three critical questions you would like the audience to consider

- What is Person-Centred Care?
- (How) Does this differ from Compassionate Care?
- How does self-management fit in with person-centred, compassionate care?

References

NHS Healthcare Quality Strategy 2010

Better Heart Disease & Stroke Care Action Plan 2009

Staff feedback in action within a School of Nursing

Authors

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Good communication and feedback are associated with successful academic departments within the United Kingdom (McDonald, Kok & Francis 2012). It has been indicated that the more people get involved in open and candour conversation, the more likely it is an organisation will be productive, innovative and become a good place in which to work (Bolton 2006). The challenge however is to identify how this is both promoted and sustained within an organisation.

Over a period of six months the authors participated in a 'Leadership in Compassionate Care Programme'; as part of this programme they focused on developing a small project relating to their working environment and the promotion of compassionate care values. After much debate it was decided to focus on developing staff communication and in particular feedback to and from the school senior management team.

Following a review of the University's staff engagement survey 2011 and from discussions with the head of school and the lead nurse in compassionate care it was decided to focus on developing a rapid feedback mechanism with the school of nursing.

The premise was that this would enhance the working lives of lecturers within the adult branch of SNM&SC by providing a bottom up rapid response communication. By opening up lines of communication it was hoped that this would provide an opportunity for rapid feedback and encourage mutual communication and responsibility.

Following a review of the University's staff engagement survey 2011 and from discussions with the head of school and the lead nurse in compassionate care it was decided to focus on developing a rapid feedback mechanism with the school of nursing.

The paper presented will discuss the context, the thought processes and progress to date of this initiative. Themes for discussion will include:

- Caring for and about staff
- Promoting compassionate care values within the school
- The value of senior management and staff dialogue

The challenges and opportunities of undertaking such a project will be explored and debated and audience participation will be strongly encouraged.

Three critical questions you would like the audience to consider

- Cultivating openness within a working environment – how is this possible?
- Will this project enhance working lives?
- Can 'rapid feedback communication' improve organisational outcomes?

References

Bolton J (2006) The candour imperative, Industrial and Commercial Training, Vol38, No7 pp342-349.

McDonald C, Kok SK & Francis H (2011) What are the leadership, governance and management behaviours that promote success in academic departments? Leadership Foundation for Higher Education, Engage, Summer, Issue 26, p11. http://www.lfengage-digital.com/lfengage/engage26#pg14

Inspiring hope through a compassionate framework

Author

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The discussion is derived from elements of an empowerment and leadership intervention process undertaken with Hospital Staff in a Rehabilitation Care setting in St Patrick's Hospital in South Tipperary Ireland. The spirit of hope leadership programme has devised 12 steps to encourage and support staff and patients alike to stay positive in the face of the challenging healthcare environments. This process is designed to facilitate staff driven by a person centred approach to connect with patients in a compassionate way, giving life to the values of the compassion footprint. The provision of health care with compassion can be demonstrated as a footprint containing the following 10 capabilities: understanding, empathy, caring integrity, hope, mutual respect, knowledge, kindness, appreciation, acceptance, and thoughtfulness. In this way, healthcare professionals become an important tool for helping others heal. This has become a valuable communication model for patients staff and advocacy officers in St Patrick's Hospital.

In addition the steps will use the human given approach to meeting physical & emotional needs of staff and patients by introducing ways staff or patient can connect with their innate resources in a conscious sense. The human given approach reflects on certain aspects of life that are a given for normal human functioning. These are known as human needs, the human given approach examines fundamental emotional needs such as security and attention. A sense of autonomy and control in their work environments. Having a connection with other team members and being part of a wider community of professionals. Finding friendships that accept them for who they are in the true sense of the word. Having privacy and time to reflect and consolidate experiences. Acknowledging their sense of competence and achievement to maintain self esteem and to be stretched in their professional areas to add meaningful purpose to their professional lives. The key is to access resources available to them, for example problem solving skills and complex knowledge and learning. Their ability to build rapport and empathise and connect to other professionals or their patients. To appreciate their creativity analyse question and plan. To accept their ability to know or "knowing" this is often instinctive as well as intellectual. To thoughtfully understand themselves as a principal of self awareness and to be gentle in their debriefing and expectations of each other.

The purpose of the discussion is based around a 12 step leadership programme, with a proactive approach to positive resourcefulness and engagement, where participants choose wisely the approach through 12 compassionate steps with two over arching principles in mind.

A. The compassion footprint for health care

B .The human given approach to understanding needs and access resources

This discussion will facilitate and strengthen the ability of participants to respond compassionately to themselves and to others. Participants are introduced to key elements, which is a way of life or a way of working, which is practice based. These elements are benchmarked on known simple resources that encourage all healthcare professionals to pay attention to simple values in a series of playful exercises in a board game format covering as outlined above.

Three critical questions you would like the audience to consider

- Is there an understanding of how important compassion in healthcare is for health professionals and their patients? How can innate resources help us to shape our thinking and prevented the wounded healer phomenian amongst caring professionals
- How can healthcare professionals develop and promote education resources including training courses, written material and electronic media to foster compassion in healthcare .by doing so foster and develop a humanistic and holistic approach to healthcare that includes consideration of emotional, psychological, social, spiritual and cultural needs of people
- What can you do in your areas of professionalism in healthcare To raise the profile of compassion in healthcare and to recognise, by whatever means, examples of compassion in healthcare

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Developing a structure of compassionate care to support staff

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Caring for staff is key to helping to create an enriched care environment where staff feel that the senses of security, belonging, continuity, purpose, achievement, and significance are met (Nolan et al 2006). It is recognised that in order to carry out compassionate care Nursing staff need support and to feel cared for. Part of caring for staff involves engaging in appreciative caring conversations (Dewar 2011). The authors aim to discuss the benefits of implementing caring conversations in the form of support sessions for staff and the positive impact in practice.

The authors are involved in a larger programme of work 'Leadership in Compassionate Care'. This is a joint initiative with NHS Lothian and Edinburgh Napier University and used action research to embed and develop compassionate caring across education and practice. The ethos underpinning the programme was that of promoting appreciative practice and relationship centred care. Both of these approaches emphasise valuing the experience and contribution of staff which we believe to be a key requisite for delivering effective compassionate relationship centred care.

With support from Dr Belinda Dewar senior nurse in compassionate care we introduced support sessions for Nursing staff and Student Nurses. Originally held once a month and now held more frequently, a time is set aside for a drop in session to explore the experience of caring. The focus of this round table discussion is to highlight the particular approach used in these sessions which was one of appreciating different perspectives and trying to support others to come to their own understandings about a situation.

We will also explore some of the themes staff brought to these sessions and to discuss how supporting staff in this way enabled them to care more effectively. The process is discussed in particular to trying to prioritise these sessions into the busy world of practice.

Richard Mackay has over sixteen years experience working within NHS Lothian. Have been a Senior Charge Nurse for 7 years. Much of this experience has been in care for older people settings. He has a particular interest in compassionate care for Patients, relatives, staff and Student Nurses.

Liz Markey, department of spiritual care. Liz has worked in the spiritual department for NHS Lothian for 7 and half years. She is responsible for providing spiritual care for patients, families and staff. She is a qualified counsellor and supervisor. Liz has previous experience of working in hospices and was keen to transfer the supportive culture for staff into an acute hospital.

Three critical questions you would like the audience to consider

- How can we best support staff working in a busy acute environment?
- How can we enable staff to feel valued?
- How can we ensure that staff get protected time to be adequately supported in a busy acute ward

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Workshops

Leadership in Compassionate Care

Day 1

Energising for excellence in compassionate nursing care

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We believe that everyone in the care environment should be able to take a lead on enhancing compassionate care. We are passionate about the need to challenge the potential barriers to compassionate care in practice today. In Compassion and caring in nursing (Chambers and Ryder, 2009) we discuss the different elements of compassionate care and we raised three potential barriers to this patient and client focused care. These were resourcing, the culture of the practice environment and individual nurse attitude. In Excellence in compassionate nursing care: leading the change we face these challenges head on and suggest ways to challenge these potential barriers in practice.

Nurses are crucial in leading practice forward and in creating a positive culture in their practice environments. Today's resource-stretched health care environment is undoubtedly stressful for all health and social care practitioners, and it can seem as if individuals are powerless to make changes they believe are needed.

We need to focus on the challenges, positive principles and actions that nurses can take in relation to difficult resourcing issues, attitudinal difficulties and the culture of practice environments. True leaders of excellent and compassionate nursing care have the following attributes in our opinion:

- Personal
- Quality
- Leadership
- Educational
- Teamleading

The main focus of this w orkshop will be on how individual nurses can develop the requisite attributes to be effective leaders of compassionate care, wherever they work, and whatever role they hold.

"We are in times of great change, and in our opinion great change and challenging times need great leadership and great leaders." (Chambers and Ryder, 2012, p 159)

We found the previous International Conferences on Compassionate Care such stimulating places to be. We would love to facilitate discussion in this innovative and energising environment again this year.

Three critical questions you would like the audience to consider

- What are the challenges to compassionate nursing care in today's nursing environment?
- How can we take a lead in addressing these challenges?
- What are the positive attributes of true leaders of excellent and compassionate care?

References

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Chambers C and Ryder (2012) Excellence in Compassionate Nursing Care: Leading the Change, London, Radcliffe Publishing Ltd

Compassion in practice

Author

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This workshop is a shortened version of a module from the 'Values in healthcare a spiritual approach' (Vihasa) training programme. For the last 7 years it has been used successfully with a variety of professional groups in the UK and overseas. It is based on facilitated experiential learning using the skills of reflection, listening, appreciation, creativity, meditation, visualisation, and play.

In the workshops we create a group that is safe and trusting and build on the experience and knowledge of participants. We set learning objectives and focus on action planning, but above all aim to create a supportive fun environment.

Dr Craig Brown was one of the team that developed the Vihasa training programme and trains facilitators to deliver the modules. He is a retired general practitioner, and Chairman of the British Holistic Medical Association.

Further information about Values in healthcare – a spiritual approach can be found at wwwjankifou ndation.org

Three critical questions you would like the audience to consider

- What is compassion?
- How do we teach it?
- What are practical things practitioners can do?

References

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Round table discussion Session 2

Day 1

Leadership in Compassionate Care

The contribution of Schwartz Center Rounds to a compassionate hospital culture®

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In recent years hospital activity, especially unplanned work, has been steadily increasing, and relationships between staff and patients are more short-term, making it challenging to provide high-quality individual care.

Theoretical and qualitative research helps us to understand the difficult nature of the work staff are doing: continuous contact with patients who are ill, in distress, maybe disfigured or dying means that staff are continuously confronting their own mortality and vulnerability.

This work, in a highly pressurised environment, has an impact on staff wellbeing, which in turn affects their ability to care for their patients with compassion. In a busy day, reflective practice is hard to sustain and staff may become isolated and possibly experience guilt, anxiety and burnout.

Schwartz Center Rounds® are one intervention that helps to address these issues. The Rounds are a multidisciplinary forum designed for staff from across a hospital to come together once a month to discuss the emotional and social challenges of caring for patients. Rounds have been running in over 230 hospitals in the United States for more than 14 years now, supported by the Schwartz Center for Compassionate Healthcare. In 2009 The Point of Care programme at The King's Fund obtained a license to run the Rounds in England, and two hospitals piloted them for a year.

The pilot was evaluated using quantitative and qualitative methods and findings showed that the Rounds are perceived by participants as a source of support and translate into benefits for patients and team working. The Rounds organisers believe that they have the potential to change hospital culture, and that, supported by senior leaders; they are a powerful way of showing that the emotional challenges for staff of providing compassionate care are recognised.

Rounds are currently running in 11 hospitals and three hospices.

References

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Keeping compassion alive on the ward

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Five years ago, Thistle Ward (formally Ground Floor Ward, Ellens Glen House), was fortunate to be accepted as one of the first four beacon wards in the Leadership in Compassionate Care Programme. For one year the team worked with a compassionate care Senior Nurse.

As the Charge Nurse of the ward after the senior nurse left the team I needed to keep the momentum going and keep all the tasks/ discussions/ education that we were involved in over the year ALIVE and at the forefront of our team vision and practice. The senior nurse kept good ongoing contact with myself.

Realising Time To Care (RTC) Initiative

Two years ago the ward embraced this initiative and with the many other areas in nursing that we all have to do, the compassionate care initiative went to the bottom of the priority list. The RTC enhanced our team working, made our ward more organised.

I noticed with a few staff that they were not as thoughtful in their care and we needed to revisit and refresh the work we did with compassionate care.

We renamed our weekly RTC meetings to Releasing Time To Care and Compassionate Care meetings and incorporated compassionate care at these meetings

What I propose to do at the round table is 'a whistle stop table tour' of some of the activities we undertake at team meetings in order to keep the momentum going in compassionate care

1. Group work: What is compassionate care, using paper table cloths as a world cafe exercise
2. Using images and postcards to describe what compassionate care looks like and re visit our practice and vision
3. Our beliefs and values as a team
   [Using a flip chart – brain storming session]

Our discussions will focus on what could you do to keep compassionate care alive on your unit / the area that you work in? The group will be invited to put up responses on a flip chart

Three critical questions you would like the audience to consider

- What is compassion in your work place?
- How do we keep compassion fresh and alive in our practice?
- Should we need to undertake ongoing refreshing?

References

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Parliamentary and Health Service Ombudsman (2011) Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people London The Stationary Office.

They are having a Laugh – Starting a Laughter Yoga club for staff and students – some early thoughts.

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We all know the saying that Laughter is the Best Medicine and there seems to be some evidence that there may be truth in the saying. Laughter Yoga is being employed increasingly in the UK as an adjunct to more traditional therapies and had been used with people with Alzheimer's, Diabetes and Parkinson's disease as well as for groups of carers and women in prison.

This presentation will outline the benefits of regular Laughter Yoga, which includes a reduction cortisol levels and the release of endorphins during sessions. We all know the benefits of having a good laugh, we feel a sense of release and an increase in joyfulness – Laughter Yoga is based on the premise that our bodies cannot tell the difference between real and simulated laughter, therefore the benefits are largely the same. Mora-Ripoll, (2011) carried out a narrative review of the literature around laughter therapy and found that overall laughter therapy had beneficial psychological and physiological results. The setting up of a laughter club will be described as well as some of the challenges of keeping the club going. A description of what happens in the laughter club will be given and live testimonies to the benefits of regular laughter yoga will be given by club members.

Three critical questions you would like the audience to consider

- Should we incorporate laughter into our work with service users?
- Should such ventures be part of employees work content?
- Are we too busy to take part in such events?

References

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Fostering Person-Centred Care – a model for co-creating interactive learning days in NHSScotland Healthboards

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We aim to stimulate a round table discussion around a model of co-creating interactive learning events which seek to promote the development of a more person-centred culture within health and social care organisations. The events we hope to facilitate aim to:

- establish a sustainable network of concerned and motivated practitioners.
- support individuals and teams as agents of change.
- offer inspiring and guiding examples and resources to promote change in practice and culture.
- facilitate the emergence of ways ahead to develop and sustain a person-centred care agenda in particular contexts

The format of the interactive days will include a mixture of short presentations, service user stories, small group and plenary discussions. The content of each event will be co-produced with representatives of the local health board and/or council as well as patients and carers. However, the following common themes will underpin planning in each case:

- Fanning the flames of shared common interest, building on good practice already in place
- Encouraging staff to (re)discover and trust their vocational motives and values
- Helping health and social care professionals to reflect on their practice -looking at what promotes people-centred care and what challenges do they have to get round (at personal, team and organisational levels)
- Helping staff at all levels to reflect on 'how' they act and relate as much as on 'what they do' – in interacting with each other and the public
- Promoting a culture of value and caring within and for staff enables more positive patient encounters and outcomes
- Self awareness at core of good communication and values based practice
- Practitioners supported in living out their personal key values in organisations that enable them to do so (link between personal values and behaviours and attitudes and organisational values) – enhances staff engagement and wellbeing

Three critical questions you would like the audience to consider

- Why did you enter the health or social care profession you are part of?
- How has your experience of practice changed/ challenged or affirmed this?
- How does the organisation you work in show they value you and how do you help promote a culture where you and your colleagues feel valued?

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The compassionate organisation – lessons from America

Author

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In the current climate of care there is concern about the culture of care and staff's experiences of care delivery. Increasing evidence suggests that we cannot expect quick fix solutions to the 'caring problem' and that approaches that focus on whole system cultural change are required (Finfgeld Connett 2008; Goodrich and Cornwell 2008). So what would whole system change to develop a compassionate organization look like?

The author is part of a larger programme of work 'Leadership in Compassionate Care'. This is a joint initiative with NHS Lothian and Edinburgh Napier University which used action research to embed and develop compassionate caring across education and practice.

The paper presented discusses the findings from a recent study tour to explore 'the compassionate organisation' in 3 centres in the USA. This travel fellowship was supported by the Florence Nightingale Foundation.

Key learning that arose from discussions and observations in each site in the USA will be discussed and include:

- Caring for and about staff
- Principles of caring as underpinning philosophy for all activity and processes in organization
- Value of consistent and coherent messaging that clearly expresses values of caring
- Strong infrastructure to support the continued development of the skills of caring
- Measurement

This key learning will be discussed and debated in the context of the plans for embedding and spreading compassionate care principles and processes across NHS Lothian and in the context of the wider literature on whole systems change to create compassionate organizations.

Three critical questions you would like the audience to consider

- What processes identified from the USA have relevance and meaning for the UK?
- What needs to happen to support the development of the compassionate organization here in the UK?
- How will we know if we work in a compassionate organization?

References

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Working with patients and families to produce a person centred environment: the ward becomes a home

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The ward team in Thistle Ward at Ellens Glen House decided to focus on the environment of the ward and consider what could be done to achieve a more person centred environment that could be more like home for their continuing care patients. This project won the category Environment of Care and the overall winner for the 2011 Patient Experience Network, National Awards. The ward cares for 30 older male and female residents with severe and enduring mental health conditions such as severe depression, schizophrenia and dementia.

The team had a number of objectives for this project:

- Improve social interaction between patients and improve relations with family and staff
- Encourage individuality
- Reduce anxiety of residents and enhance their well being
- Reduce experiences of aggression
- Enhance job satisfaction for the team

The ward had excellent basic facilities but staff wanted to work with residents to create a more individualised setting that felt warm and comfortable. Social spaces were changed to maximise social interaction, one resident raised money to fund changes. Residents were encouraged to choose their own personal items for their room and took part in shopping trips using their own money. Residents and staff worked together to individualise rooms but changes had to be made in accordance with health and safety and infection control standards. Staff made extra efforts to overcome challenges e.g. fire proofing curtain and cushion material.

Outcomes:

- Staff and residents take more pride in their environment.
- Less evidence of self isolation and greater use of social spaces.
- We see the true person in an environment that they have pulled together.
- Residents enjoyed the focus of this activity and understanding the reality of their situation
- There was evidence of lifting of mood and

Three critical questions you would like the audience to consider

- How can Person-Centred environments of Care be promoted in other continuing care settings?
- What helps staff focus on individualising care in this way?
- How do staff overcome barriers to this sort of development?

References

NHS Healthcare Quality Strategy 2010

Round table discussion Session 3

Day 2

Leadership in Compassionate Care

Embrace people, enjoy what you are doing, work with them without an agenda': Lessons Learned from the Leadership in Compassionate Care Programme

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This round table discussion draws together findings from a 3-year longitudinal qualitative study of the Leadership in Compassionate Care Programme conducted between 2008-2011. It was specifically concerned with the Beacon Strand of the Programme which aimed to embed compassionate care in all aspects of NHS practice. The study was based on a *realistic evaluation* (Pawson and Tilley 1997) methodology which aimed to answer the question of what worked, for whom and in what context? The data presented here is drawn from interviews with 12 of the 33 stakeholders involved in the study at the end of the 3 years and includes the Programme facilitators, clinical nurse managers, charge nurses and members of the Steering Group. It will focus on what they described as the lessons learned from their experience of being involved, the approach taken and the meaning of compassion to them.

Following a review of how compassion was perceived by stakeholders at the end of the Programme, the discussion will address five key areas: a model for the implementation of this type of programme; the role of relationship-centred care; the importance and skills of facilitation; the pace of culture change; and the significance of the leadership programme.

Using quotes taken directly from the study participants will be invited to reflect on how these mirror their own experience of delivering compassionate care initiatives.

Three critical questions you would like the audience to consider

- Is it possible to go in and work with patients, relatives and staff without assumptions?
- How can relationship-centred care be embedded in practice?
- How can we develop and resource skilled facilitators to support this type of work?

References

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Compassionate/Relationship Centred Care delivery in a Primary Care Setting: A Pilot study with community nursing staff

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Background

The literature reviewed highlights a number of key issues in relation to compassionate care in nursing and more specifically to community health nursing. A number of projects across the UK have been introduced to develop practice responses to enhance care delivery. However, the majority of these programmes and interventions are being implemented and tested in the acute care sector or within services for older people. Whilst these are important areas in their own right there is only limited literature examining this topic from a community/primary care perspective. The importance of compassionate care is clearly relevant to all healthcare sectors, including nursing staff working in the community.

Objectives

The study aims to evaluate whether the Leadership in Compassionate Care Programme (LCCP) model as developed in acute/in patient settings can be transferred to primary care staff working within a community context. The specific objectives of the research are to:

Develop an increased understanding of compassionate, person centred and relationship centred care and actively use these concepts to develop practice with community nursing staff

Gather data from clients, relatives and staff within a primary care context based on their experiences of giving and receiving care, data will be analysed and results shared to enable staff to embed compassionate care practice within a community setting

Methods

The study adopts an action research approach based on appreciative enquiry and relationship centred care. The study involves: observation of staff (both formally and informally) within the workplace and clients homes when delivering care. Interviews with take place with staff, patients and relatives, regarding experiences of giving and receiving care, information gathered will be analysed, results will be shared with staff and a plan of action put in place. All data gathered from the community will be analysed and findings disseminated via a report.

Progress

The pilot project commenced in January/February of this year. The researcher is working with a team of Health Visitors and a Team of District Nurses from one cluster in the Edinburgh/Lothian area. The researcher met with teams from the area to provide information and discuss how the pilot project would be taken forward. One Health Visitor and One District Nurse from each team agreed to undertake the Leadership Programme provided by Edinburgh Napier University and NHS Lothian. The programme commenced in April 2012 and will allow both members of staff to develop their skills as transformational leaders and will enable them to share their learning and development within the cluster area. To date four staff/client observations have been undertaken and two staff interviews.

Intended outcomes

This research project will contribute to our knowledge about key processes and indicators of compassionate/relationship centred care based on the experiences of staff, patients and their families specifically within a community care context. This knowledge has the potential to impact on direct patient care through directly influencing strategic processes such as quality frameworks, practice education, and workforce development.

Three critical questions you would like the audience to consider

- 'What does compassion look like in the community or should it look any different?'
- 'How can we measure if compassionate care has taken place?'
- 'How can we ensure compassionate care becomes the norm in community care?'

References

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Supporting staff wellbeing to enhance patient centred care

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Background

The Hospital Pathways programme (HPP) is a prototype service improvement initiative working with 10 teams in 5 English NHS trusts in 2010/11. Our objectives included improving staff's experience and wellbeing to support staff to deliver compassionate care. This is an acknowledgement of the importance of staff wellbeing in itself and in recognition of the importance of the wellbeing of the workforce to the wellbeing of patients.

Methods

We delivered learning events and on-site, bespoke support from experienced Improvement Advisors, including the support of an organisational psychologist to support staff to build resilience, to enable them to focus more effectively on patients' experience.

This included interventions at the level of in the individual and the team which focused on understanding the emotional impact on staff of caring for patients in particular clinical areas, and identifying sources of support to build staff resilience. Work at the level of the team included work on building effective teams, and building resilience into team roles.

Results

Our interventions revealed that healthcare staff tended to think about staff experience and stress as an individual problem, despite knowing it is a common experience.

We found that staff experience was a more useful concept than wellbeing: language was important in framing discussions of staff experience and, for staff, the concept of wellbeing seemed too far removed from the reality of the pressures facing them. Discussing resilience and resources available to support staff generated different ways of thinking about staff experience and created opportunities for optimism, creativity and a consolidation of current coping strategies and individual, team and organisational strengths.

Implications

Staff experience has a direct impact on patients' experience. There is scope for a much more systematic approach to supporting staff in NHS organisations. Both structural and process interventions are needed at individual, team and organisational level.

Three critical questions you would like the audience to consider

- What should supervisors and managers do to help staff develop resilience to the emotional and psychological pressures of work?
- How is it possible to make staff aware of shared experiences at work and what they have in common?
- Is the concept of staff well-being helpful in the current NHS environment?

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14. Additional authors' details
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Exploring staff experience of providing Compassionate Care through their Audio Diaries

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The purpose of the project was to explore staff perceptions around what was most important to them in their working lives and how this related to the care they provided. The journey began around defining those questions which staff would find most rewarding to explore in a semi-structured recorded interview.

Building on the principles of Appreciative Inquiry, we gathered together a group of senior nurses to discuss how to engage staff from two of our Adult In-Patient units. The following questions emerged from our discussions:

- What does a good day feel like for you?
- Can you tell me about one intervention that made you think.....that's why we are here?
- Which of Lancashire Care's values most reflects you and your practice?
- Have you shared a good outcome or experience with your colleagues?
- If there is one thing you could change about the service, what would it be?

We set up a small project team consisting of senior nurses and therapists from two of our Adult In-Patient facilities. These units were chosen to test out the questions in parallel with a similar programme to collect patient perspectives of their care on the ward. The first impressions among the project team were that we were surprised by the overall quality and quantity of the material. In total around 15 staff participated, creating a candid record of what it feels like to work in the front line of patient care.

These audio diaries have now stimulated a further set of opportunities to explore what staff find most rewarding in their work. This is being done in a way to stimulate the creation of locally owned programmes to improve the quality of care and experience for our patients.

Three critical questions you would like the audience to consider

- What is the role of the nurse and nursing in creating Compassionate Care?
- How do we create continuity of care across services?
- How do we make the Recovery Model central to all we do in nursing?

References

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Enhancing compassionate care on the island of Crete, Greece: a report on current initiatives from the University of Crete (UoC)

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Greece is currently badly affected by economic crisis, and at such times, healthcare systems and the morale of patients and healthcare professionals are bound to be affected. Against the back-drop of such a crisis, the benefits of 'compassion' may prove even more essential. The concept of compassion is a prominent interest of the UoC, and in recognition of the importance of focussing on the patient as a 'whole' person, UoC has brought together various initiatives. These include: an elective on 'compassionate care'; development of a primary care unit (PCU) in Heraklion (specifically serving people of low socioeconomic status); delivery of care to individuals in rural and remote areas; and research initiatives including the investigation of relationships between compassion and psychosocial/physiological factors.

Following discussions in 2009, the 'compassionate care' elective was developed with the aim of introducing medical students to the concept at an early stage in their career development, and raising their awareness of potential distress in patients/families and in members of the healthcare team. Offered in 2011 and in 2012, the elective attracted large student numbers. Many students expressed interest in participating in the Heraklion PCU, which is a collaboration between UoC and the Municipality of Heraklion, and a service wherein compassion plays a crucial role.

The UoC also participates in the 'University of the Mountains' initiative, developed as a network and mechanism of activities for reaching people in remote/rural areas. Medical specialists voluntarily visit and provide care to these people, emphasising the importance of compassion together with an understanding of their rural values and traditions.

Compassion may be related to more positive psychological/physiological outcomes in both the provider and the recipient, and as such UoC is entering into research based on potential biological attributes of compassion.

We welcome the opportunity to share the above experiences, hoping that these initiatives can help to improve services in a country currently in the depths of financial instability.

Three critical questions you would like the audience to consider

- What is the role of compassionate care in countries experiencing severe financial crisis?
- To what extent should compassionate care be considered as an essential or core issue within academic departments, and in medical and nurse training?
- To what extent should compassionate care be considered as a core competence in defining general practice and family medicine?

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Essential Conversations

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Talking about death is never an easy topic. The main aim of the project was to create a DVD to address the fears and apprehensions of health and social care staff about having conversations around the end of life of people with dementia with their families. It was hoped that the DVD would provide an important resource for educators and practitioners and assist in addressing a skills gap which has a profoundly negative effect on people with dementia and their families at a most vulnerable time in their lives.

Artlink were commissioned to develop the DVD and work on marketing strategy was undertaken. Using Alzheimer Scotland links carers were identified and an initial day was set up with the film maker to discuss what we wanted to achieve and for the carers to see if they would feel comfortable being filmed.

To ensure the widest possible exposure a specific website was created www.essentialconversations.org. Also postcards were designed and printed with the message 'are you prepared' on the front and details of the DVD on the reverse side. Over a thousand postcards have been sent out to care homes, health boards, and professionals. In addition we have worked collaboratively to get the link to the website on as many websites as possible it is also linked www.alzscot.org

It is hoped that the DVD will enhance skills and confidence in supporting people with dementia to allow conversations about death and dying to take place in a timely and respectful manner.

The DVD has been externally evaluated and although there is need for more work the evaluation recognised the DVD as a valuable resource.

Explicit changes in practice were highlighted in the evaluation one example was 'Having just seen it, it helped me to be open to have a conversation with the wife of a young man with dementia recently. It was hard because the doctor was not open – he was giving hope that was not appropriate – so it is hard when you want to be honest but the doctor is working in a different way'. Another example was; 'I have tried some open conversations and have been surprised about how open the family are'.

Three critical questions you would like the audience to consider

- Are you prepared for your own death?
- Are you prepared and feel confident to have anticipatory conversations?
- What would make it easier for you to have this type of conversation?

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Where does our knowledge of compassion come from? Can we learn anything from the modern media about compassion?

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The basic question to explore is compassion something very individual or is it a universal virtue in all of us? From 'know thyself' of ancient Delphi and 'to thine own self be true' – Polonius's advice to Laertes in Shakespeare's Hamlet, there is an injunction to know how we construct ourselves as a person. The adage being how can you know others unless you know yourself? Can you be compassionate to others unless you are compassionate to yourself? This is the notion of self compassion, a difficult concept to conceive, as the question must be asked can this be achieved without self guilt.

From the origins in the ancient Greek of Homer and in the Bible, it is argued that 'evil' and 'compassion' can only be understood in a symbiotic comparison with each other. One person's evil begets another person's compassion. Also as in the case of the Good Samaritan compassion can often come from those you least expect it from.

In looking at the self, and where an awareness of compassion comes in, it is useful to look at how we construct narratives. Both how we construct our world as individuals and how outside influences also have a part to play in this. Compassion is difficult to grasp as a concept because the word continually deconstructs itself.

A difficulty lies in the inextricable link that compassion has with any particular ideology. As a ruling system of ideas ideology differs from society to society and country to country, to understand this link is to understand why compassion may go wrong.

Our aim is to look at how compassion gets treated as part of the ideologies involved in the 21st century. In trying to understand this, brief scenarios from Hollywood movies will be presented for analysis and discussion as to how a narrative of compassion can be created.

Three critical questions you would like the audience to consider

- With the ideas expressed here, would it be possible to develop a small package to cascade for nurses/health care professionals exploring these issues as an introduction for compassion.
- Are there advantages to involving media such as films in exploring compassion?
- In terms of compassion going wrong, can it sometimes be seen as necessary to examine the set of ideas (ideology) within which it gets located?

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Unlocking compassionate creativity to make the best use of organisational resources

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To meet the pressures of greater care needs, greater care possibilities, and fewer resources governments and managements are looking through a 'crisis lens', proposing to 'have a grown up conversation' with the public about limiting the kinds of care available from the NHS; or to 'tackle the vested interests of producers' by increasing competition or by making commissioning 'more powerful'; or by simply requiring health care organisations to make massive savings on 'an unprecedented scale'.

If we looked instead through an 'unlocking lens' we would seek ways of unlocking the creative and compassionate energies of all of those involved, and identifying and unlocking resources that have become trapped, and unlocking attitudes that have become rigid and defeatist .

We could see this as the most critical role of clinical commissioners and clinical leaders and develop their ability to

- have *productive* face to face conversations with clinical colleagues across organisational boundaries, that forge a connection and develop a creative collaborative energy
- be purposeful and determined but also non-judgemental and non-punitive
- maintain a firm but gentle pressure for change while allowing ways forward to emerge from the conversations (rather than going in with their own solutions)
- help others re-engage with their sense of meaning and purpose
- keep a focus on enabling all concerned to flourish – at a time when external pressures may encourage more punitive or belittling stances

To do so we will need to offer development that draws upon recent insights from neuroscience and ancient insights about mindfulness; evidence based leadership theory and practice; chaos and complexity theory; and the evidence about the vital role of conversations that are radically challenging as a result of their roots in empathy.

Three critical questions you would like the audience to consider

- What kind of preparation would you need to undertake before having what you want to be an empathetic conversation with a consultant surgeon about how to unlock resources from a service that you believe is not using them as effectively as is possible?
- What would you need in the way of information, behaviours and attitude, in order to be heard and understood and respected by your consultant colleague?
- What would be the impact of ignoring the tariff and instead commissioning using real costs, including marginal rather than average costs where appropriate? Would that help restore flexibility and sensitivity into decisions about admissions to secondary and tertiary care?

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A Visible Outcome for Compassionate Care

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The development of High Dependency / Intensive Care of severely disabled people in the Community began in The Royal Infirmary of Edinburgh between 1965 and 1984, following the review of morbidity and mortality from preventable causes. One main Clinical Lead put ideas in place, tested theories and encouraged collaborators. With great audacity and lateral thinking, the first ventilated patient went home in 1982. Through learning by doing, a template was constructed, and one of these first patients continues to live independently at home.

The Griffiths Report of 1988 resulted in Care in the Community being attempted in a multitude of formats, with no clear or unified concept of a visible and measurable outcome. Professionals and users express frustration with current practice. As stress on our hospital beds and incidences of physical abuse in Social Care increase, an Empowerment Centre offers a possibility for compassionate care.

The 2000-2005 pilot project was based on the 1982 model but with the added financial assistance of Direct Payments. My role was that of facilitator, coordinator and trainer in providing a safe environment for a ventilated patient. Practical elements and educational structure were examined alongside barriers to inclusion. This exemplar fulfils the Quality Strategy, and answers the Christie Commission's calls for prioritising prevention and promoting equality.

Patient empowerment occurred through handpicked and personally trained staff. Here the patient learned management of his/her condition, alongside collaboration and leadership, and practice could be reviewed and adjusted. Economic benefits were considerable; educational and employment opportunities were created. After 2005, the model was adjusted to accommodate a retired Consultant with physical difficulties. She had no family, and did not wish to go into Care. Seven years on, she lives independently in the Community, with daily assistance of her choice.

These participants have enjoyed a Quality of Life, envied by many.

Three critical questions you would like the audience to consider

- Does visible empowerment encourage creative and innovative practice?
- As "needs" has never been defined, what importance is accorded to Quality of Life issues during assessment?
- What are the advantages of patient empowerment through collaboration and education?

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Workshop

Leadership in Compassionate Care

Day 2

Planetree International Designation Workshop

Susan Frampton

This hands-on workshop will provide a brief introduction to the practice of patient-centered care and a set of standards for excellence in its delivery in acute, long-term and behavioral health settings. The development of international Patient-Centered Designation Standards will be described, and the outcomes of adherence to these standards will be shared. The session will then describe the process that an organization may complete in order to apply for formal recognition, including what it takes for health care leaders to cultivate and maintain a patient-centered organizational culture.

Case studies of patient-centered hospitals and long-term care centers will shift the focus of the discussion from the conceptual to the practical and will illustrate how core patient-centered care concepts such as access to information, involvement of family, patient activation and personalization of care have been integrated in tangible ways into patient care, resulting in measureable improvements.

The session will also detail, from a tactical perspective, how the Planetree Patient-Centered Hospital Designation Program can accelerate hospitals' patient-centered quality improvement efforts by providing a set of actionable criteria that drive outcomes. Participants will engage in a number of hands-on activation exercises and a mini-self assessment designed to deepen understanding of the session content and to provide insights into current status of their organization on patient-centered progress.

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