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Humanising Care, Health and Wellbeing conference

ABSTRACT BOOK

Bournemouth University
29th-30th June 2017

Welcome to the Humanising Care Health and Wellbeing conference. This is our third conference and we are growing year by year. This is the first time we have had a two day conference and from the response we have had I feel we will need to make the conference even bigger next year!

This is also the first year that we have invited external presenters and it is wonderful to see that we have attracted such high quality contributions.

At this conference people can share and celebrate their work in education, practice and research all of which are equally valued.

Although the presenters are speaking about different clinical or social areas I am sure you will find resonance with your own interests because what we all share is a commitment to work where subjective experience and Being Human are privileged.

These two days will provide a space to share, reflect, learn, laugh and celebrate.

Have a wonderful time at the conference !

Caroline Ellis-Hill
On behalf of the conference committee

Humanising care: Translating theory into practice to support caring and creativity in a stroke service

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Background: Over the last decade acute stroke care has been transformed through technological advances. The pace of service delivery is now very fast. This can challenge caring, and the wellbeing of staff, patients and families. The eight interacting dimensions of the humanisation framework (Todres et al, 2009), which uses a lifeworld perspective, may offer directions for practice to enhance caring and sense of wellbeing.

Aim: As part of a larger study, we aimed to explore the meaning and relevance of the humanisation framework alongside service users and providers in a stroke service. Here we focus on the process of translating humanising theory into practice

Method: In this theory-led action research study; six practitioners (nurses, therapists and healthcare assistant) from the stroke service met with five former stroke service users and four researchers over nine monthly one hour sessions in a room near the ward. Using embodied and creative practices, the group shared their experiences of stroke care, engaged with the eight dimensions, and used the framework to guide humanising care projects.

Results: All members recognised and could use the humanisation dimensions especially when they were linked to personal stories and explored through embodied arts-based activities. The safe appreciative space allowed exploration of humanising language and experiences, leading to 'seeing anew' and providing energy and inspiration to create new caring possibilities. Outputs included: Humanising Champions, noticing and appreciating small moments of humanising care in the service, a Humanisation tree, a DVD of stories, a toolkit and ongoing enthusiasm by staff to explore the world in a humanised way.

Conclusion: This study has shown the potential of the humanisation framework to a) support caring service development projects and b) as a focus for engaging service users and providers through the shared experience of being human.

Beautiful Being: Nature, presence, and the aesthetics of care

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Encounter with natural beauty has the potential to enhance capacity for therapeutic presence in lifeworld-led practitioners. The conditions which foster therapeutic presence have been mooted but not widely researched. It is acknowledged that the capacity to be fully with the other in lifeworld-led care places a high burden of responsibility on the practitioner. Not only must technical knowledge be acquired and kept up to date (the presence of 'head'), and skills be learned and practiced (the presence of 'hand'), but also the less tangible, more essential epistemological underpinning of the heart must be cultivated. The heart allows connection between practitioner and patient, but that is not its only function. The heart has also been observed to be the center of perception through which insight, imagination and intuition are cultivated – qualities which connect us to a wider and deeper sense of self and reality. This potentially allows lifeworld-led care to take its place as a form of care more complex than simple patient centred or patient led practice, but rather as care which honors interconnection, transformational potential, and wholistic wellbeing.

The heart can also be seen as the seat of the perception of beauty. The understanding and appreciation of the value of beauty has gone through a number of moments, from objectivist, subjectivist, radical deconstructivist, and finally to an emerging position arising out of feminist, humanistic, eco-psychological and transpersonal positions which seek to reclaim beauty as an embodied experience of flow and connection, and as potentially having transformative potential for the perceiver. From this perspective, the encounter with beauty in nature may offer the possibility for expanded awareness, fostering increased capacity for heart based practice, and offering an

accessible alternative or complement to mindfulness or spiritual practices for the development of resilience for practitioners of lifeworld-led and related forms of care.

Humanising Phenomenological analysis: using focus groups, food, and drink to collect data for Descriptive and Interpretative Phenomenological Analysis (IPA)

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Aim: To explore the use of focus groups, specifically those involving a meal, as a method for phenomenological data collection.

Method: Six focus groups were conducted, in order to examine participants' perceptions of the authenticity of food. The data were analysed using Descriptive, and Interpretative Phenomenological Analysis (IPA). This is somewhat controversial as many commentators maintain that focus groups cannot be used to collect phenomenological data, however, Smith (2004, p. 50) maintains that: "While cautious about the use of focus groups for IPA this is another area ripe for exploration." Therefore it is a legitimate thing to try. At the same time, the Dialogical approach to phenomenology is based on cyclical interaction between researchers, literature and data where understanding is developed through discussion and reflection, amongst the researchers. Why not include some discussion and reflection, amongst the participants, and in a study looking at food, why not at a meal? What could be more human?

Findings The focus groups produced data that lead to the construction of a rich phenomenological account. Analysis of the group dynamics, after Jacques Derrida, indicated a very constructive, supportive, but also refining environment.

Conclusion The use of focus groups is an interesting and useful method of collecting data for phenomenological analysis and should be investigated further, along with the philosophical arguments for such an approach.

Reference

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Is There Welfare State 3?

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Background Welfare state 1 had public administration and the employment of professionals at its heart. In 1989-1991 welfare state 2, based on market thinking, was legislated into local public services. With subsequent decades central government has built on this, creating `hybrids`: a combination of pre-existing bureaucracy AND market oriented/managerial practices.

Aims: Many practitioners still operate from hybrids, what humanising possibilities arise from within such `hostile` contexts? Are we currently seeing the beginning of the end of welfare state 2 Does `humanising` also stand for an emerging body of thinking and practice heralding a welfare state 3 If so what does that look like?

Discussion: Question 1: Using 3 experiences to suggest humanising possibilities within the current status quo a) The `tactical anti-disciple` developed by a learning disability service becoming able to fulfil the wishes of its users as an independent mutual b) `The centre` for people with physical disabilities, and the empowering leadership which went far beyond contractual requirements c) Practitioners in an adult social services department completely changing how they worked with carers.

Questions 2, 3 & 4: Drawing from research by Frederic Laloux (1) and thinking by Prof Steven Groarke (2) to explore `autonomous teams` as an emerging practice and their contextual requirements, as well as the `stickiness` of managerial ways of thinking and how we can debrief ourselves to reclaim genuine humanity and working from the heart.

Conclusions: Within existing contexts `hostile` to humanising, possibilities exist. Autonomous teams come from a coherence of thinking and practice which is developing right across Britain and

elsewhere in the world. The article ends by drawing these developments together and setting out what welfare state 3 looks like. Britain`s `operating system` has changed three times in the last 150 years. The article suggests a fourth type of operating system.

References

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How does the culture of a Day Hospital support the identity needs of frail older people?

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Frailty is condition which can occur in older people and means that they are at more risk of physical decline and more susceptible to illness (Age UK and British Geriatric Society 2015). Half of all people in the UK aged over 85 are now estimated to be living with frailty and this is expected to rise. People experiencing frailty often report low levels of wellbeing particularly in relation to their sense of identity and increasing dependency, which in turn can lead to poorer health outcomes and reduced engagement in therapeutic interventions (Twigg and Martin, 2015).

To date, frailty research has mainly focused on physical interventions and measurements of frailty. There is little exploration of the lived experience of frailty, particularly in relation to how frailty impacts upon identity. Christchurch Day Hospital has an innovative service for the frail older person; service users report that the way that they are made to feel has an impact on their outcomes and how they feel about themselves however it is unclear what processes underpin this.

This future ethnographic study aims to understand how patients' needs are met in relation to their sense of self and identity within a Day Hospital environment. The culture of day hospital will be explored via observations, collaborative interviews, focus groups and documentary analysis in order to determine key processes which need to be in place to create positive identities and could be transferred to support future best clinical practice in other health care settings.

References

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Kindliness in Dorset –Enabling neighbourliness and peer support in sheltered housing.

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Background Financial pressures have resulted in deep cuts in funding for Sheltered Housing. Dorset County Council's response led them to work in partnership with Bournemouth University using the concept of 'kindliness' to increase neighbourliness and peer support.

A methodology and toolkit was developed with the aim of helping to create vibrant mutually supportive communities where residents felt able to ask for support and to offer support to their peers.

Methodology The team used innovative scheme-based sessions involving poetic enquiry and forum theatre with residents and staff and facilitation training with Housing Association staff.

Findings Workshops discovered difficulties around 'change management', organisational culture and the need for kindly treatment of staff and also that residents would like to see more young people. The workshops identified barriers to 'kindliness' and possible solutions: **o** Limitations of facilities **o** Lack of staff time for community development activities **o** Lack of recognition of emotional problems **o** Limited signposting knowledge

The future Longer term outputs are likely to include a range of activities relating to health and wellbeing: **o** sheltered schemes which develop their own community to respond to local needs, aspirations and strengths, increasing neighbourliness, social capital and reducing social isolation and the deterioration of health and wellbeing **o** development of a skilled, fluid and person-centred workforce working in parity with residents and the wider community create individual and collective agency to shape how sheltered communities develop **o** an evolving toolkit for Dorset and elsewhere

Conclusion *"It's brilliant to see a local authority working with a university and housing association to use Kindliness as a means of building community and tackling our loneliness epidemic. I strongly believe that the Kindliness initiative's use of poetry and theatre offers creative ways to raise awareness and bring people together. Kindliness is not dead…. The Kindliness Conference can help to unleash it."* George Monbiot, February 2017.

Humanisation of Higher education: It is easy if you try!

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Background: We experience the world with our feelings and emotions and this in turn affects our social interactions and social understanding of the world. However, in a higher education environment where more value is placed to scoring systems and outcomes (NSS scores, TEF, REF for example), it may be difficult for students and staff not to feel objectified, isolated or dislocated.

Aim: Explore how Todres et al. (2009)'s humanisation framework can be applied to Higher education to develop a more humanised teaching and learning experience.

Key points: Findings from a qualitative doctoral study with ten students and four academics exploring ways to improve provision to support students to develop their socio-emotional intelligence in higher education highlighted the need for academics to encourage, support and engage students in a way that is caring, nurturing and compassionate. Consequently I propose the integration of Todres et al. (2009)'s humanisation framework. This framework consists of eight dimensions for humanization and dehumanization within the context of caring professions. I argue that these dimensions can be applied to the context of teaching and learning in higher education, as it is clear that there is a need to do so, especially in the current climate. Using examples from my practice and research findings I will explore these dimensions accounting for an embodied relational understanding, enabling us to practice with our ''head, hand and heart''. This would go towards developing practice and instigating a conscious effort to go towards the humanisation of higher education.

Conclusion: Applying Todres et al. (2009)'s humanisation framework to HE practice will support us in developing our socio-emotional intelligence and enable us to work more effectively with an embodied relational understanding. This can increase the wellbeing of our students as well as our wellbeing and will therefore have a positive impact on our lives.

Becoming a more human, human being?

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Background: Karen has been working for twenty five years on the front line of child protection in an ever changing landscape that includes the increasing humanitarian tragedies of modern slavery, people

trafficking and child sexual exploitation. Yet, she has found a surprising capacity to face these with an increasing openness, softness and enthusiasm in her work having started out with a far more judgmental and aggressive attitude.

Aim: This paper is a phenomenological exploration of what it is that has supported these changes and her reflections on the contribution of Heartfulness meditation practice.

Key Points Some new potential aspects of relationship are identified from considering the impact of centreing responses within the heart.

What's the sense of humour?

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Humour is a lubricant that helps us connect to other humans (Higgins, cited in O'Hara 2016). Additionally it is recognised as serving a variety of roles for us throughout life. In the healthcare setting, the forming of establishing and maintaining a good therapeutic relationship is integral to effective intervention. Health professionals use humour consciously and unconsciously in their clinical roles to encourage effective communication with patients. Using humour, the client can more easily convey inhibiting factors to the clinician, including fears and anxieties.

Black humour (sometimes referred to as gallows humour) can help deal with the more difficult aspects of life, and is recognised to be used by people working in particularly emotionally challenging professions, for example firefighters and medical staff. Understood as being a mechanism for coping, it can be viewed as distasteful but serves as a powerful tool for the individual at that time. Expressions of emotions, including rage and frustration can be safely vented through effective use of humour, facilitating a feeling of empowerment through communication of feelings and opinions.

Humour is recognised to improve symptoms of physical discomfort, including reducing muscle tension – leading to reduced pain. Norman Cousins (1979) reported that 10 minutes of laughter afforded him two hours of pain-free sleep, where no pharmaceutical intervention could help him. Used constructively, humour can enhance team working by reinforcing group values and strengthening shared bonds, gaining group cohesion. Additionally it can aid individuals' understanding of a team's underlying philosophy. However, used thoughtlessly or unkindly, humour can exclude others.

Conclusion: Humour serves a variety of functions for humans, helping us to gain perspective, facilitating communication and bonding, thus aiding us to cope with stressors. Humour must be used appropriately to avoid detrimental effects on others.

'Pausing to connect' - Developing relational knowing on a stroke unit

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Background: Variations in the quality of care experiences in the NHS and stroke care are widely reported, with at times care being dehumanised and lacking person focus. There are models available to support the delivery of relationship-centred care in acute care settings, and this study aims to explore how relationship-centred care can be developed specifically in a stroke unit where a significant number of patients have limited communication ability, and how the entire multidisciplinary team can develop together relationship-centred care rather than solely the nursing workforce.

Aims: 1. To describe how people with stroke, their family and health care staff on a stroke unit describe their valued relational care experiences. 2. To identify what processes can enrich relationship centred stroke care for all.

Method: 40 stroke unit staff, 10 patients with stroke, and 3 family members from a stroke unit in a District General Hospital in the South West of England participated in the study. An appreciative action research approach was used. Data collection was through direct care observations, discussion groups and semi structured interviews.

Results: The initial co-participatory analysis will be presented. Initial results include the stroke team 'making pauses' to connect with patients or team members. These pauses can

range from momentary to longer interactions.   Examples include a brief moment of banter with a colleague, using silences or touch within an interaction with a patient.

Conclusion: This study shows that different staff groups within the stroke multidisciplinary team tend to use different processes to develop relationships in the stroke unit setting. The context and culture in which their professional group organises their care can affect the way in which they 'make pauses' in their working day to connect with people.

Towards the 'abiding expanse': treatment components and processes in the 'HeART of Stroke' feasibility trial to support confidence and wellbeing post stroke.

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Background: Improving wellbeing is a priority for people post-stroke. Evidence for benefit of arts programmes with various patient groups is growing, but in stroke is limited. Definition of treatment components and processes is required to conduct good trials of complex healthcare interventions.

Aim: Our aim was to identify artists' practices from our feasibility trial of a community Arts and Health group post-stroke (HeART of Stroke; HoS) that might promote wellbeing.

Method: Group exploratory discussions (6 hours over 2 occasions) were held between two researchers and three artists. Techniques drawn from co-operative enquiry were used alongside reference to reflective diaries and participants' creative work to develop insights into practices and participants' responses within the HoS groups. Meetings were audio recorded, transcribed, coded and key themes arising from the discussions identified.

Results: Analysis is ongoing. A dynamic sense-making process was described in which the artists encouraged participants to explore materials spontaneously guided by sensory experience. This allowed tentative identification of possible visual, tactile or auditory 'provocations' to facilitate participants' creative exploration. This process of sensory attunement and exploration led to a 'languaging' of experience by the participant within the group.

Conclusions: We have identified specific AfH practices that might facilitate a dynamic 'languaging' process that could support simultaneously a compelling invitation to step into possibilities (adventure) and settledness (home) to embrace the unknown - the 'abiding expanse' described by Galvin and Todres' (2011) 'dwelling-mobility' wellbeing framework. These insights contribute to the exploration, and tentative description, of HoS change processes that may be of use in future clinical trials.

Embodiment and humanisation: reflections from midwifery

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Background: this presentation has been co-created from a joint concern for the humanising of midwifery care for women. Humanisation of care has extensive historical roots within midwifery on a national and international basis. Embodiment as a form of midwifery knowledge encapsulates humanised care through its connection between the woman and midwife.

Aim: to explore the concepts of humanisation and embodiment within midwifery practice

Method: this discussion is underpinned by a phenomenological study exploring intuition within independent midwifery practice

Findings: Embodiment as a form of midwifery intuition encompasses specific and vague forms of bodily and emotionally sensed noticing

Conclusion : Continuity and humanised care are requisite to utilise embodiment

Human Henge: Cultural heritage therapy and its' impact upon mental health and wellbeing

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Background: Human Henge is a collaborative project funded by Heritage lottery fund, run by the Restoration Trust in partnership with BU, English Heritage and Richmond Fellowship, National Trust, and supported by the National Trust and Avon and Wiltshire Mental Health Partnership NHS Trust. Drawing on recent ideas that Stonehenge was a place of healing in ancient times, Human Henge takes insights from various traditions and cultural contexts to create an immersive experience. Over ten weekly three-hour sessions two facilitated groups, each of up to 16 local people with mental health problems walk the landscape. Reaching through time to other humans whose traces are illuminated by accompanying pre-historians, curators and musicians, each group makes meaning and draws inspiration from the terrain, monuments, weather, soundscape and each other.

Aim: To explore how historic landscapes can be used to achieve sustained, measurable health improvements for people with mental health conditions.

Method: Mixed Methods research involving a mixture of qualitative and semi-quantitative surveys. Mental health and wellbeing was assessed using the Short Warwick Edinburgh Mental Wellbeing Scale, in addition questions regarding the participants' interests in history, heritage, and archaeology were asked. Qualitative data was sought utilizing focus groups, creative activities inspired by photovoice methodology as well as personal reflections.

Findings: This paper will present some of the initial findings from the research to date exploring the potential of heritage and history as a therapeutic intervention.

Conclusion: Whilst early days in the research it is evident that historic landscapes have much to offer people with ongoing mental health conditions.

Reducing health inequalities through public health practice - the role of the Lifeworld

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This paper reflects work in progress as we apply humanisation theory and the life world approach to public health practice. In particular we are focussing on the reduction of health inequalities and in the process of exploring how the politics of representation (or how people are portrayed) can lead to the creation of 'otherness' and 'othering' and ultimately dehumanising practice in public health. Historically, public health policy has been guided by socio-demographic risk factors identified through epidemiological investigation (Rigg et al., 2014). A problem with the creation of such a bio-medical, risk – based agenda is that people can become stigmatised and labelled if they do not comply with risk-reducing interventions, or indeed live in areas of perceived high need or/and low resource. We propose that people can become 'locked' into a cycle of disadvantage and inequality because 'poverty knowledge' and the politics of representation have an impact on public health

practice and perceptions that people are `hard to reach`. We suggest the life world approach as a constructive alternative to generating knowledge to underpin policy and practice. This type of knowledge is based on uniqueness rather than homogenisation because through knowing about people's sense of themselves and their experiences we can learn about their life world and transform services to become `easy to reach` responsive and relevant.

Integrating humanisation into practice: a dementia education and learning case study

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Background: Government policy advocates that by 2020 all staff employed by the National Health Service (NHS) should receive dementia training appropriate to their role. Educational frameworks, such as the Dementia Core Skills Education and Training Framework, outline the key competencies for health care professionals working with people with dementia. However, audits of dementia care in hospitals have identified a gap in knowledge, skills and attitudes and appropriate training is required to improve the delivery of care.

Aim: To provide quality dementia education and learning for health and social care staff across the UK in regular contact with people with dementia and their carers (Tier 2). Health Education England commissioned the Ageing and Dementia Research Centre (ADRC) at Bournemouth University to develop a new programme (building on previous programmes) called 'Dementia Education and Learning Through Simulation 2' (DEALTS 2). DEALTS 2 is a simulation toolkit underpinned by the Humanising Values Framework (HVF). The programme is based on an experiential learning approach to put health care staff into the shoes of a person with dementia and facilitate a positive impact on practice. Simulation-based education in health care settings provides a safe space for staff to replicate real world situations, practicing core skills whilst protecting patients from unnecessary risks. The ADRC is currently rolling out DEALTS 2 nationally through a 'train the trainer' model (between May-July 2017). A Process Evaluation documenting any iteration of materials, the short term outcomes of the train the trainer sessions, barriers and enablers that trainers experience in rolling out training in their own trusts, and the longer term impact of the training generally, as well as the integration of HVF in practice is also being undertaken.

Findings: This paper presents preliminary findings based on feedback data from trainers (n=104) that have already attended the train the trainer sessions, alongside observations of the challenges and learning of implementing theory (HVF) into practice.

Understanding masculinities to enable social inclusion in older men with dementia

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Background: Older men living with dementia are often viewed as a homogenous, androgynous population. Although research has demonstrated that masculinities persist as men grow older and can impact on their experiences of dementia, this gendered aspect is often neglected by academics, practitioners and policy makers.

Method: This presentation will outline a three year Doctoral study that aimed to promote social inclusion in rural-dwelling older men with dementia through the use of a men-only, community-based gaming Technological Initiative.

Findings: The findings showed three features were integral to the success of the project: the use of technology; the male-only environment; and the approach adopted.

Conclusion: Drawing on this research, I will argue that community-initiatives designed to enable male social inclusion would be advised to consider these gendered experiences and promote them through the activities offered, the environment created and the method of delivery.

The role of the Expert Companion for relatives of people with a severe brain injury: humanising practice to create a cogent "neuro-narrative".
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Background: Advances in emergency healthcare are leading to increasing numbers of people living with the consequences of Acquired Brain Injury (ABI). The condition disproportionately affects younger people and outcomes, particularly functional and social outcomes, are extremely difficult to predict. Standard health/social care services are poorly equipped and lacking in knowledge related to ABI, in particular the invisible, complex and interrelated impairments to executive functioning, behaviour, cognition, mood and insight. It is therefore unsurprising that relatives are greatly affected by the condition and that they have views on what approaches, support and interventions that they find helpful and humanising.

Aim: To investigate and understand the relative's lived experience of ABI and of the services encountered and to define that which is reported as effective.

Method: An online survey of 110 relatives of people with an ABI and 16 face to face interviews was undertaken and a thematic analysis of the results synthesised with the literature relating to the condition.

Findings: Relatives report significant difficulties with services, with the changes that the ABI brings and with a specific and ambiguous lifelong loss they experience. Inappropriate, dehumanising or absent services exacerbate harm and fail to support the relative as they adapt to changed lives. Positively reported upon services co-produce a valued future that incorporates an understanding of unending grief and unwelcome changes to loved ones.

Conclusion: Professionals, acting with humility, working alongside relatives of people with an ABI, can fulfil the role of the Expert Companion, developing a shared understanding of lives irrevocably changed post-ABI and create a valued and cogent new "neuro-narrative" by which to live. The specific nature of ABI and of the ambiguous losses this creates are better responded to by such an approach to practice and this is co-terminous with the Todres et al approach to humanising healthcare.

The older male carers research project
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Background: Over 51,000 carers in England are men over the age of 85 a number which has more than doubled in the last decade. Carers over the age of 85 are the only demographic of carers where men outnumber women (59%). Local data from the Bournemouth and Poole Carers Centre suggests that older male carers are the group least likely to ask for help and often present to them through GP services at crisis stage.

Aims: •Establish a research group of older male carers who are valued for their expertise and insights •Gain a deeper understanding of the needs of older male carers and to draw on their expertise to develop carer support and provision which improves the quality of life and citizenship for this growing and often hidden population of carers •Create representations and resources to enhance support and provision for older male carers

Method: A unitary appreciative inquiry (UAI) seeks to gain rich and deep insight, understanding and knowledge of an experience from the person themselves. Co-collaborators are recognised as the expert of their own experience and power is shared through participatory and appreciative approaches. The aim is for co-collaborators to benefit directly from the research process as they are supported to express, analyse and reflect on their experience and to make changes which could improve the quality of their lives as well as by contributing new knowledge and perspectives from which others can learn. Insight gained from the presentation of research findings can provide a

catalyst from which others can reflect, analyse and evaluate their own practice. Eleven older male carers were recruited (using diverse sampling) and are being supported by the Bournemouth University PIER Partnership and the Bournemouth and Poole Carers Centre. This presentation will provide an update on progress

Creative Arts and Dementia – A Project Overview

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Background This is an ongoing, weekly visual arts and dementia project set up by Poole Housing Partnership in 2016 after a short pilot.

Aim: This presentation will cover an overview of project, including approach, use of volunteers, choice of activities, engaging carers, attendance and evaluation.

Development goals: we would like to extend the work to other groups, bring in music and dance, and build in a more robust evaluation methodology.

Promoting compassionate care: UK and Czech Republic educational case studies

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Background Reports such as the one into the events at Mid Staffordshire NHS Trust where poor nursing care and organisational failures were highlighted drew attention to the need for compassionate care. The publication of the expected behaviours and values by the Department of Health and NHS Commissioning Board in 2012 for health and social care staff - the 6Cs - has provided a platform for innovation and contributed to a stronger focus on the humanisation of health care.
It is against this background that the University of Greenwich (London) and Dartford and Gravesham NHS Trust (Kent) collaborated on the implementation of a post–registration course on Compassionate Care. This was a pilot project which led to collaborative working in developing the notion of compassionate care within a Master's degree in Intensive Care Nursing at Masaryk University.

Aim To discuss the implementation and content of an interprofessional accredited unit in Compassionate Care (UK) and how this contributed to the curriculum of a Master's degree in Intensive Care Nursing in the Czech Republic.

Key points The pilot level 6 unit in Compassionate Care was deemed a success by the participants (four Doctors, three Nurses and one Midwife).   The development of the unit led to a three dimensional model of compassion, which included the Humanities and Social Science perspectives. Aspects of the unit informed the curriculum of a Master's degree in Intensive Care Nursing at Masaryk University.

Conclusion This was an innovative pilot project that used a framework that is transferrable to any health and social organisational or administrative setting to enhance compassionate care, not only in the UK but also globally.

Creating and sharing digital stories: Innovation in midwifery education that supports student midwives academic creativity and woman centred practice.

Dr Jen Leamon in collaboration with Dr Sue Way and the students
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Background: Women's experience of midwifery care exists in a dynamic and evolving context. Preparing undergraduates involves the development of knowledge and understanding from multiple sources of evidence and experience to reflect the art and science of practice.

Story sharing for student midwives has been part of undergraduate reflective development for over ten years. In years 1 and 2 students select an experience and create a narrative in a format of their

own choosing including: monologue, reflective story, poem, pictures, song and more and share it with a small group of their peers.

The evolving context includes, sharing stories of human experience via multiple media formats, and the NHS challenging professionals to develop creative solutions in response to people's needs. Our response has been to include a digital story creation and sharing into a year 3 unit.

Aim Of the digital story creation was to challenge the students to:

- Identify and lead change that could make a difference to women and their families care.
- Be enabled via their digital story creation to celebrate their woman centred approach to compassionate care and celebrate their academic creatively.

Methods The students were introduced to the concept in their unit and supportively enabled to create their own digital stories via the fusion focused unit.

Findings and conclusion Student's submitted digital stories for women and their families, for midwives and students and they did this with creative inclusion of: videos, drawings, photos, poems, role play, annotated images, and animated videos. The range of women and family centred midwifery practice topic was vast, and showed the everyday extraordinariness of women's and midwives experience. They showed how human experience is significant and how in midwifery the interaction between mother and midwife calls for humanity and compassion alongside knowledge, understanding and courage developed from multiple sources of knowing.

Compassionate Community, Zen and Chaplaincy : Working with Humanization Principles in the Community

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The presentation will use illustrations from practice within a compassionate community project (in Wiltshire, UK), that draws on principles of humanization in healthcare (Todres et al, 2008). It also utilizes ideas from Zen, in particular the three tenets of Not Knowing, Bearing Witness and Compassionate Action. The presentation shows the weaving of these concepts in the development of compassionate community.

Humanising care and culture: how can the humanisation framework support organisational change from board to ward

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Background: The humanisation framework (Todres et al, 2009) comprises eight interacting dimensions or values proposed as a sensitising tool to develop understanding about what makes people feel more (or less) human within healthcare interactions. A previous study by Galvin et al (2016) explored the use of the humanising framework as a tool to support practitioners, older service users and researchers, to consider ways in which the dimensions might enhance humanising care and practice on an acute stroke unit and outpatient skin care service.

Aim: In this presentation, I will describe the process of using the humanisation framework to underpin a programme of system-wide organisational change at a small independent hospital for people with profound and complex neurological disability. I will describe the activities undertaken in workshops with both clinical and non-clinical staff. I will illustrate some of the resulting humanising practice initiatives, and report the learning to date from organisational efforts to develop and embed humanisation across the system.

Key points: The eight humanising dimensions proved relevant, applicable and useful to staff working directly with patients, as well as to those in non-clinical and leadership roles such as board members and administrators. Multi-disciplinary workshops with ward based staff clarified personal and organisational meanings of the eight dimensions, highlighting, for example, the way a focus on personal journey, sense of place and uniqueness support more humanised experiences for patients and residents with persisting disorders of consciousness. Interpretations of togetherness, agency

and personal journey were strong themes for discussions of more relational ways of being human with colleagues at work. Further work and analysis is required to guage how to scale up, embed and sustain humanising practice and culture.

Conclusion: The humanisation framework provides a meaningful and constructive tool to support organisational change at a clinical and infrastructural level.

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The Humanisation of me: reflections on my D.Prof experience

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A Professional Doctorate places value on the interaction between the person, their experience and the creation of knowledge and understanding (Fulton et al 2013). The vessel in which this scholarly chemistry takes place is the D.Prof student and the ingredients can be many and varied. In my case I brought fifty nine years of life experience, thirty seven years of professional experience in the NHS and seven years of new academic perspectives together in such a way that, at first, it destabilised and disconcerted me. The process of adjustment which has enabled the incorporation of a new academic me has been challenging but also rewarding and illuminating.

In my presentation I will show how the Humanisation Framework of Todres et al (2009) provided me with a structure within which I could reflect on the complexity of me and how I relate to myself and my environment. Through using the Humanisation Framework as both a reflective and a reflexive tool I believe that I have been able to put my new insights to good use and develop both myself and my research. I propose that use of the Humanisation Framework can be helpful in supporting both personal and practice development.

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Adult nursing students' values from selection to qualification: a longitudinal study of how students describe their values when exposed to a curriculum based on a humanising philosophy

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Background: Nursing values are recognised through codes of professional practice and focus on the person and their human rights. Values can be described as the ideals and beliefs expressed consciously and unconsciously through a person's actions. The manifestation of these values among nurses have come under scrutiny in recent years with practitioners, educators and managers being challenged to re-establish the person at the centre of care. In studies undertaken with student nurses findings suggest that caring values can become tempered with "professional realism" as students begin to merge theory with practice and that caring behaviour can decline by the end of the course.

Aim: To develop a deeper understanding of how student nurses described their values and what they perceived to be the factors that influenced those values as they progressed through a nursing curriculum based on a humanising philosophy.

Method: In 2013 new undergraduate nursing students (n=161) were invited to take part from one English university. A co-operative inquiry approach was used and ethical approval obtained. Students were invited to establish their values at the outset and half way through the programme They went on to analyse what challenged and supported their values as they progressed through their course, and finally, to evaluate how the course had influenced their value base at the point of qualification. Methods for data collection included: a values clarification questionnaire, focus groups and co-operative inquiry groups. Data were analysed using inductive qualitative content analysis.

Findings: Five themes were identified in year one and these were analysed and evaluated by the co-researchers as the study progressed. The findings that unfolded began with "students' ideals and aspirations", followed by a period of "reality and uncertainty" to a position of "living and flourishing with reality and uncertainty".

Conclusion: Students readily drew upon their *experience of living* to identify person-centred values about nursing and being valued as individuals. They identified that the course had help them to build their knowledge and resilience, to challenge bad practice and respect humanity.

Getting the measure of therapy on stroke units

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Background: UK national stroke guidelines state that 45 minutes of each relevant therapy should be provided to patients deemed appropriate. Therapy time is now being measured and reported on in a national audit, with hospitals receiving scores for their delivery of therapy, among other things.

Aim: This ethnographic study sought to investigate the delivery of therapy on stroke units, including whether it was influenced by the new guideline and audit, and if so, how.

Method: An ethnographic study, including participant observation and interviews, was conducted in three SUs in the South East of England.

Findings: The attempt to standardise practice was undermined by variation in the nature of stroke units, the definition of therapy that was enacted in them, varied interpretations of the guideline and varied auditing practices. Desiring to do the best they could, but realising their limitations, therapists developed patterns of practice, modified the concept of their jobs, and also modified the concept of their clients in order to justify their decisions regarding resource allocation. There was potential for these routines of practice to lead to dehumanising care. Patients were rarely offered choices, or involved in decision about their care. In interviews patients expressed the importance of their individual histories and experiences being listened to, but they were rarely given the opportunity to tell their stories.

Conclusions: Therapists felt that if they provided a good service this was in spite of the audit, not because of it. This study demonstrates the importance of ongoing engagement between strategic leaders, patients and clinicians, to identify areas for improvement and ensure that quality of care does not become secondary to 'playing the numbers game'. Focussing on specific aspects of care should not be at the expense of person-centred working across services.

'My Bones Won't Break Me:' My Experience of Living with Osteoporosis as a Young Active Female

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Background: 'Osteoporosis' is the accelerated loss of bone density and most commonly affects post-menopausal females. The resultant low bone density makes those with osteoporosis susceptible to low force fractures that are both painful and debilitating. Premenopausal osteoporosis is a poorly understood condition in which otherwise healthy, premenopausal women have low trauma fracture and very low bone mineral density. Being diagnosed with a chronic condition at any age has been shown to have profound psychosocial implications for the individual. The significance of a diagnosis of osteoporosis for a premenopausal female and their health care providers, is that the age of diagnosis contrasts so markedly from the common cultural paradigm for the condition. There is a

paucity of literature on the patient experience of osteoporosis and literature on the patient experience of premenopausal osteoporosis seems absent altogether.

Aim: The aim of this study is to explore the experience of living with osteoporosis, as a young active female.

Method: Autobiographical methodology was employed utilising life story narrative, personal diary and blog entries over a 2 year period, from 3 months pre-diagnosis to 21 months post diagnosis, to allow the breadth and depth of the experience of living with premenopausal osteoporosis to be captured through storytelling.

Findings: Stories of lost identity, low self worth, exposed physical vulnerability, fear and uncertainty stem from a feeling of premature aging and the position of 'stranger', both within the diagnostic group and with one's peers. The diagnosis of osteoporosis as a young woman marks a biographical shift from an anticipated progression through life, to one that has deviated markedly from this path to an unknown endpoint and this brings with it unanticipated questions over longevity, quality of life and a feeling of being robbed of a 'normal' life.

Conclusion: The findings suggest that being a non-traditional patient for a condition adds a unique dimension to processing and living with a diagnosis. First person narratives are a powerful tool to build an understanding of the experiences of individuals living with chronic conditions such as osteoporosis.

Cancer survivorship from a perspective of shared humanity.

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Background: In Humanising healthcare practice and research we explore the subjectivity of patients' illness experiencing and how they create meaning in a way that is specific to their self and their life. Our concept of well-being resonates with free personal creation rather than with determination. Contemporary theories of Embodied Enactive Cognition (EEC) point out that thinking and creating meaning happens 'with' our bodies rather than just 'within' our bodies (Johnson, 2007). This non-dualistic body-mind view makes links between general spatial and kinaesthetic schemas and the conceptualising of personal experiences. It also links biological striving for survival and flourishing with the direction and sequence of psychological processing.

Exploring subjective experiencing through the lens of EEC embeds human freedom and uniqueness in a given and non-conscious aspect of humanity. As this lens taps into the basic sameness of human bodies it invites empathy. In other words incorporating an ECC perspective in our Humanising practice and research can contribute to a fuller knowing and sharing of humanity.

Aim: This study explores how thirteen adult survivors of bowel cancer who are between a few months and 20 years after finishing their treatment think about their Self in relation to cancer. I aim to understand their experience from a perspective of ECC.

Method: According to ECC the unconscious thinking mechanisms that engage a bodily logic are embedded in the metaphorical conceptualising of experience (Lakoff & Johnson, 1999). This research brings to the fore the spatial and kinaesthetic structure of participants' metaphors, compares them for similarities and differences, and explores potential links from a developmental perspective.

Findings: Based on the spatial kinaesthetic schemas of people's metaphors subtle but distinct diversification of cancer survivorship experiences emerge.

Conclusion: This study will contribute to and potentially complement the overall body of research that aims to refine the understanding of survivorship.

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Exploring the unique physical, emotional and financial implications of facing cancer while alone: an integrated approach to qualitative research and art-based enquiry

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Background: Cancer diagnosis and treatment often has a significant impact on people's lives long after the end of the medical treatment. Partners and families are seen as the main source of support for people living with cancer however little is known about how people cope when living alone, particularly in areas of geographical isolation and socioeconomic deprivation.

Method: This qualitative research project on survivors' experiences was complemented by an art-based enquiry facilitated remotely via telephone and email with individual participants by an experienced arts for health facilitator. Living Alone with Cancer Explorations (LACE) aimed to offer a supportive and non-judgemental space to enable cancer survivors to explore their new situation and reflect on changes in their lives using art.

Findings: We found that even though cancer patients who live alone were not eager to participate in art workshops with people they didn't know, they were comfortable working with an artist after being introduced to the nature of the activity at the end of a qualitative interview. They produced poems, photographs and drawings that either directly reflected or were metaphors of the effect of cancer in their lives. The findings from the patient experience interviews were triangulated with the observations and interviews from the participants in the art workshops in order to investigate the ways by which art-based non-lexical data elicitations complemented qualitative interviews of cancer patient experiences.

Conclusions: Issues and challenges in engaging hard-to-reach patients through this medium will be discussed.

Humanising the curriculum: Perspectives from BU PIER Partnership

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Todres et al (2009) state, 'To be concerned with humanisation is to uphold a particular view all value of what it means to be human, and furthermore to find ways to act on this concern.' The humanisation of healthcare: a value framework for qualitative research' presents the main aspects of what it means to be human as eight dimensions of humanisation/dehumanisation.

Hemingway et al. (2012) suggest that focusing care on what is important to us as human beings enables practitioners to always put the person first, and pre- registration education clearly has a role to play in this.

The PIER Partnership seeks to reinforce the centrality of the person (patient) and their carer(s) in health and social care practice by their involvement in the undergraduate programmes in HSS.

Using Todres' eight dimensions of humanisation, this presentation will demonstrate how the PIER partnership contributes to the curriculum in a variety of ways:

- Providing a vital link between theory and practice
- Enabling students to practice skills in a safe environment with time for critical reflection
- Helping students see beyond the label of diagnosis, to see people as people first with their own unique context and history.

Humanisation of Mental Health Care through Person Centred Psychiatry – An Interdisciplinary Approach from a Nursing Perspective

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Background: Psychiatry is a medical discipline. Therefore, mental health care is predominantly based on clinical models of the understanding of mental illness, such as the biomedical or biopsychosocial model. And even though recovery, empowerment and person centeredness are more talked about, there still seems to be a gap between a truly holistic approach and the services provided.

Aim Within the person-centred approach which the World Psychiatric Association promotes there is the person centred integrative diagnosis (PID) that includes aspects of ill health as much as positive health and a clear focus on experiences of health and illness. It is the aim of this paper to explore potential contributions of nurses to the PID and how this could help transform psychiatry towards humanisation of mental health care.

Key Points The understanding of person-centeredness, personal recovery or simply mental illnesses, varies within and in between disciplines and professions, but also among users and their kin. Within the PID with its key components ill health and positive health, the focus on ill health and its intrinsic and extrinsic contributors might well be a psychiatrists' or psychologists' domain whereas positive health and resources seem more of a nurses' focus. However, only the user can put the aspects in perspective with personal experiences and what he or she needs for a better wellbeing.

Conclusion An interdisciplinary approach to mental health services is key to develop a more person centred and humanistic approach of care. However, real change needs a shift from a problem based and reductionist focus towards a user perspective that encourages new ways of thinking and new approaches in supporting individual needs. Humanisation of mental health care demands not only the person in the centre of attention, but a psychiatry of the person, for the person and most of all with and by the person.

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