

# Humanising Care, Health and Wellbeing conference

## ABSTRACT BOOK



**Bournemouth University**  
**21<sup>st</sup> -22<sup>nd</sup> June 2018**



**Welcome to the Humanising Care, Health and Wellbeing conference.**

*This is our fourth conference and we are growing year by year. We had such a wonderful response from our two day conference last year and I am really looking forward to seeing how we take things forward this year.*

*We invited external presenters for the first time last year and the message we received was that we need to spread the word! This year we have contributions from a larger number of Universities and from outside the UK. It is wonderful to see that we have attracted such high quality contributions.*

***In this booklet abstracts are presented in alphabetical order by the surname of the corresponding author***

*At this conference we share and celebrate work in education, practice and research, all of which are equally valued.*

*Although the presenters are speaking about different clinical, social, and educational areas I am sure you will find resonance with your own interests because what we all share is a commitment to work and understanding where the lifeworld, 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*

## The humanizing and dehumanizing effects of the research ethics process: an auto ethnographic reflection by a panel chair.

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### Background

All Bournemouth University research is required to undergo a process of ethical reflection, the formal part of this process may involve deliberation by a research ethics panel. I have been a panel chair for more than four years.

### Aim

To reflect, using an auto ethnographic approach, on my experiences as a research ethics panel chair

### Method

According to Holman Jones *et al* (2013, p. 22) auto ethnography is, “the use of personal experience to examine and/or critique cultural experience.” They go on to say that the purpose of autoethnography is to disrupt the norms of research practice and representation; to work from insider knowledge; to manoeuvre through pain, confusion, anger and uncertainty and make life better; and to break silence, (re) claiming voice and writing to right. But why would a panel chair be thinking in this way, after all panel chairs are the ones in a position of power.

### Findings

I find that the ethics review processes hold disparate humanizing forces. I think that ethical reflection is central to the research process and that it is not unreasonable that professional researchers should be able to, and be required to, explain the ethical basis of their work. Researchers use public resources and in many cases ‘take from their unrewarded participants’ time and experience. For me this is a humanizing process. However many researchers seem to find the process by which they are held accountable to be dehumanizing. In my position as chair I have experienced disdain, sarcasm and at times aggression from some researchers though I am at a loss to work out why they feel the system is so dehumanising that it warrants this reaction; possibly it is a symptom of something else.

### Conclusion

I understand that there are two sides to every story (probably more), but all is not necessarily how it first appears.

### References

Holman Jones, S., Adams, T. E. and Ellis, C., 2016. Coming to know autoethnography is more than a method. In: S. H. Jones, T. E. Adams and C. Ellis (Eds.), *Handbook of autoethnography* (pp. 17-48). Abingdon: Routledge.

## Seeing the Person not the Diagnosis – a humanised approach to dementia care through simulation-based education

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### Background

Worldwide the numbers of those with dementia is increasing and nurses will be caring for people with dementia and their families in all care settings. The importance of seeing the person not the diagnosis is key if humanised, person centred care is to be achieved. Yet in clinical practice staff can find caring for people with dementia emotionally demanding which is exacerbated by a lack of understanding of dementia (Heaslip and Board 2012).

### Aim

This paper will provide examples of how simulated learning has been used in undergraduate nurse education, to provide learners with an opportunity to understand the lived experience of dementia.

Simulation-based education in health care settings provides a safe space for students to replicate real world situations, practicing core skills whilst protecting patients from unnecessary risks. Simulated learning can be delivered through a wide spectrum of activities including video, vignettes, role playing, body manikins, virtual reality and augmented reality (ASPiH and HEE, 2016). In this paper examples of using one of these approaches in an HEI setting to large groups of undergraduate students (n=400) will be shared emphasising the challenges and outcomes of this approach. I will share some work we are doing with Alzheimer's Research UK evaluating their A Walk Through Dementia (AWTD) App which is a 3D film developed with people with dementia to help others understand the lived experience of dementia. This paper will present the undergraduate's perspectives of the AWTD app and how it has influenced their practice and see the person beyond the diagnosis.

#### *References*

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Heaslip, V., Board, M., 2012. 'The impact of staff vulnerability; does nurses' vulnerability affect their ability to care?' *British Journal of Nursing*. 21 (15).

### **Beyond participatory methods – qualitative research using an ethics of care**

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#### **Background**

Ethics of care has gained increasing attention across many disciplines since its first iteration as Gilligan's difference between care and justice. In this presentation, the way that ethics of care can affect research is outlined, as a response to the challenges of coproduction and participatory approaches.

#### **Aim**

Drawing on research in partnership with Maori in Aotearoa New Zealand, and with mental health service users, this presentation discusses a research manifesto that addresses common frustrations in undertaking research. Grounded in a wish to avoid colonising practices, the integrity of care can guide research practices that work in solidarity with marginalised groups.

From its inception, the ethics of care has theoretically developed and been applied in various ways, but as yet to research practices. Tronto (1993 and 2013) offered a broad definition of care that (paraphrasing) covers most organic life and refers to the activities that repair and maintain our world in its life sustaining web. Tronto's ethic of care has two prongs; whereby marginalisation and inequality are recognised and acknowledged and action is taken to ameliorate injustices. The integrity of care includes five aspects that enable careful practices; they are attentiveness – caring about, responsibility – caring for, competence – taking care of, responsiveness – receiving care, and solidarity – caring with. These aspects of care can guide and critique practices of any kind, here considered in relation to research practices. Participants in this conference will be asked to consider their own experiences of careful research and challenges to working in partnership with marginalised groups and what care work is necessary for research that upholds the aspirations of marginalised groups.

#### *References*

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Scheduled care – as a way of caring. A phenomenological study of being cared for when suffering from alcohol use disorders.

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### **Background**

Excessive alcohol use is health damaging and is identified as one of the major avoidable risk factors. Alcohol use disorders are classified among the most harmful, debilitating disease categories and patients are frequent visitors in the emergency departments. Further, patients suffering from alcohol use disorders are often characterized by complex problems and health pictures spawned by chaotic lifestyles. However, the experience of a hospitalization from patients' perspective is poorly documented.

### **Aim**

The aim of this study was to elucidate the lived experience of how patients with alcohol use disorders experience being cared for when admitted to acute medical units.

### **Method**

The data set consists of 15 in-depth interviews with patients suffering from alcohol use disorders admitted to an acute medical unit. A purposive sampling strategy was used and the interviews were conducted as open dialogues with an open ended-approach.

### **Findings**

Being cared for when hospitalized was experienced as a two-staged process that changed throughout the hospitalization from an experience of scheduled care experienced as caring to an experience of scheduled care experienced as non-caring. Four constituents further described the variable experiences: being in a safe haven, sharing a tacit but mutual goal, being in a chaotic space, and being on your own.

### **Conclusion**

The study showed that patients suffering from alcohol use disorders call for an intentional and distinctive attentiveness and authentic presence from the carers throughout their hospitalization. Being met in an authentic presence by carers was a powerful tool that helped ease the hospitalization as a transfer of attention within the patients was noticed and responded to in the care provided.

## **Wolf Medicine**

**Dr Kim Brown, Founder Director of Nature Therapy CIC**

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### **Background**

Recent increases in drug related deaths, homelessness and suicide is a growing concern. Substance misuse impacts on every layer of life including the individual, family, friends and the wider community. It carries long term impacts for children of those abusing substances. We needed to understand the underlying evidence to achieve positive outcomes. Despite ongoing support being a determinant of continued recovery, outside of the 12 Step approach there are limited options. Cultivating roots and connections is an essential element of ensuring each day in recovery is a successful experience. Our nature therapy work with ex veterans helped us understand their needs. This included their relationship with substances and challenges with sensory processing.

### **Method**

With the help of 23 Experts by Experience we started out to design a programme they would wish to be part of. Wolf Medicine was the result of this extensive work. Without their voices, insights and experiences, Wolf Medicine would not have been able to breathe life, success and meaning into the

experience of social recovery. Following piloting of the initial programme, we walked alongside 92 people in recovery. The aim was to determine effectiveness in involving wolves, horses and ancient knowledge in social recovery. We used a pre and post-test Likert scale applied immediately before and after the course and again at 2 months post participation. We used discourse analysis to deconstruct feedback received from participants.

### **Findings**

Main findings included positive shifts in nine areas of recovery. A significant reduction in severe anxiety was maintained for up to two months post participation. A key insight was a change of paradigm from a belief recovery was impossible, to the ability to visualise a more positive future free of substances. The main insight was based on expressed feelings of a spiritual connection to the planet, self and others. Participants felt modern medicine does not address the whole person in terms of their spiritual way of being in the same way as Wolf Medicine.

### **Kindness at Bournemouth University**

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### **Overview**

Service Excellence is a key corporate objective for Bournemouth University (BU). We engender this, celebrate achievements and share practice by means of the annual BU Service Excellence Conference, which is attended by approximately 300 BU staff, in addition to a small number of invited guests.

We challenged ourselves to come up with a key concept/word that embodied Service Excellence and we were drawn towards Kindness. The official definition of kindness (generosity, friendliness and consideration) was used during a talk and presentation given by BU Head of Service Excellence, Susanne Clarke, to open the 2017 Service Excellence Conference. This definition of kindness is perfectly aligned with our BU Values and the BU reputation as a friendly campus. Launching a kindness initiative provided a “call to action” for our staff to be more mindful of seeking opportunities to be kind; where could we show even more consideration to others; be even friendlier and seek actions that were even more generous towards others?

Other activities followed to draw more attention to kindness across a number of themes:- Research – seeking out opportunities to collaborate across disciplines, research topics included; Kind Leadership; Kindness as a brand value, and Corporate Citizenship. A student research submission was successfully supported to develop a student/staff co-creation project.

Practice – running seminars to explore kindness, which included workshops to examine the Humanizing Framework (Todres et al 2009), as well as introducing concepts and ideas to promote the philosophy of human kindness through Ubuntu.

BU2025 – kindness has now been included as an action embedded with the BU Strategic plan.

Other activity included a ‘Random Acts of Kindness’ week to support students living in halls of residence. Inviting the Antony Nolan Trust to run a campaign to encourage students to join the bone marrow donation programme.

### **Realising potential through support and consciousness**

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### **Background**

In my writing I am exploring people being able to better realise their potential, and Britain as a country being able to better realise its potential.

I am writing about that realising of potential for an individual in terms of the *support* around them. Support is central to humanising and building a society of true care. So although I am writing about potential, there is a substantial overlap (some might say total overlap) with humanising.

In my writing I explore the notion of a living ecology of support for realising potential that is both *within* the individual and *surrounding* them.

There is also a powerful reflexivity in that this ecology can apply to individuals as *users or carers* of users of state or voluntary sector care/health services. But it can also apply to *practitioners*.

The consciousness that drives the current mainstream of public services is about throughput, efficient use of increasingly scarce resources, volume of service, outcomes, targets, performance etc. This consciousness powerfully shapes the ecology of support possible through the work of practitioners. Humanising practitioners find themselves contesting this consciousness.

#### **Aim**

In my presentation I want to

- 1) Clarify this ecology of support
- 2) Use Wilber's four quadrants as a conceptual tool practitioners can use in contesting the mainstream consciousness and asking what consciousness is doing this contesting?

### **Supporting students to gain a sense of place during transitions by applying the tourist metaphor**

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#### **Background**

Commencing undergraduate students unfamiliar to higher education environments may feel that their sense of place is lost, developing a feeling of dislocation (Todres et al. 2009). This may be related to physical environments, but it also accounts for a sudden loss in their sense of belonging, security, or continuity, especially to those away from home for the first time and having to manage life skills they may not have done before. With a raise in students mental health issues when starting university (Devis-Rozental 2018), it is vital that those involved in this transition support students to settle and thrive.

#### **Aim**

In order to help students develop a sense of place, I propose that within our induction we should see these students through the lens of the tourist metaphor (Devis-Rozental 2018). This metaphor sees students both home and international as tourists to our country (our university), using different currency (marking criteria), laws (policies and procedures), language (academic skills, technical vocabulary), guides (University staff, who does what?) geography (campus), customs (independent learning, teaching styles), time zone (timetable), welfare (wellbeing centre, additional learning), entertainment (clubs and societies) and more.

#### **Conclusion**

By gaining this perspective we avoid presuming what students know, helping them in developing a sense of belonging improving their student experience and perhaps proactively protecting their mental wellbeing as they progress. This type of practice will further embed humanisation practices within higher education, supporting students in developing their sense of place, their personal journey, their insiderness and other dimensions within the humanisation framework.

#### **References**

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Todres, L., Galvin, K. T. and Holloway, I., 2009 The humanization of healthcare: A value framework for qualitative research. *International Journal of Qualitative Studies on Health and Well-being*, 4 (2), 68-77.

**“It made me feel warm, seeing a person with the same heart as me” - an exploration of relational well-being on stroke units.**

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### **Background**

Variations in the quality of care experiences in the NHS and stroke care are widely reported. At times services can become dehumanised and lacking care. There is some evidence around the delivery of humanising relationship-centred care in hospitals. However there is little evidence on its development in stroke services and, in particular, how the entire multidisciplinary team beyond nurses alone, can develop relationship-centred care together.

### **Aim**

In this PhD study, the overall aim is to describe how people with stroke, their family and staff describe their valued relational care experiences, and the processes that can enhance relational approaches in practice.

### **Method**

Using appreciative action research in two stroke units; data were collected using direct observations, discussion groups and semi structured interviews with 65 stroke unit staff, 17 patients with stroke, and seven family members in two NHS District General Hospitals. Data were analysed together with participants to co-construct understandings of their most valued care experiences. Further in-depth analysis was conducted by the authors to confirm the themes.

### **Findings**

Participants described how through meaningful connections with each other they felt comfortable, warm and at ease. Through understanding each other and not why they were there (i.e. their diagnosis or clinical role), they described a feeling of community and being together that supported each other's well-being. Staff were able to sensitise themselves to relational experiences, and connected with others through pausing from the usual operational and clinical activity and being focused in the present.

### **Conclusion**

Previous research into relationship-centred care has focussed on establishing relationships through conversations. This study highlights all participants (staff, patients and relatives) value similar relational experiences of connecting with each other at a human level. This occurred at a felt or embodied level and created moments of warmth and well-being that improved the care experience for all involved.

**Relationships as assets: togetherness as a key factor in rehabilitation for people with aphasia**

Dr Ciara Shiggins (Academic Fellow, School of Health Sciences, University of East Anglia); [Dr Fergus Gracey](#) (Senior Research Fellow, Dept Clinical Psychology, Norwich Medical School, University of East Anglia); Mr Ian Duffy (Person with aphasia and expert by experience); Dr Simon Horton (Lecturer, School of Health Sciences, University of East Anglia)

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### **Background**

Around 150,000 people have a stroke for the first time in the UK each year; nearly one third of these people will have communication impairments, including aphasia, a language impairment affecting one or more language modalities. Compared to stroke survivors without aphasia, people with aphasia (PWA) are at greater risk of social isolation; changes in social roles and networks; and emotional disorders, including acute and chronic depression. While PWA are at risk of reduced well-being and quality of life because of their communication impairment, close family members are liable to 'third party disability'. Currently most interventions offered focus on language and communication function, with inconsistent attention to psychosocial issues.

## **Aim**

In this paper we explore how an asset-based approach, based on the theory of salutogenesis, and incorporating the concept of togetherness through relationships between PWA and health care professionals, family members and peers may have the potential to promote and enhance well-being for PWA at all points on the stroke pathway.

## **The Mechanism of Action of an Equine Assisted Intervention: A Pilot Study**

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## **Background and statement of problem**

There is now an accumulation of evidence of the vital contribution that emotion makes to learning. Within this broad advance in understanding is a growing body of research emphasising the embodied nature of this emotion based learning.

## **Study Aim and Objectives**

This paper reports on a study of the mechanism of action of an equine assisted therapy based on natural horsemanship using hetero-phenomenology.

## **Study Design**

It was hypothesised that the established success of this intervention was due to emotion based learning, measurable by somatic psychophysiological changes. Three research methods were used to collect data, phenomenological data was collected through interviews, psycho physiological data was collected and video data was collected.

## **Study population**

Seven healthy participants undertook the equine intervention.

## **Data Collection Methods and Measures**

The first four participants had emotion-related psychophysiological changes (heart rate, breathing, heart rate variability, facial EMG, skin conductance) measured while they viewed their experience on video in the lab, and the final three experienced a development of the methodology as their responses were captured in real time on video while participating in the intervention. All participants were also interviewed while watching themselves completing the intervention on video to explore their emotional experience.

The sessions were analysed by five independent researchers who matched together the psycho physiological responses with what was happening in the video of the individual engaged in undertaking the intervention and their responses when interviewed while watching themselves on video. This was done in order to identify any emerging patterns of change in the psycho physiological responses in relation to the exact timing of what was happening on the video.

## **Duration of study**

Two stages, over two years.

## **Outcome/Results**

The results supported the hypothesis that the primary learning process in the intervention may be an embodied emotional response as consistent patterns of measurable change in skin conductivity responses were found at particular points in the intervention.

## **'Walking in someone else's shoes': humanising dementia care through simulated learning.**

**Dr Michelle Heward**<sup>1,2</sup>, Dr Michele Board<sup>1,3</sup>, Ashley Spriggs<sup>1,3</sup>, Dina Blagden<sup>1</sup> and Prof Jane Murphy<sup>1,2</sup>  
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### **Background**

There is a lack of simulation-based dementia education programmes for acute care settings that support the development of interpersonal skills pertinent to good care, and few studies examining the impact of such programmes on practice over time. The Ageing and Dementia Research Centre (ADRC) were commissioned by Health Education England (HEE) to develop and evaluate the Dementia Education And Learning Through Simulation 2 (DEALTS 2) programme. DEALTS 2 is a national simulation-based education toolkit informed by the Humanisation Values Framework and based on an experiential learning approach, putting staff into the shoes of a person with dementia aiming to facilitate positive impacts on practice.

### **Aim**

This paper provides an overview of the iterative approach to developing the DEALTS 2 programme and preliminary data indicating the programme is positively impacting dementia care across England.

### **Methods**

We delivered DEALTS 2 across England through a Train the Trainer (TTT) model. Key stakeholders were asked to critically feedback during the development process. Evaluation data is being collected through questionnaires and telephone interviews (quantitative and qualitative) with trainers that attended TTT workshops (n=196) and, once implemented in individual Trusts, the staff that the trainers trained.

### **Findings**

Trainers thought simulations were: 'thought-provoking' and 'insightful'; provided a more holistic outlook on dementia care; enhanced the training and reflection on the underpinning theory. Potential barriers to roll out were: approval from line managers; course content heavy; time given for training. However telephone interviews with 18 trainers reveal most (n=17) are already using the materials in their training, with some already identifying the programme as positively impacting on the care of people with dementia in their own Trust.

### **Conclusions**

Our findings demonstrate the value of using simulated learning as an approach to put staff into the shoes of a person with dementia, humanising care and supporting the wellbeing of both people with dementia and staff in acute care.

## **Using graffiti to support identity and well-being in people with dementia.**

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### **Aim**

This presentation reports on a series of graffiti workshops that were used as a creative psychosocial initiative to support identity and well-being in people with dementia.

### **Activity**

The workshops took place at Bournemouth University and an Assisted living facility in Brighton. Participants were encouraged to develop their own 'tag' to express their sense of 'self' and use spray paints to portray their creative message.

### **Outcome**

The final art pieces were displayed around public locations as a means to challenge negative assumptions of dementia and graffiti as well as raise dementia awareness among the general population.

**Humanising social work practice. Reflections on writing a book with service users and carers. A Guide to Statutory Social Work Interventions: The lived experience.**

**Dr Mel Hughes**, Principal Academic in social work, Academic lead for the BU PIER (Public Involvement in Education and Research) partnership

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**Background**

The BU PIER partnership works with over 90 individual members (people with lived experience) and local, regional and national organisations to embed the lived experienced in health and social work education and research. Our members often explain that they enable students to learn and develop their practice in ways students can never get from a text book. Well...until now that is.

**Aim**

Palgrave Macmillan have commissioned us to write a text book with service users and carers on statutory social work interventions such as being detained under the Mental Health Act, having a child removed to a place of safety or having a carers assessment. Each chapter is written by someone with that lived experience. They share their background, the context in which the intervention took place; what happened; what has happened since and what their message to social workers is. Formal content such as underpinning legislation, policies and research, have been added by a social worker or social work academic (or combined when contributors have both areas of expertise) along with the social worker's perspective. The book will enable students and practising social workers to learn from the expertise of people with lived experience and to use this to consider how the law is enacted in practice and the impact of this on people's lives. As one of the contributors says, however brief, when you become involved, you then form part of that person's history. In this presentation, I will reflect on the progress of writing the book with service users and carers and on the significant areas of learning for humanising social work practice.

**Material Citizenship: Introducing citizenship practice in care homes through a material lens.**

**Kellyn Lee**, Dr Ruth Bartlett, Dr Rebekah Luff, University of Southampton

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**Background**

Questions such as what does citizenship look like in care homes and how is it practiced have not been fully addressed. In addition, whilst there is growing literature on the subject of citizenship regarding people living with a dementia, it remains under-theorised and lacks a material lens. I draw upon my doctoral work in care homes to argue that locating citizenship is the introduction of 'material citizenship'. I define material citizenship as 'the right to be included in decision making relating to belongings and opportunities to use functional objects'. The concept combines psychological and sociological concepts of everyday routines and rituals, and maintains and reconstructs a person's identities through the subjective and material worlds in which we live and perform through the use of functional objects. Material citizenship is highly relevant to people living with a dementia in care homes, where institutional policies and procedures are designed to meet care needs rather than promote rights and citizenship.

**Methods**

An ethnographic study consisting of 22 interviews, 96 hours of participant-observations and documentary sources. Participants included people with a dementia, care staff and family members. Data was analysed using a critical realism framework.

**Results**

Four main themes were found: (1) people with a dementia are rarely included in decision making relating to objects, (2) residents are largely viewed as passive recipients of care, resulting in limited opportunities to use functional objects, (3) objects are managed on a 'risk' basis, and (4) keeping people 'safe' can lead to a loss of identity and dehumanisation.

## Conclusion

Material citizenship can help locate citizenship, advancing dementia care. It gives opportunities to use functional objects, repositioning people as active participants in their own care. This not only helps maintain identity but also affords people with a dementia the same rights as everyone else.

## Humanisation theory in social work education

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### Background

Social work is sometimes portrayed, and experienced by practitioners and users, as a bureaucratic, legalistic, judgemental even oppressive profession (Lishman et al 2018). Yet social work values commit practitioners to work in precisely the opposite way: to advocate for the right to full inclusion, to challenge oppression and discrimination and promote the views of the individual and their networks of support in ways which recognise people in their full humanity (BASW 2012). Reconciling these opposites requires practitioners to have a deep understanding of their professional purpose informed by knowledge about what it is to be human.

### Aim

This presentation reflects on insights gained from working with social work students to explore humanisation theory as it applies to their own personal experience and the experience of users of social care services. Introducing humanisation into social work education enables students to engage with humanising and dehumanising theories and frameworks and use these to develop ways of working which adheres to social work values whilst acknowledging the lived experience of social work. Social work practice informed by humanisation, with its fundamental concern for human well-being, embodies the underpinning principle of the Care Act, 2014. The well-being principle requires practitioners to be prepared and able, to support people in identifying what impacts on their own well-being. This exploratory, collaborative, approach to well-being has the potential to uncover sensitive issues which present practitioners with opportunities to directly apply their interpersonal skills in ways which reinforce their own and others humanity.

### Reference.

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<https://www.basw.co.uk/codeofethics/>

Lishman, J., Yuill, C., Brannan, J. and Gibson, A. (Eds) 2018. *Social Work: An Introduction*. London: Sage.

## Mosaics, ambiguity and quest: constructing stories of spirituality with people with expressive aphasia

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### Background

Despite the current emphasis on person centred, holistic care in health, the concept of spirituality has been discussed very little in the field of speech and language therapy (SLT). The nursing spirituality literature has proliferated in the last twenty years but, by contrast, very few SLT studies exist which mention the spiritual needs of patients with communication problems and how they express them.

Individuals experiencing severe, life-changing events, such as a stroke, may need to engage with and discuss their spiritual needs, in order to make sense of what has happened to them. The aim of this study was to discover what it is like to express spiritual issues when one has an acquired communication impairment (aphasia).

## **Aim**

I used a hermeneutic phenomenological approach in order to interview eight people with aphasia about their spirituality. Participants with aphasia used a variety of strategies to express these ideas, which included employing non-verbal communication techniques, such as gesture, writing key words, intonation and artefacts.

## **Method**

Each interview resulted in a participant story. People with aphasia talked about religious themes, such as visions and prayer, but also non-religious life meaning-makers, such as gardening and art. The stories were then explored through the interpretive lens of some concepts propounded by Merleau-Ponty (2002), namely ambiguity, lived body, language and thought, and wonder. Frank's (2013) illness narratives (chaos, restitution and quest) were also considered in order to analyse the participants' stroke journey in relation to expressing spirituality.

## **Key points**

People with aphasia can and do discuss their spiritual concerns, particularly when they are entering a quest phase of their illness narrative. They employ many non-verbal mosaics in order to convey spiritual issues, and are helped by the listener employing a phenomenological attitude of openness and attentiveness

## **Conclusion**

Being able to express spiritual needs can enhance wellbeing, help foster therapeutic rapport, and enable people to engage more fully in the rehabilitation process.

## **References**

Frank, A.W. (2013) *The Wounded Storyteller: body, illness and ethics (second edition)*. Chicago: The University of Chicago Press

Merleau-Ponty, M. (2002) *Phenomenology of Perception*. Abingdon: Routledge Classics

## **Exploring the lifeworld experiences, lifestyle changes, and well-being, of individuals with type 2 diabetes who consume alcohol**

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## **Background**

Alcohol consumption can exacerbate type 2 diabetes (T2D) and affect the well-being of individuals. Individuals with T2D who consume alcohol require lifestyle changes that are not easy achievable. The impeding factors for lifestyle changes relate to the lack of supportive social networks and to the blaming culture towards individuals with T2D for the lack of control and poor management of the diabetes, for alcohol drinking, and for their unwillingness to change their lifestyles.

## **Aim**

To understand the lived experiences of individuals with T2D who consume alcohol with regard to the existential challenges they face in changing their lifestyles, and in constructing meaning of their lifeworld as to achieve a sense of well-being.

## **Design**

An interpretive phenomenological design was implemented as to acquire understandings of the lived experiences of individuals with T2D who consume alcohol with regard to lifestyle changes and to achieving a sense of well-being.

## **Method**

A total of 12 in-depth interviews were conducted with individuals with T2D. Purposive sample was selected and the data was collected in North of England in UK's diabetes support groups. Data were analysed using thematic analysis framework.

## **Findings**

A total of four themes emerged from the findings, namely; a) Collective determinants influence on lifestyle changes, b) Contextual and cultural framing of lifestyle changes, c) Embodiment of intersubjective interactions, and d) Being and well-being with T2D.

## Conclusions

Alcohol consumption for T2D individuals has symbolic signification, along with the unregulated and poor labelling of alcohol drinks, and the dominance of the medical model of care impedes the initiation and sustainment of lifestyle changes. Healthcare professionals can support the lifestyle change processes by respecting the personhood of T2D individuals, incorporating family members in the care processes and assist individuals with T2D to become attuned with the T2D situation and to commence plans for the future.

### Dignity and 'Other' - ethical and spiritual issues. Humanisation musings from the chaplaincy bedside.

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## Aim

Drawing partly on the work of Roshi Joan Halifax on 'edge states' together with reflections from the hospital bedside, I hope to draw thoughts that set humanisation principles within an ethical and spiritual context.

### What goes on? More than I could see and more than words can say: Reflections on my lived experience of being a participant observer of dancing sessions for people who experience Parkinson's.

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## Background

I have been part of a team evaluating dancing sessions specifically designed for people who live with Parkinson's. I have been listening to the meanings and experiences of dancers and I have been joining in with their sessions as a participant observer. Through being actively involved in the group as a dancer I have realised that I have not just been seeing what occurs, I have been feeling it too. Through the role of participant observer I appear to have gained a bodily sensed understanding of what is going on. This bodily sensed understanding is a form of embodied knowing that I had not been expecting to experience. However on reflection I realise that this is knowing from the head and heart and that it has stemmed from more than I could see as a participant observer. My challenge now, is to adequately express my embodied understanding and to do so I draw on the notion that the lived experience is more than words can say (Todres and Galvin 2008).

## Aim

During this presentation I hope to act as what Todres and Galvin (2008) have described as an 'evocative mediator'. I will be offering a free verse poem about my experiences of what goes on in Parkinson's Dance sessions and because the lived experience is more than words can say, I enrich the poem with the languages of music and visual imagery.

## Reference

Todres, L., Galvin, K. T. 2008. Embodied interpretation: a novel way of evocatively re-presenting meanings in phenomenological research. *Qualitative Research*, 8 (5) 568-583.

## **A mixed methods investigation into the impact of ICCI (Intentional Compassionate Communication Interventions) for older people in A&E**

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### **Background**

Growing awareness of the importance of compassionate care, particularly for older people, has driven the development of a specific Intentional Compassionate Communication Intervention (ICCI) within an A&E of a district hospital where proactive communication-focused support is offered to older people.

### **Aim**

To explore the personal experience of older patients (65+) admitted via the A&E of a district hospital in relation to the delivery of ICCI and that of their relatives and the hospital staff caring for them, while investigating possible correlations with the incidence and detection of delirium.

### **Methods**

This is a mixed methods study.

The qualitative part will use a Phenomenological approach inspired by Gendlin's Experiential Phenomenology to explore lived, embodied experiences through in-depth semi-structured one-to-one interviews with patients, relatives and staff, employing creative-expressive techniques where appropriate.

In the quantitative part, instances of delirium will be identified from patients' clinical records in order to identify possible correlations between ICCI and delirium symptoms.

### **Key points**

- The proportion of older people within the UK population is increasing and this in turn increases the number of older people accessing hospital emergency services, which can be a frightening experience.
- Fear and anxiety can act as a trigger for delirium, a common complication in older patients.
- There are very few studies that have explored compassionate communication within the specific setting of A&E and no published studies on a possible relationship between ICCI with older patients in this setting and the incidence of delirium symptoms.

### **Conclusion**

This study will contribute new knowledge of how an ICCI can impact on the experience of older patients, their families and the hospital staff caring for them in A&E. It will also explore possible correlations between compassion and tangible, measurable complications like delirium and thus positively impact on older patients' hospital experience and recovery.

## **The Worm and the Woodpecker: Our life experiences of developing a relationship centred approach in stroke care.**

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### **Background:**

In 2016 Farley Stroke Unit participated in a research trial from Bournemouth University investigating relationship focused care in stroke. We spent time looking at the relationships we built both with other staff, and with patients and their relatives and discovered the importance of building rapport and relationships that weren't purely professional but allowed connection on a more human level. Since the study has finished, we endeavour to maintain a culture of relationship centred care across the unit in Salisbury.

### **Aim**

To describe our experiences of developing a relationship centred approach through highlighting stories and occurrences on the stroke unit that have exemplified this approach.

### **Method**

The study used appreciative enquiry to explore and discover the positive aspects of relationship focused care on the unit. Since the end of the formal study we have collected stories and examples of positive practice across the MDT to increase awareness of relationship focused care and instil it into stroke unit culture in day to day patient care.

### **Findings**

1. This is not “a thing” to do and should be part of who we are, not what we do.
2. Sometimes you have to be brave and take off your “professional hat”
3. This is something we do anyway, the reason we came into healthcare, highlighting awareness and bringing it to the forefront of people’s minds makes this easier to maintain across the team.

### **Conclusion**

Relationship focused stroke care is hard to define but it is clear when it is done well. Highlighting good practice through different examples across the team has helped to improve awareness on the stroke unit and embed it into team culture.

## **The process of adjustment from the place of loss and disconnection into rediscovery of sense of wellness following Acquired Brain Injury: A qualitative Study**

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### **Aim**

The aim of this study was to gain insight into the experience of well-being post-acquired brain injury and explore the resources people draw on to help them achieve this, extending previous research into identity and well-being in this population.

### **Method**

Eleven individuals with ABI were interviewed about their experiences of well-being following-ABI, using semi-structured interviews. Interviews were analysed using Interpretative Phenomenological Analysis (IPA).

### **Findings**

Six main themes were identified which illuminated the experience of wellbeing in relation to internal and external resources. The themes were: (1) Having the right information and knowledge can empower you; (2) Being able to help others gives you a sense of pride and social-role; (3) Being valued and supported by others / freedom to find your own way; (4) Love the life you live but keep trying to make it better (5) Live in the moment: experience the world to its fullest; (6) Doing the thing(s) you love makes you feel alive: ‘It means the world’.

### **Discussion**

This study offers valuable insight into the felt experience of well-being following ABI and the resources that contribute to these experiences. The findings are idiographic and at the same time resonate with broader theoretical models of well-being, with implications for practice. Being in the moment, and embodied experiencing of the world were the most powerful accounts of well-being described by the participants. The findings suggest a rationale for including approaches that foster in-the-moment or embodied knowing such as cultivation of mindfulness, or use of creativity or arts-based approaches within the care pathway

## Elucidating perceptions of ageing through drawing

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### Background

Drawing was historically valued as intellectual practice in the West, but now it becomes redundant in childhood when text-based literacy takes precedence with adults being anxious about their drawing skills. Drawing or mark-making was connected to ageing, a prevalent issue. Health professional students will care for increasing numbers of older people but there is evidence that they hold negative views of older people. As students themselves will age and become old, the new approach taken was the opportunity for students from different professional pathways and people over sixty to consider their own future ageing through drawing.

### Aim

The aims were to create a Drawing Programme (DP) for exploring perceptions of ageing and to analyse participants' experiences.

### Method

The DP fused a participatory drawing methodology with phenomenography. Fourteen participants met for four drawing workshops over one month. They utilised generative drawing, a style of exploratory drawing cultivated from both objective and subjective drawing, to think about their own ageing. Participants explained, discussed and reflected upon five drawings in total connected to ageing.

### Findings

Participants moved from habituated to embodied and transformed thinking practices where ageing was no longer Othered but part of the Self's future. Phenomenographical analysis generated a collective account of five distinct experiences. These increased in complexity from representing ideas in pictograms (category 1) to surrendering to the drawing process (category 2) where they gained insights from various sources (category 3) enabling them to identify dominant narratives of drawing and ageing they had unthinkingly absorbed (category 4) which helped them construct new ways of being (category 5).

### Conclusion

Drawing is an intellectual process which challenged Cartesian dualist notions of mind and body. Aspects of the DP have been used with students, general practitioners and can be further adapted for use in research and health education.

## Using a Humanisation approach to support a Constructivist adult learning model

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Trust

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### Background

The Dorset Speech and Language Therapy Service Dysphagia Training Team have incorporated the use of some humanising techniques in their Dysphagia Training Programme. The day-long training session uses a constructivist approach, facilitating students to make meaning from their learning by contextualising it within their own experience. The Dysphagia Training programme focusses on what a person with disordered eating and drinking may experience; the risks to their health and wellbeing; and how best to support someone with dysphagia in order to reduce those risks.

### Aim

Following a Humanisation in Healthcare workshop it was recognised that some of the concepts embodied in the Humanisation Framework could make a useful contribution to the Dysphagia Training programme and the team introduced a new activity right at the beginning of the day. Learners are now asked to choose from a selection of images that relate to eating and drinking, and discuss with each other what their chosen image means to them personally.

## Outcome

As a result of making this small change to the programme we have found that the learners make much quicker progress towards achieving an understanding of what makes good practice in assisting people with eating and drinking disorders. Encouraging learners to connect with their own relationships with food and drink has unlocked the potential for much richer discussions to take place and we have observed that the shared learning experience is enhanced.

### Academic Advisor (personal tutor) role modelling a humanising approach: how & why?

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#### Background

Bournemouth University (BU) has developed the complex role of Academic Advisor (AA) – also known as the personal tutor in other settings - with the expectation that, at the point of qualification student nurses are professional and compassionate. Therefore the AA role is vital to help students become resilient, employable and at the point of graduation ready to enter the Professional Register.

BU has a diverse range of students, and the AA uses a student centred and humanistic philosophic approach to support students in their academic, professional and personal development.

#### Aim

Presenters will share their experiences and teaching strategies in developing the role of the AA and how these are pivotal to students learning and development. They will cover a range of pedagogical approaches which support the development of resilience and compassion and which are applicable to other students. The AA role includes reflection upon practice, small group recall days, 1:1 discussions, peer support and Year 3 Peer Assisted Learning to develop empowerment, self-esteem and management of self and well-being. Alongside this, giving students a sense of agency and recognising their uniqueness in their personal journey.

To guide them on this journey, the AA needs to be a credible role model, skilled facilitator, compassionate and have a humanised approach to the student's journey as they progress through the programme and continue with Life Long Education.

### Proposing a 'Biographical Echoes' approach to understand the idiographic nature of patient experiences and promote humanised health care practices.

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#### Background

Premenopausal osteoporosis is a poorly understood condition in which healthy, premenopausal women have very low bone mineral density. This makes them susceptible to potentially painful and debilitating low trauma fractures. Being diagnosed with a chronic condition at any age has been shown to have profound psychosocial implications for the individual. A diagnosis of osteoporosis for a premenopausal female is significant as the age of diagnosis contrasts markedly from the common cultural paradigm for the condition (the older post-menopausal woman), with its established health care pathway and support systems. 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 was to explore the experience of living with osteoporosis, as a young active female.

## **Method**

Autobiographical methodology was employed utilising a reflective topical autobiographical approach. Data included personal diary and blog entries over a two year period, from pre-diagnosis, to 21 months post diagnosis. The breadth and depth of the experience of living with premenopausal osteoporosis was captured through storytelling.

## **Findings**

Seven reflective themes were produced from the illness experience data: Engagement with the medical profession; information seeking as an educated patient; managing invisibility and disclosure; social interaction; the impact on physical activity; a stranger in a biomedical land; and the emotional journey. Each theme highlighted the experience of living with premenopausal osteoporosis as being a disruptive and dehumanising one. Each element of the experience was impacted upon through the resonance of biographical and emotional echoes from biographical antecedents, such as life experiences, coping resources and personality.

## **Conclusion**

If health care professionals adopt a 'Biographical Echoes' approach to their patient care, the ideographic nature of chronic illness experiences would be acknowledged, encouraging elements of humanisation in their approach to professional practice.

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## **Background**

Critical illness can occur at any age, but it is more often associated with middle age and beyond, often exacerbated by multiple co-morbidities. Commonly patients experience the physical symptoms of illness and disability before acknowledging them fully on an emotional level; denial is an example. Likewise after a return to health, or learning to live with chronic conditions, patients still experience concerns and fears related to their critical illness. Sometimes the critical care unit is perceived as a place where fragile lives are vigilantly monitored, cared for and on the whole preserved. Understanding how critical illness impacts on, and what critical care means to patients and their families, can help nurses to provide individualised humanised care for these patients and their family. The authors used Todres and Galvin's Humanising dimensions and real life case studies to help leaders in Critical Care explore with their junior staff how to offer humanised care. Working with practice staff we wrote a Humanising book for Critical Care Nurses. A key focus of this is that the expert nurse explores care through the lens of the professional gaze (the professional practice of engaging in scanning, selective perception, recognition, diagnosis of and response to clinical deterioration) and the factors that affect clinical decision making in practice and we explore how s/he can do this at the same time as using the humanising dimensions.

## **Aim**

This presentation will explore how using case studies together with the humanising framework helps nurses develop their professional gaze and offer complex holistic humanised patient-centred care.



