



ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Using creative methods in practice development to understand and develop compassionate care

Belinda Dewar

NHS Lothian, Edinburgh, Scotland. Email: b.dewar@napier.ac.uk

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Abstract

Background: Compassionate care is a key priority for policy and the profession, yet the meaning of the concept and the processes that enable it to happen in the context of everyday practice is unclear. Creative methods within a practice development study helped to engage participants in a deep understanding of compassion.

Aims and objectives: One of the aims of the study was to explore the experiences of staff, patients and their families in giving and receiving care within an older people care setting in an acute hospital. The use of creative methods in helping to explore this aim as well as enhancing engagement with the inquiry process and ownership of findings is the focus of this paper. The methods discussed include photo-elicitation, role enactment and poetry.

Conclusions: Use of creative methods enabled a clearer articulation of the concept of compassion and an inclusive approach to data generation and analysis, dissemination and the use of findings in practice. It could be argued that these methods enabled a deeper understanding about compassion and how this is experienced in practice compared to more traditional methods such as asking questions and sharing results through reports. Being confident in the initiation and facilitation of these methods however requires a degree of courage and confidence. There is more scope to share reflections on the experience of using such approaches to enables others to develop this courage and confidence.

Implications for practice: Using creative methods in practice:

- Is valuable to tap into complex concepts in health care
- Is valuable in bringing about greater engagement in the practice development process
- Requires confidence and skilled facilitation

Keywords: Creative methods, practice development, appreciative inquiry, photo-elicitation, role enactment, poetry, compassion

Introduction

Compassionate care is a key priority for government health care policies and professionals (Scottish Government Health Department, 2007, 2010; Darzi, 2008; Iles and Vaughan Smith, 2009). The challenge that lies ahead is how people can be supported to develop and deliver caring skills consistently in the context of everyday practice.

Making explicit which dimensions of patient care comprise compassion is challenging due to the often 'invisible' nature of this work. The literature emphasises the relational nature of compassion (Sabo, 2006; Sanghavi, 2006; Paulson, 2004; Von Dietze and Orb, 2000). In other words it revolves around the way in which we relate to other human beings. It is not so much about what we choose to do **for** other people but what we choose to do together **with** them. Liaschenko and Fisher (1999) discuss the fact that relational practice is not recognised as work. Pearson (2006, p 22) talks about the 'invisibility' of small acts of compassion as '*simple not clever; basic not exquisite; peripheral not central*'. Such acts are thought to be important but in reality have little status to those managing and developing services. They are often more noticeable by their absence. The 'invisibility' of the concept has significant implications for its recognition and assessment in practice. There is a need to understand the meaning and processes that enhance compassion in the everyday world of health care practice.

Because of the challenges in articulating the concept, creative methods were used alongside a range of other methods in the study described in this paper that enabled people to tap into tacit knowledge that underpinned caring actions. In addition creative methods were used to support people to share understandings and develop practice further.

This paper thus describes some of the creative methods used with staff, patients and their families in one ward area caring for older people to help to a) discover what compassion means, b) identify the key processes that are at play when compassionate care works well and c) develop ways to share learning about compassion so that it can flourish and grow across teams and the organisation.

The study

The study is set within a larger programme called the '*Leadership in Compassionate Care Programme*', a three year programme undertaken by Edinburgh Napier University and NHS Lothian, with a vision to establish compassionate care as an integral aspect of all nursing care (Dewar et al., 2009; Smith et al., 2010).

One of the aims of the study was to explore the experiences of staff, patients and their families in giving and receiving care within an older people care setting in an acute hospital from April 2008 - Jan2009. This ward was part of the wider Leadership in Compassionate Care Programme. During the first four months we worked to find out the best of what was happening on the ward using the approach of Appreciative Inquiry (Cooperrider, Whitney and Stavros, 2003). This involved initial interviews with all staff; together with observation; patient, family and staff stories; and informal observations and discussions recorded as field notes. Determining 'what was the best of what was happening' was co-constructed with myself, as the appreciative inquirer in the setting and the participants, through real time feedback, discussions and the iterative process of analysis.

Appreciative Inquiry has been defined as:

A theory and practice for approaching change from a holistic framework. Based on the belief that human systems are made and imagined by those who live and work within them, Appreciative Inquiry leads systems to move toward the generative and creative images that reside in their most positive core - their values, visions, achievements and best practices. (Watkins and Mohr, 2001, p 262).

Appreciative Inquiry aims to work towards emancipatory transformation (Grant and Humphries, 2006; Reason and Bradbury, 2001). The approach focuses on exploring with people what is valuable in what they do and how this can be built on, rather than on problems (Cooperrider, Whitney and Stavros, 2003; Dewar and Mackay, 2010). Although Appreciative Inquiry does not have a prescribed set of methods, those that are most commonly highlighted in the literature are interviews and

affirmative questioning to collect and celebrate the good news stories of a community or organisation. Authors also support the use of creative methodologies that would encourage a range of different voices to be heard (Reed, 2007).

Using creative methods in health care is not new. A range of activities have been used by researchers and practice developers which include visual media, poetry, music, drama and movement (Coats et al, 2004; Simons and McCormack, 2007).

A range of ways of exploring and communicating ideas and issues was developed to invite participation in this study and the wider Leadership in Compassionate Care Programme which included:

- Photo elicitation
- Role enactment
- Poetry

Each of these methods and how they were used with participants on the ward are described in turn.

Photo elicitation




Staff participants found it hard to articulate responses to questions about the meaning of compassionate caring. For example, in trying to define compassionate care, staff described this in very general terms such as humanity, being with another person, empathy, and individual care. They gave very little elaboration on these points and seemed to be detached from the words they were using. We made a decision to use photographs to prompt further discussion about the meaning of compassionate care.

The use of photos in research has a history in anthropology (Schwartz, 1989). The method is called photo elicitation. Photographs have been used for example, to help people to communicate intangible aspects of culture and to bring out emotions associated with the phenomena under study, that may remain hidden with verbal interview (Lorenz and Kolb, 2009). Other authors have advocated their use in research as a valuable tool in the development of knowledge (Banks, 2001; Hansen-Ketchum and Myrick, 2008). Harper (2002) suggests that photos can evoke deeper elements of human consciousness and stimulate greater cognitive response than words alone.

In order to try to elicit what compassionate care meant to participants they were asked to select an image from a range of 30 that I had selected from a web-based source. They depicted, for example, landscapes, people, and objects that summed up for them the meaning of compassion. Staff and patients selected an image and explained why they had chosen it.

Three images and statements used to describe compassionate care are illustrated in the Table 1.

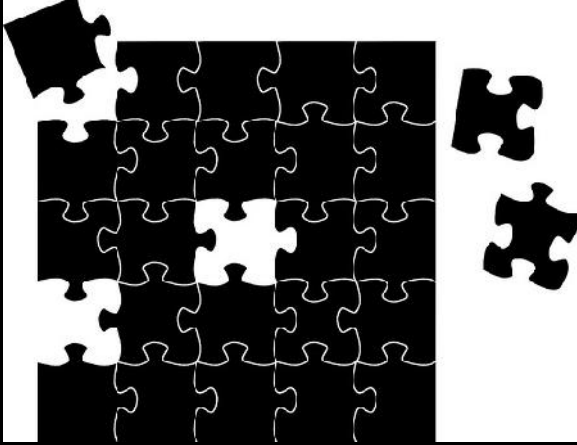

Table 1. Images and statements used to describe compassionate care

Image selected	Words used by participants to describe compassionate care
	<p>It is about making a real effort to understand people and get along with them even if you don't always agree with what they are saying. (Staff comment)</p>
	<p>I think compassionate care is about making sure you reflect on things so that you are continually wondering if what you did was caring enough. (Staff comment)</p>
	<p>This is what care is like here – good and comforting except from the cuddles – I don't like when staff or my family do this it makes me cry. (Patient comment)</p>

Within these statements, participants began to articulate not only the meaning of compassion to them but some of the challenges inherent in giving or receiving this type of care. This method resulted in more tangible and unique insights into understanding the meaning of compassion and the experience of giving or receiving this type of care. The final image and quote from a patient challenged staff and family members' assumptions about what mattered to that person. Challenging assumptions is a key aspect of the process of practice development but it takes courage to be able to do this. I believe the image helped this particular patient to articulate this in a way that felt comfortable to her.

In the final interviews with staff, the photo-elicitation method was used to identify their learning. Some of the images and statements used to describe their learning from the study are illustrated in Table 2.

Table 2. Staff perceptions about their learning from the study

Image	Quote
	<p>The missing part of the jigsaw for me was the patient and family experience. I thought I knew what they needed and wanted by imagining what I would want myself – this was wrong. I know now that checking out with them is part of compassionate care. They may want something quite different to what you think they want. (Staff comment)</p>
	<p>For me it's about going on a journey with the patient – taking the ride with them and trying to find out every part of the way about the journey so that you can tell others. (Staff comment)</p>

The images prompted staff to articulate new understandings about the way in which they cared, that is the processes of compassionate caring which included ‘understanding how others feel about their experience’ and ‘knowing who people are and what matters to them’. Staff enjoyed this exercise and were happy to have their images and quotes displayed on the ward. This in turn engaged a wider audience on the ward to reflect and discuss the content.

Co-analysis is central to the philosophy of participatory inquiry. Photo elicitation was used to prompt co-analysis of the data and dissemination of key messages from the study. A distinct aspect of participative approaches to inquiry is the anticipation that staff will read written materials and discuss and debate them to further consolidate and refine their knowledge about practice (Hummelvoll and Severinsson, 2005). In reality however, this is often not the case. Staff rarely read information about the study or emerging data unless I or the charge nurse worked with staff to go through the data. Staff felt that they had too many other documents and papers to read. I was aware of the limits of an approach to co-analysis that focused purely on textual interpretation of the data and made attempts to work with staff to present analysis using both visual imagery, metaphor and poetry. For example, we developed statements of positive care practices from the data and presented these alongside images using a digital photoframe (Dewar, Pullin and Tocher, 2011). The mapping of statements to images builds on the photo elicitation method where it is suggested that photos can stimulate a greater cognitive and emotional response than words alone (Rosenbaum, Ferguson and Herwaldt, 2005). Examples of statements and images that were displayed using the digital photo-frame are shown in Figures 1 and 2 below.

Figures 1 and 2. Examples of statements of positive care practices



We created a daily opportunity to discuss and debate each statement using the framework of questions:

- How does it make you feel?
- Does it happen most of the time?
- What helps it to happen?
- How can it happen more of the time?
- What action do we need to take?

This enabled staff to engage in a meaningful way with the messages, debate them and decide on future actions if appropriate. Staff continued to add positive caring practices elicited through patient, staff and family stories to the photo frame beyond the timeframe of the study. This meant that their values and beliefs of delivering compassionate care were not static but dynamic and were dependant on feedback they elicited from stories about giving or receiving compassionate care.

Photo elicitation was thus a useful creative method that helped staff to uncover the meaning of compassionate care and to share key messages with others about how to deliver this in their local context.

Role enactment

Supporting staff to develop their practice through learning about the data that emerged from the study was also challenging. Role enactment, an interactive drama process, was used to play back to participants, in a real way, stories from practice. This draws on the forum theatre method developed by Augusto Boal (1992, 2000). The purpose is to engage with participants to explore how personal interactions work in as deep a way as possible by watching and reshaping a scenario.

The sessions took place in a quiet room off the ward and lasted for approximately one hour. Staff had identified they sometimes felt a degree of uncertainty and discomfort when dealing with relatives who were angry or upset. Real situations that highlighted dialogue between staff and relatives were re-enacted by me and the charge nurse. It was important to select a range of stories from practice that showed both positive and negative interactions.

The staff closely observed the scene that was re-enacted. While the initial scene was loosely scripted, all subsequent dialogue was directed by the staff, who were first invited to reflect on the story and

to identify what they would like to understand better, what aspects of the interaction they thought worked well and what worked less well. They were offered an opportunity to ask me and the charge nurse how we felt about what happened, and why we acted in the way we did. They then considered the range of perspectives and developed alternative dialogue.

The scene was then re-run to allow staff to intervene and offer alternative ways to interact. This allowed them to test out and rehearse specific ways of interacting in a facilitated learning environment. By inviting participants to step inside the story, it brought the assumptions and misperceptions that can be embedded in everyday care encounters into focus, in a place where they could be dealt with safely and constructively.

Many participants very quickly formulated opinions about what had happened and what they would have done in the situation. When invited to ask characters questions that would enhance understanding from different perspectives there was a tendency to offer solutions. Staff often needed support to recognise the need to take time to uncover initially hidden aspects of behaviours and relationships. Having gained these deeper insights, participants were more able to appreciate the motivations and efforts of each character and to construct dialogue that was appreciative in nature.

Staff valued these sessions and felt that it gave them an enhanced understanding of their own interpersonal competence and the confidence to try out some of the specific strategies in practice. They got to see how different behaviours work, and to 'see themselves' within situations. It thus resulted in a powerful tool to change some of the deeper less tangible aspects that promote compassionate care.

Using poetry to share the process and outcomes of the research

A key aspect of practice development and participatory research is to work with participants throughout the process. In the past I have found it difficult to fully engage participants in the analysis and presentation of findings and therefore used both traditional and creative methods in this study. An example of this is where I was concerned that presenting the written evaluation report of the findings would not engage with all staff. I made a decision to produce the written report but in addition use the data we had gathered and analysed to develop a poem that encompassed the key learning and outcomes from the study on this particular ward. Staff felt ownership of the poem and displayed this for all visitors to the ward to see. In addition they used it in the induction of nursing and medical staff to the ward, as they felt it was a powerful account of 'the way we do things around here'. A key advantage of using poetry is that a lot of material can be presented in a relatively short space. It also allows for reiteration of words that can serve to reinforce particular points.

Poetic representation of the findings evoked emotional responses not just for the staff in the site but for others outwith the setting. There was an element of surprise and provocation in the poem for example 'I used to call people love honey or poppet, I still do but now I know to ask others if they mind me using these terms'. The poem helped to create a shared understanding and a connection with the experiences.

Faulkner (2009) suggests that a good poem is one that is authentic, courageous and accessible. Readers can use this criteria to judge the extent to which the poem developed in this study, and presented in Box 1 below, achieved this.

Box 1. Poetic representation of the study findings

I used to.... but now I....

A poem about giving and receiving compassionate care

(derived from excerpts of data gathered in the study from patients, staff and families)

Shaking my hand oh what a welcome, saying a prayer with me, where did that come from, allowing me to swear out loud when the pain was unbearable were you breaking the rules or just being compassionate? What is compassion – these things are compassion. This is how we define it. How can we make it happen more of the time?

Too much milk, soggy cornflakes, no plates, biscuits served on the table, single room for an infection, what infection nobody told me. Good to find out, good to ask, good to talk, good to share. Learning about others' experience – the most powerful teacher.

We notice the specialness of things that might seem routine – not just showering the patient - using the opportunity to talk to them, to help them feel less embarrassed about being naked in front of you.

What's normal, what's special? We now know. We can tell others.

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

I didn't realise that was the side she normally lies on.

I didn't realise that she liked the company of those patients who are a bit confused.

I didn't realise the relative wasn't angry with us.

Checking out assumptions. There's an element of surprise. Keeps us on our toes. Stops us thinking about how we want to be cared for and makes us **ask** about how you want to be cared for.

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

What do you think about that, why do you do that, what are you going to do now, how do you feel about that, what helps you to do that?

Talking about care, sharing stories about care, sharing how we feel about care. No time to talk about care, **make** time to talk about care. Without this we can't reflect and develop.

Where am I now?

I used to rush things I spend more time now.

I used to hide when relatives came on the ward, I go out and greet them now and ask them questions about how they are.

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

I used to tell people what they were not doing well, now I commend people for things they do well.

I used to tut when few patients were up and dressed in the morning, how were we going to get through the work, now I can be more flexible. I know I will get through the work.

I used to hide the fact that I shared stuff about me as a person with patients, now I realise it is an okay thing to do and something that helps the relationship.

I used to think why are we asking everyone what they would like, it is not a hotel service, but now I know that when people appreciate the small things you try to do for them, this gives me pleasure in my work and makes me want to ask them more often.

I used to call people love, honey or poppet, I still do, but now I know to ask others if they mind me using these terms.

We do this around here, we do that around here, we don't do this around here, why are you doing that around here? We are proud of what we do. Saying it out loud helps us to stick to principles of person centredness.

It's given us a voice and a license to take risks. Moving from a place of learned helplessness to learned hopefulness – it feels good to give and receive compassion.

Being creative and weaving this into the practice development process had several benefits which included:

- Being better able to tap into the tacit nature of the meaning of compassion for staff, patients and families
- An opportunity for including a wider range of participants in the process
- More meaningful engagement with practitioners in shaping emergent findings of the research and communicating outcomes and learning
- A deeper understanding of own behaviors and the impact of these in practice

The benefits of using creative methods were thus important for gaining a deeper understanding of compassion and for engagement in the inquiry process. Using creative methods however did require building strong relationships with the participants, a confident approach to facilitation and belief that there was a real value to using such methods. My journey is just beginning.

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Belinda Dewar (PhD, MSc, RGN, RCNT), Senior Nurse Compassionate Care, NHS Lothian, Edinburgh, Scotland.