

Measuring Compassion: through a collaborative and appreciative approach

Leadership in Compassionate Care Programme

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The Vision

Embed compassionate care as an integral aspect of all nursing practice and education in NHS Lothian and Edinburgh Napier University.

4 Programme Strands

- Beacon Wards
- Leadership Programme
- Undergraduate Programme
- Newly Qualified Practitioner Programme

Theoretical approaches adopted to achieve compassionate care

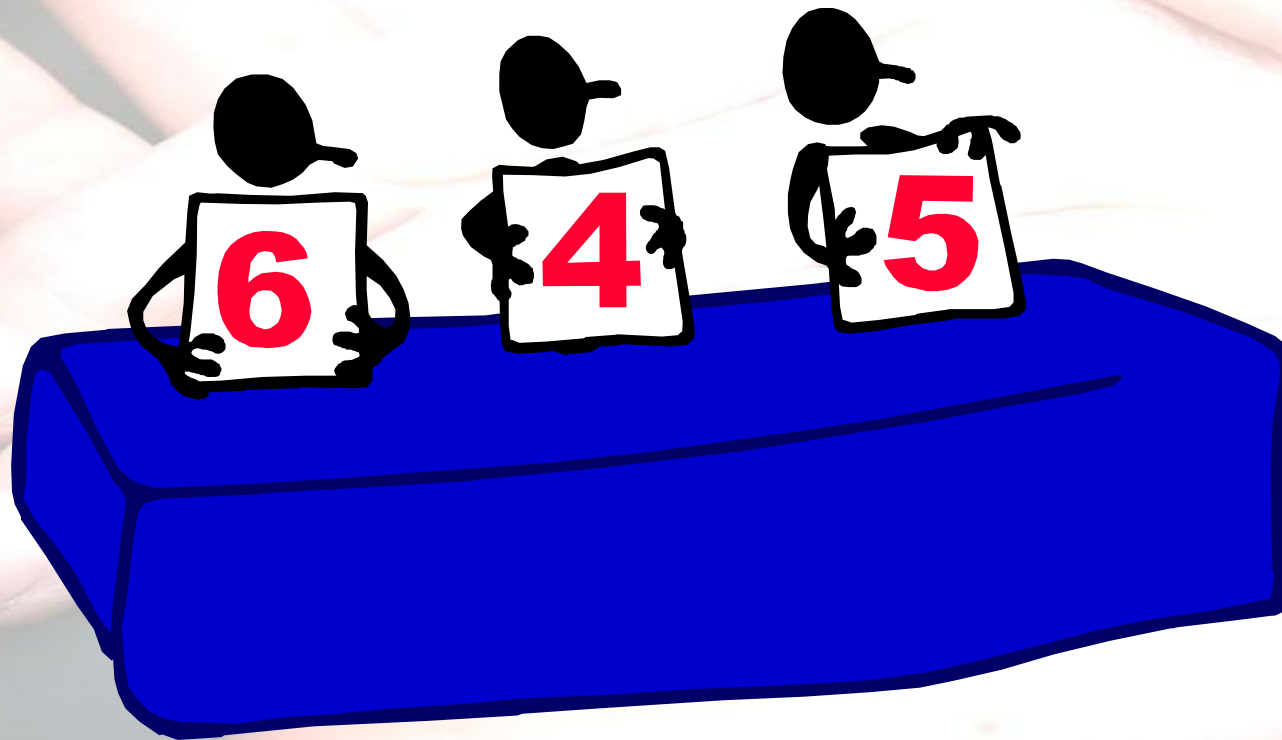
Action research approach



Relationship centred care

Appreciative enquiry

Measurement






Collaboration





Appreciation





Beacon
Wards -4

Development
Sites - 4

Development
Units - 5

Data generation within the Beacon Wards / Development sites

- Beliefs & Values Clarification
- Image work
- Stories: Patients, Relatives & Staff
- Emotional touch points
- Observation: Informal / Formal (WCCAT, McCormack et al, 2007)
- Action Learning
- RCN Dignity DVD
- Facilitating practice development projects e.g. person centred discussions on ward
- Exit interviews with staff

Development of key themes & positive care practices

Caring conversations

Flexible person centred risk taking

Feedback

Knowing you knowing me

Involving valuing and transparency

Environment????

**Theme Caring Conversations: Being proud and firm
sticking to the principles of person centredness**

Doctor came onto the ward the other day and stated
“I’ll take the alcoholic back and we’ll give you a
stroke” that’s unacceptable behavior”

[OT comment]

Compassionate care measurement processes.....thus far

- Compassion looks different in different places...complex scenarios
- A practice development process that focuses on individual wards / units, supported by facilitator
- Production of a toolkit focussed on initial assessment (incl. staff questionnaire), practice development and improvement methodology
- Toolkit based on key themes identified from CC data generated by patients, relatives, staff
- Practice development processes have dual purpose: both an intervention and an outcome
- Evaluation of action projects leading to enhanced measurable CC practice

Positive Care Practices

Saying to patients when you
are busy I will be back as
soon as I can rather than
I will be back in a
minute

Useful references

- Cooperrider, D. L., Whitney, D., and Stavros, J. M. (2003) *The appreciative inquiry handbook*. Bedford, OH: Lakeshore Communications
- Bate P and Robert G (2007) Toward more user centric OD: Lessons from the field of experience based design and a case study *Journal of Applied Behavioural Science* 43,41
- Nolan, M., Grant, G., Keady, J., Lundh, U. (2003) New directions for partnerships: relationship-centred care. In Nolan, M., Grant, G., Keady, J., and Lundh, U. (Eds.) *Partnerships in Family Care*, Maidenhead, Open University Press.

How should we measure compassionate care and how do we know if initiatives to promote it lead to transformational change?

Joint Project : Edinburgh Napier University & NHS Lothian
Belinda Dewar (Senior Nurse Compassionate Care and PhD
Student)

Larger Programme

Leadership in Compassionate Care Programme

Dr Stephen Smith, Mandy Gentleman, Jenny Kalorkoti,
Simon Pullin and Ria Tocher

Aims

- To examine how we measure compassion appreciatively **with** people
- To present evidence about the impact of the programme
- To argue for a model of measurement that is appreciative and collaborative

What is compassion?

Compassion is about the way in which we relate to other human beings and can be nurtured and supported.

*It involves noticing another person's vulnerability, experiencing an emotional reaction to this and acting in some way **with** the person, in a way that is meaningful for people.*

It is defined by the people who receive it and therefore interpersonal processes that capture what it means to people are an important element of its promotion. (Dewar 2010)

The problem with measuring compassion

- Compassion not always visible
- Made up of a range of factors that are not easily reduced to one act capable of measurement e.g. smile
- May look different in different contexts
- It is defined by the person who is receiving it
- It cannot be delivered as a target and measured as it has to be negotiated

Being appreciative in measuring compassion

- **Appreciate**
 - Recognise the quality, and significance of
 - To be fully aware of or sensitive to

Asks questions about underlying assumptions and beliefs

Explores:

- What works well?
- Why does it work well?
- What could we do to make this happen more of the time?
- Supported by attitude of wanting to understand, explore, learn, expand
- Not a technique to cross examine people or find fault
- Helping people to build on what works well

Being appreciative and collaborative in measuring compassion – what does this look like?

1. Identify with participants what they wanted to get out of the programme

- Be able to say what we do well to others
- A more united team with compassionate caring acts happening more of the time by more people
- Be recognised by others as a ward that demonstrates excellence in caring

Being appreciative and collaborative in measuring compassion – what does this look like?

2. Identify with participants what compassion looks like in their setting

- Stories from staff about good practice
- Stories from patients and families using emotional touchpoints to understand how people feel about their experience of caring
- What worked well today
- Working alongside staff to capture the ‘invisible good’ and feedback in real time
- Beliefs and values
- Photo elicitation

What did we learn?

One thing that I will never forget was one of the nurses at the end when mum had died. That young lady was amazing. I was kneeling at the bed and the nurse came round and said would you like me to say a prayer – it was beautiful. Where it came from I don't know. She did it so nicely – she had her hand on my mum and said these words – it's something that I will never forget. I know it's not something that everybody would want but the nurse knew her – she knew how strong her faith was. It's funny because praying for somebody in such an open way is not something we all can do or feel comfortable with. The nurse realised though that it was totally fitting to the situation – I will remember this forever (Relative story).

What did we learn?

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

What did we learn?

One of the staff nurses went up to a patient who had a degree of cognitive impairment and said good morning Elizabeth – did you sleep well. The lady said yes and that she could call her Beth if she wanted. The staff nurse asked her if she would like her to change the name above her bed from Elizabeth to Beth so that we all knew this – the patient said ‘no I don’t think so I think it is a bit childish to have the names above the bed because I know who I am’. The staff nurse and the patient laughed together. The staff nurse told the patient she would not change the name but asked her if we could leave the name as it was above the bed as it helped others to use her name when they spoke to her at the bedside. (Observation)

What did we learn?

My mum has names for everyone – they are not necessarily the right names but she calls them by that anyway and it's nice because the nurses answer to it, they don't try to correct her. We really respect that.' (relative story)

What we learnt


- Shaking the hand of a new relative to the ward – a deliberate welcome
- Offering handwashing facilities to a person after they have been to the toilet even if they have not wiped themselves
- Listening to a person who has told you the same thing 4 times over as if you have heard what they are saying for the first time
- Knowing what side a patient normally lies on, knowing that a person likes to wear makeup, Knowing that a person likes to be read the bible, knowing that a relative finds it a privilege to visit their loved one as they normally don't get the chance to sit and talk to them at home as they are so busy cleaning, washing and caring for their loved one

Being appreciative and collaborative in measuring compassion – what does this look like?

Work with people to identify positive caring statements that they want to defend and be measured against

Identified 72 statements from initial data set

Statements represented real care that was happening some of the time on the ward and that people were willing to be measured against



Making a point of **welcoming** patients
and relatives by shaking their hand
when you first meet them.

WELCOME

Originated from Ward 50 WGH
NHS Lothian and Edinburgh Napier University

Leadership in Compassionate Care Project 2009

**Always offering the patient
handwashing facilities after a person
has done the toilet whether they
have wiped themselves or not .**





**Telling other fellow patients
that someone has died
on the ward if
appropriate.**

Originated from Ward 50 WGH
NHS Lothian and Edinburgh Napier University

Leadership in Compassionate Care Project 2009

mz dreamer

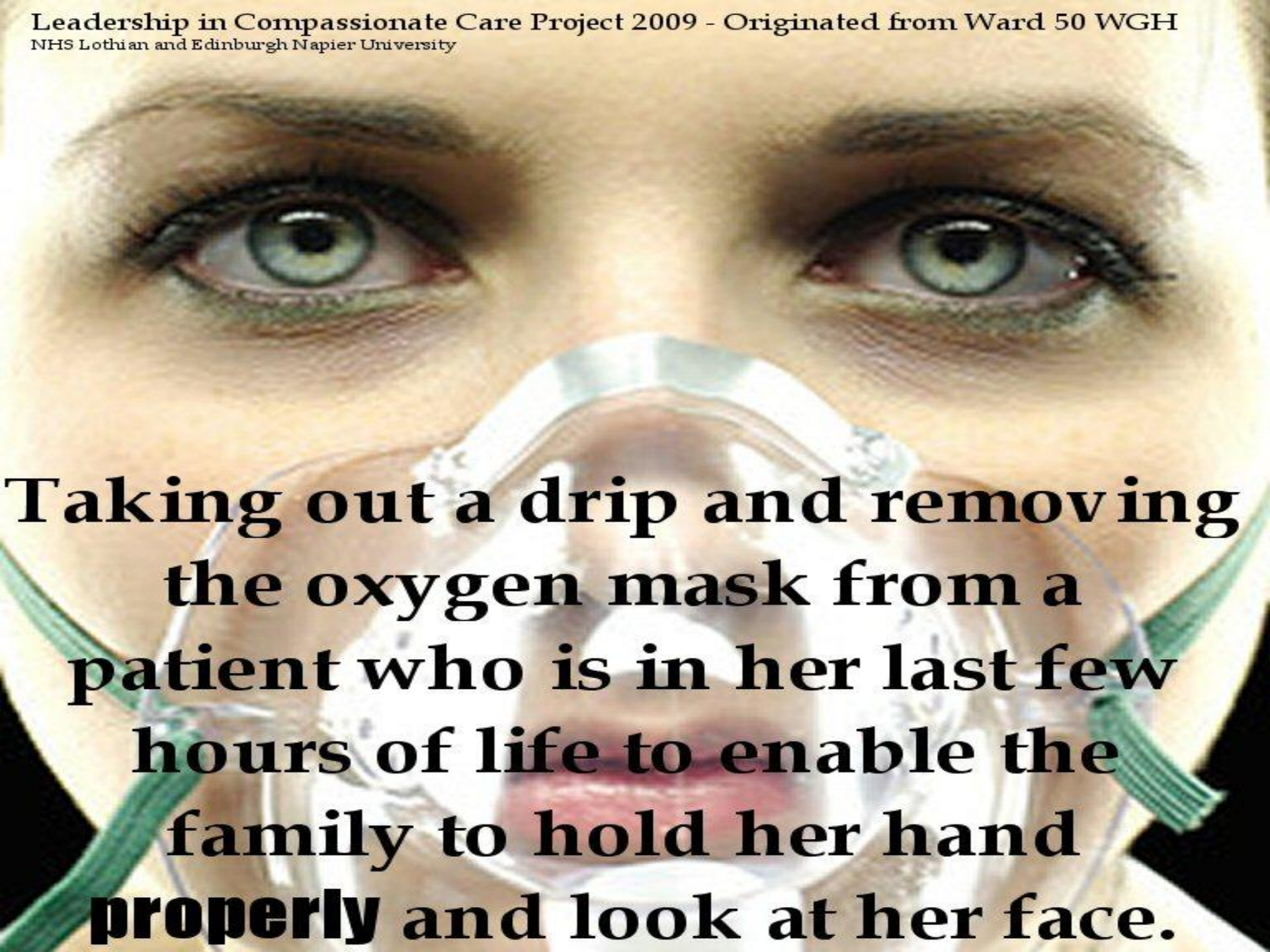
Putting makeup on a lady who was unconscious but who **normally** liked to wear makeup and learning that her husband was **pleased** as he felt his wife looked like herself rather than a patient.



Finding out what **really matters** to the patient and **trying** your best to act on this. For example, reading an excerpt of the bible to someone who is blind.

Originated from Ward 50 WGH
NHS Lothian and Edinburgh Napier University

Leadership in Compassionate Care Project 2009



Taking out a drip and removing the oxygen mask from a patient who is in her last few hours of life to enable the family to hold her hand properly and look at her face.

Being appreciative and collaborative in measuring compassion – what does this look like?

4. Support them to adopt processes that enable them to debate and assess if these positive caring practices are happening

Engage in caring conversations

Develop action

Key process

- Discover what is working well
- Develop positive caring statements
- Share, debate and refine this so that it has a collective meaning
- Develop actions to enable this process to happen more of the time
- Work with staff to enable them to identify how we know if this caring practice is happening most of the time – would include caring practices such as observation, feedback

Being appreciative and collaborative if things are not happening?

- Audit of all about me sheet framework of questions
- 3 out of 24 patients had been asked questions using the framework
- BUT Observation showed food charts completed for patients
- Key questions
 - How do you feel about results of audit
 - What is important to you about filling in the all about me sheets
 - What helps you to fill in the food charts
 - Is there anything we can learn from this that would help us to fill in the all about me sheets

A new state of being/Enhanced awareness

- *It used to be on here that all the washes had to be done by lunchtime but now you hear people saying oh they have had a bad night or they are in pain I think we should leave them till later. It has made us more aware of the bonding with the patient. You are not just showering a patient you are using the opportunity to be with them, to talk to them, to help them to feel less embarrassed about being naked in front of you. I think we are much more aware of this. We also have more discussion about compassionate care. We know more about the little things that matter to them and this is talked about more'*

New knowledge versus simply new processes

I have changed my viewpoint – I used to think I would treat patients how I would want to be treated or how I would want my family to be treated. I think from doing the patient stories/touchpoints I have had to challenge my assumptions – the patient may want something that surprises me. So I think finding out what the patient wants and not assuming I know is the big thing. I do see this rubbing off on other staff now. I see staff checking things out with patients more on several occasions (staff interview)

Did the project measure up to what the participants wanted as outcomes?

'the project helps people to recognize what they are doing. The biggest things for me about doing the work on the project is feeling much more aware about how I behave, being braver to ask patients and families more direct questions, being stronger in sticking up for the things I believe in and being much clearer about what it is we do well around here.'

'it's brought us more together as a team. We talk about care more now and help each other out'

'more people commend us now for the little things we do well'

- Be able to say what we do well to others
- A more united team with compassionate caring acts happening more of the time by more people
- Be recognised by others as a ward that demonstrates excellence in caring

An approach to measuring compassion

- Work with staff, patients and families to uncover what it is that is to be measured
- Work with staff to achieve excellence over time (value of small steps, recognition that we are all human and can't get it right all of the time)
- Work with staff to refine measurement based on context and a balance of needs for all participants
- Work with staff to develop a vision or benchmark that is specific, exciting, they have ownership of and are willing to defend
- Find creative ways of expressing and celebrating achievements

Cautionary note – celebrating achievements

‘The care is excellent here but the one thing I really worry about is making a mess of the bed during the night. I call out but I never know if the nurses have heard me and I worry that I will mess the bed. I have always been a clean and tidy person and this would be terrible. It would really upset me. The nurses say that I have not to worry and that they don’t mind if they have to clean me up. But I really mind. It has never happened so far, the nurses always come but I worry.’(Patient)



I Used to but now I
A poem about giving and receiving
compassionate care
Derived from data from project



Teaching and measuring compassionate care in pre registration nurse training

Liz Adamson, Belinda Dewar, Ria Tocher

Background to undergraduate strand

- Focus groups
- Key themes emerged:

Embedding Compassionate Care into teaching and criteria of assessment in acute care episodes

- Action project
- Collaborative approach: Senior nurses, Lecturer, Student, Charge Nurse Combined Assessment & Acute Medicine for Older People



Aim of the action project

- To make compassionate relationship centred care more explicit within the module
- To provide a template of how this could be done in other modules.
- To obtain feedback from students about the value of caring elements

The Module: Recognising acute illness and deterioration

- Teaches students to recognise and respond to acute illness and deterioration
- Blended learning: Theory through WebCT then application during practical simulation sessions
- Practical assessment and written exam

How was it before?

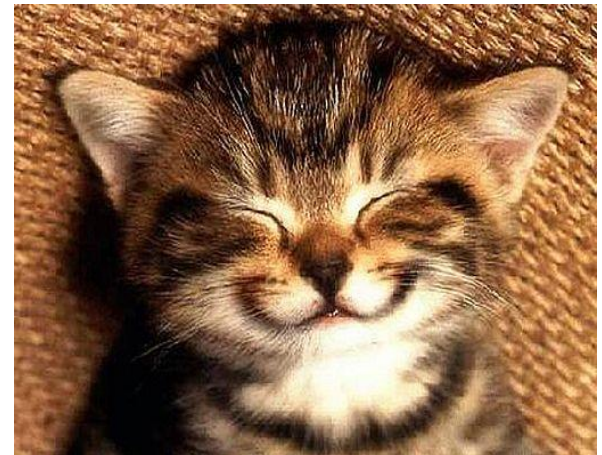
- Assessment focused on primarily physical and technical skills and life saving interventions.
- Little evidence of the assessment of interpersonal elements.
- Taught during the module but not made explicit in the assessment thus making them feel more optional rather than necessary.

What we did and how we did it

- Collectively considered important caring acts for acute hospital admission – told stories around this
- Considered themes derived from compassionate care programme (5 key themes and 52 subthemes) and their relevance
- Examined existing teaching and assessment materials
- Chose 1 scenario and integrated compassionate caring elements

Themes

- **A deliberate welcome and a smile costs nothing**
- **Making a connection and clicking**
- **Being kept in the loop**
- **Knowing how people are feeling acting and responding**
- **Knowing the little things that matter**
- **Feeling you have been heard**
- **Understanding the dilemmas of giving compassionate relationship centred care**
- **Being open and real about expectations**



Making a connection and clicking

- *It makes a difference if you try to find out something about the person. There is a man in bay 2 and even although it's hard to talk to him – I've managed to have a wee bit of a conversation with him – he likes Hearts – I told him what the Hearts score was yesterday. I look in the notes or speak to the relatives to try to find something– this man had a hearts strip – so I knew. It's good to have common ground to work with. I always try to do this. I've never come across a time when I couldn't make some connection.*
[Staff comment]



Feeling you've been heard

- *I feel listened to on the doctor's rounds. The doctor will sit down and touch my arm and really look at me – you know he is listening – he doesn't always touch your arm but this is nice. He will ask questions like tell me how you think you are doing rather than just telling me what he thinks. **[Patient comment]***



4 elements to consider

- Theory – delivered online through WebCT
- Practical sessions – patient scenarios
- Debriefing – reflection on action and feedback from actor patients
- Assessment – practical and written



Table of Contents for Unit 2

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- 3 Revision Section
- 4 Intro initial assessment
 - 4.1 Inspection
 - 4.2 Resp history
 - 4.3 Pulse oximetry
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- 5 Advanced assessment
 - 5.1 Arterial blood gas
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- 6 Adjuncts intro
- 7 Anaphalaxis
- 8 Compassionate Care: Being kept in the loop

Your location: Home Page > Unit 2 > Compassionate Care: Being kept in the loop

Compassionate Care: Being kept in the loop

Description (click to collapse)

Compassionate Care theme: Being kept in the loop
"It would have been very easy for the doctors and nurses to bamboozle us with all the medical terminology but they were very good at keeping us informed without the use of jargon or confusing abbreviations" (Relative)
 Reflect on an occasion when you have been aware that jargon has been used when communicating with a patient or relative. How could this have been explained differently?

Topic Type: Threaded
 Graded: No
 Peer Review: No
 Posting Restrictions: Allow post and reply
 User Identification: User Name

Create Message

View Drafts

There are currently no messages in this view.

Create Message

Practical sessions: patient scenario

- A young man is in his first week of a new job. He is a type 1 diabetic. He accompanies his colleagues to a wine bar and has a few drinks. He expects to have something to eat but the kitchen has closed as the chef walked out. He appears to be a little agitated. His friends find him collapsed in the toilet and call an ambulance. They report to the paramedics that they think he may have been fitting. He has a small cut in his bottom lip.



Debrief

- Student have an opportunity to reflect on What they have done,
What they missed
What they would have done differently
- What is required to ensure patient safety
- What is important to the patient
- Actor feedback/patient voice about the experience

Assessment

Practical assessment

- Formative: Peer assessment
- Summative: Invigilated practical assessment
- Criteria: Essential and non essential
- Aspects of compassionate care

Written Assessment

- Invigilated exam
- Patient scenario

What's improved

- Compassionate care is more explicit within the online teaching material
- Compassionate care is more explicit within the practical sessions and debrief
- Elements of Compassionate care are assessed within both practical and written assessments

Section of practical assessment criteria

Airway and C Spine control	Ask for as much detail as possible from the paramedics.	
	Approach patient from the back and immediately take control of the head – explain rationale for action to patient e.g why coming from behind important not to turn head	
	Introduce yourself to the patient and ask what they would like to be called	
	Explain initial sequence of events and rationale for these	
	Reassure the patient that someone will stay with them at all times	
	Look in mouth and ask patient to speak to assess airway. Patient responds = <i>airway patent</i>	
	Use help of team to size collar and demonstrate how to size correctly	
	Fit collar correctly- sandbags +tape. Reassure patient that should they need to move the tape will be removed and they will be assisted to roll. Do not let go of head until collar is fitted	
	<i>Checking out. Ask patient “ is their anything that you would like to know?”, ” What is important for you right know?</i>	

Written examination: marking key

Action	Rationale	Mark
Approach patient from behind and take control of the head immediately without covering ears	To prevent further spinal injury Before speaking with the patient as if you speak to them from the side they will turn their head Do not cover up ears so patient can hear	
Introduce oneself and ask patient what they would like to be called. Provide reassurance throughout	Frightening to be flat on back. May not know where they are A reassured patient likely to cooperate and provide information required for diagnosis more readily than an agitated frightened patient	
Request medical assistance as appropriate	Vital in clinical decision making to know when to request help	
A-Airway. Check in the mouth . Patient is speaking so airway patent.	If airway compromised patients life is threatened Check for potential obstruction	
Checking out	Finding out what is important to the patient Ensuring the patient understands information and explanations given by the nurse	

Challenges

- Cues need to be developed to prompt compassionate caring acts – e.g making a connection and clicking– what is the patient wearing?
- How do you prompt ‘being open and real about expectations’ –
- Patient might say *“you won’t leave me will you?”*
- Capturing the importance of context – the value of the debriefing session
- What is essential criteria within assessment – life saving criteria but this can be provided in a compassionate way

What we feel about what we've done

- Very positive to work together as a team
- The student input to the development of this module was important
- Validation of content from experienced charge nurses was invaluable.

Summary

- Care can be compassionate even in emergency situations
- Patient stories provide real experiences that can influence the curriculum
- Compassionate care can be assessed

Developing Competence and Compassion: The Experiences of Newly-Qualified Staff Nurses

❖ **Four strands to LCC Project:**

- ❖ LCC (Senior Nurses)
- ❖ Beacon Wards – followed by Development Areas
- ❖ Undergraduate Nursing Curriculum
- ❖ NQ Staff Nurse Experience

❖ **Evaluation of each strand**

- ❖ **NQ Staff Nurses:** 4 study days in year one following registration – attendance to some extent optional
 - ❖ Content in morning (eg motivational speaker, use of emotional touchpoints), small groups in afternoon

- ❖ Research questions : *How do Newly-Qualified Staff Nurses perceive compassionate care and what facilitates and inhibits its delivery?*
- ❖ Little evidence about experiences of NQ staff nurses in relation to compassionate care (although terminology varies in literature)
- ❖ Constructivist grounded theory approach (Charmaz 2006)
 - purposive sampling, concomitant collection and analysis of data
- ❖ Approval to proceed provided by Faculty's Research Ethics and Governance Committee
- ❖ Potential participants recruited at LCC study days for newly-qualified staff
- ❖ Focus groups (7 to date, n=42, and individual interviews, n=2): audiotaped and transcribed verbatim

Agenda (flexible)

- ❖ Expectations of role
- ❖ Whether these were met
- ❖ Support in new role
- ❖ Preparation for practice in undergraduate programme
- ❖ Concept of compassionate care
- ❖ Factors that facilitate/inhibit provision of the best possible care in a given set of circumstances

Re Methods

- ❖ Small scale study, purposive sampling (future study: theoretical sampling)
- ❖ NQ RNs who attend LCC study days may not be representative of NQ RNs in general
- ❖ Focus group participants may not be representative of study day attenders in general
- ❖ Data from focus groups is forged in the interaction between participants
- ❖ Collection and analysis of data ongoing – analysis of one focus group data compared with earlier analysis
- ❖ Synthesis of data analysis used to shape agenda for subsequent focus group

Themes/Categories

- ❖ “In at the deep end”, “sink or swim” – little formal support
- ❖ For most who did receive support it was eclectic rather than structured or embedded; down to the individual who provided it
- ❖ “In with the bricks” – entrenched views of some staff
- ❖ “Institutionalised negativity”
- ❖ “Resistance to change” even of a low key nature
- ❖ Didn’t appreciate how well-supported they were as students

Preparation for practice in undergraduate programme:

- ❖ Skills sessions (although sometimes provided well in advance of when they could be applied in practice)
- ❖ Theory eg breaking bad news
- ❖ Management/Consolidation placement
- ❖ Should focus more on reality of being a Registered Nurse

Compassionate Care

- ❖ Tautology for most ie compassion is an integral component of care
- ❖ For others = ‘more than just a job’, ‘emotional engagement’
- ❖ Re factors that facilitate/inhibit care: relationship between agency and structure ie the ability of individual agents to act within their environment
- ❖ Some environments may be more conducive to compassionate care than others eg community settings identified as promoting therapeutic relationships between staff and patients
- ❖ Compassionate care is not confined to staff/patient relationships but also to:
 - ❖ Patient/Patient
 - ❖ Staff/Staff

Future:

- ❖ Integrate findings with those from other strands of the LCC Project
- ❖ Implications of findings for undergraduate programme
- ❖ Develop themes in remaining focus groups (3 more study days)
- ❖ Theoretical sampling: possibly focus groups/individual interviews with staff who are NQ but who have not attended study days