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Title

Developing Caring Conversations in care homes: an appreciative inquiry

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Abstract

Relationship centred practice is key to delivering quality care in care homes. Evidence is strong about the centrality of human interaction in developing relationships that promote dignity and compassion. The Caring Conversations framework is a framework for delivering compassionate care based on human interactions that was developed in the acute healthcare setting. The key attributes are: be courageous, connect emotionally, be curious, consider other perspectives, collaborate, compromise and celebrate. This paper reports on a study to explore its relevance to the care home setting and the development of an educational intervention, based on the framework, to enhance development of human interaction. The study used the approach of appreciative inquiry to develop Caring Conversations in the care home setting. Appreciative inquiry has a unique focus on what is working well, understanding why these aspects work well and co-creating strategies to help these good practices happen more of the time. The aim of the study was to celebrate and develop excellent human interaction that promotes dignity between staff, residents and families in care homes. The study took place in 2013-14 in one care home in Scotland, over 10 months. Participants included staff (n=37), residents (n=20) and relatives (n=18). Data generation methods involving residents, relatives and staff included; observation and interviews about experiences of interaction. An iterative process of data analysis involved mapping core themes to the Caring Conversations framework.

Findings were mapped to the Caring Conversations framework.

How people communicated mapped well to the Caring Conversations framework. Building on knowledge of what works well, staff developed small 'tests of change' that enabled these good practices to happen more of the time. Appreciative inquiry proved a valuable approach to exploring Caring Conversations, developing practice and developing an educational intervention that could be shared across other care settings.

Keywords: Caring Conversations, appreciative inquiry, care homes, relationships, interpersonal skills, educational intervention, compassion, older people.

What is known about this topic?

- Relationship centred practice promoted by skilled human interaction is central to good quality care

- The evidence based Caring Conversations framework can promote compassion and dignity in the care giving relationship in a hospital setting

- Traditional communications training needs to be developed to enhance outcomes of mutuality and connectedness in the caring relationship

What the paper adds

- Confirmation that the Caring Conversations framework has applicability beyond the hospital setting to a care home setting

- Appreciative inquiry is a powerful educational strategy to promote excellent human interaction

Introduction

Several high profile reports indicate that unacceptable standards of care for older people remain prevalent in the UK and internationally (Parliamentary & Health Service Ombudsman, 2011; Care Quality Commission, 2011; Department of Health [DoH], 2011; Tadd *et al.* 2011; Tolson *et al.* 2011; DoH, 2013; Scottish Government, 2014). The result in UK policy is a more explicit emphasis about the centrality of compassion and dignity in health and social care and the importance of relational models in promoting these practices (DoH, 2008; Scottish Government, 2011; Bate & Robert, 2006; Darzi, 2008; Goodrich & Cornwell, 2008; Local Government Association *et al.* 2012; Nolan *et al.* 2003; Tadd *et al.* 2011). Internationally there is a focus on improving quality of life and care for residents in nursing homes, plus the need to support this workforce to flourish in increasingly complex and changing environments (Tolson, *et al.* 2011; Jeon, *et al.* 2015).

Against this focus to improve the **way** care is delivered, there is growing evidence about what matters to older people receiving care. The Commission on Dignity (Local Government Association *et al.* 2012) highlighted the work of Bridges *et al.* (2009) whose, meta-synthesis concluded that older people in caring environments value processes that enable staff to; see who they are, connect with them and involve them. The Commission on Dignity also valued Nolan *et al.'s* (2006) work, which advocated supporting the development of enriched environments that enable the senses of belonging, security, continuity, purpose, achievement and significance to be achieved for staff, residents and families. Achieving these six senses allows excellence in dignified care experiences to be realised. The achievement of the senses require the development of skilled interpersonal human interactions.

A framework for skilled human interactions, namely the Caring Conversations framework, has been developed to enable relationship centred practice to be achieved (Dewar 2011; Dewar & Nolan 2013). In Dewar's research, a model for compassionate/dignified care was created which has, at its heart, Caring Conversations. This model was developed from observing excellent human interactions between staff, patients and families in an acute in-patient setting for older adults. The Caring Conversations have seven elements which are:

- Be courageous

- Connect emotionally

- Be curious

- Consider other perspectives

- Collaborate

- Compromise

- Celebrate

This framework helps us understand the focus of developing skilled human interaction. However, questions remain in how best to support people to work with this framework in everyday practice. Despite a wealth of literature discussing human interaction, and the emergence of person-centred training programmes, challenges remain in terms of how communication between the older person, their family carer and staff, that helps to promote policy and practice aspirations, is realised (Lown & Manning, 2010; Dewar & Nolan, 2013; Dewar *et al.* 2011; Edinburgh Napier University & National Health Service (NHS) Lothian, 2012; Sheard, 2007).

Interpersonal skills that staff require, to work with, and for, older people in a meaningful way, include sensitivity, connecting emotionally and showing vulnerability. Doane (2002) suggests dignified and compassionate care can be taught, but mechanistic models focussing on behavioural communication skills, including listening and questioning aimed at problem resolution, do not adequately address the relationship that is crucial to delivering compassionate and dignified care.

Moriarty *et al's*. (2013) review of research studies focused on outcomes of communication training for care home staff, residents, families and friends. The majority of studies concentrated on training related to 'practical ends', such as communication to help residents become more independent or exercise choice. Few studies focused on broader approaches to communication aimed at human relating based on appreciation of peoples' connectedness, with the emphasis being with people rather than doing for them (Dewar, 2011; Doane, 2002). Furthermore most interventions highlighted in the review were based on relatively short sessions

ranging from two hours, to a day's training. They focused on enhancing staff resident interactions, instead of wider engagement and developing relationships within the home between staff/relatives and staff/staff. Isolated training, without individual feedback and a period of supervision following the training, had limited impact on outcomes (Lintern *et al.* 2000; Moriarty *et al.* 2013).

Innovative examples where practitioners, including nurses, are supported to develop skilled interpersonal relationships that promote dignity are being developed (Dewar, 2011; Local Government Association *et al.* 2012; Help the Aged & the National Care Homes Research and Development forum, 2007). For example, Heliker & Nguyen (2010) found an innovative storytelling intervention, compared to traditional communication training, enhanced mutuality and connectedness in the care giving relationship. Studies incorporating specific feedback on real time interactions have found this promoted more positive respectful interactions (Caris-Verhallen *et al.* 2000; Bourgeois *et al.* 2004; Williams 2006).

Further development of interventions is required that focuses on work based educational models with real time feedback, supporting people to engage in a way that demonstrates attunement, openness and curiosity. The focus should be on actively involving people in a way that is comfortable and taps into strengths and capacity and think creatively about possible solutions that mean something to individuals (Moriarty *et al.* 2013). The Caring Conversations framework (Dewar, 2011; Dewar & Nolan, 2013) has been shown to support skilled human interaction, but has not yet been tested out in the care home environment. The care home is an important care provider in the UK and internationally (Tolson *et al.* 2014). Older people in care homes often have complex needs and staff are critical to supporting residents to enhance their quality of life. Caring Conversations may help enhance experiences of caring in care homes.

The aim of this study was to celebrate and develop excellent human interaction that promotes dignity between staff, residents and families in a care home setting. The specific objectives of the study reported in this paper include:

1. Mapping existing examples of excellence in interactions that promote dignity with the evidence based Caring Conversations framework (Dewar, 2011), and refine this as required;
2. Developing, delivering and evaluating, with participants, practice based education based on real-time feedback that supports participants to develop skilled human interaction that promotes dignity.

Methodology

Appreciative inquiry (AI) was used in the study, which has a unique focus on existing organisational strengths, rather than weaknesses, and the underlying assumption that people and organisations are full of assets, capabilities, resources, and strengths that can be located, affirmed, leveraged and encouraged. (Cooperrider *et al.* 2008; Dewar & Mackay, 2010; Kavannagh *et al.* 2008, Sharp *et al.* 2016). The AI process, adapted by Dewar, consists of four phases; discover, envision, co-create and embed (Dewar *et al.* 2016).

The Discover phase focussed on what is working well (in this case, in relation to interpersonal communication) and questions focused on:

- What excites us during engagement with others?
- What makes a difference to us as staff, residents and families during interactions?
- What are we proud of, why do things work well, and what helps these things to happen?

Findings from this Discover phase were fed back to participants to work with people to envision the desired future. This was followed by co-creating, with staff, residents and families, specific interventions to achieve the ideal, that could be tested out in the care setting. Two interventions are reported in this paper. The embed phase focused on embedding new developments in routine practice, and considering what people need to continue to learn and flourish. A skilled facilitator of AI nurtures dialogue, has the competence to provoke and reframe the status quo in a sensitive and inspiring manner, and interrupt the dominant discourse and vocabularies (Bushe, 2013). The first author was the lead facilitator of the inquiry and had led several participatory research studies previously. AI was used with staff, residents and families to discover skilled human interaction that promotes dignity, and use this

to inform an educational intervention that could be tested, refined and used more widely. In AI, the process of the research acts as the intervention. Thus by discovering interactions that work well, discussing how these could happen more of the time is in itself an intervention.

Setting and Participants

The study took place over 10 months in 2013-14 in one four unit care home in Scotland which was registered for 72 residents and employed 100 staff. Six meetings were held with 48 staff, over the first 2 months, which discussed study aims and the nature of participation. Following this meeting, staff were invited to join a core group to lead the study with the researchers. Six staff volunteered (care home manager, two registered nurses and three senior carers/activity coordinators) and formed the core group, taking the study forward in two units within the home. These individuals attended study meetings and played an active role, assisting with data generation, raising awareness of the study and providing ideas for further development. The core group engaged relatives (n=20) and residents (n=18) in the study, who were primarily involved in the Discover phase. Of those relatives and residents who were invited to take part, none of them declined the invitation. The core group remained connected to the study throughout its duration.

Methods

All data collection took place within the care home setting, either in the open areas or in individual rooms. The data collection methods are outlined in Table 1.

Table 1 - Overview of Phases and Data Generation Activities

Phase	Activity/Data Generation
Phase 1 -Setting the scene and establishing relationships	- Field work including informal observation and informal discussions - Informal interviews with staff to explore their views about the project and Caring Conversations in the workplace (n=48)
Phase 2 – Discover – what is	Structured participant observations

Phase	Activity/Data Generation
working well?	(n=8 events) • Staff discussions (n=10) • Photoelicitation (staff n=6, residents n=6, families n=1) to explore both the 'meaning of dignity' and 'conversations that work well' • Relative discussions using positive inquiry tool (n=8) • Resident discussions using positive inquiry tool (n=5) • Relative group interview using motional touchpoints (n=8) • Field work including informal observation and informal discussions
Phase 3 – Envision – What would like to see happening more of the time?	• Feedback sessions to staff (n =5 sessions attended by 32 staff) • Field work including informal observation and informal discussions
Phase 4 – Co-create – What do we have to do to achieve our vision? Test this out and evaluate the activity.	• Group discussions with staff to generate provocative statements • Field work using informal discussions to monitor impact of any development activity
Phase 5 – Embed – What has worked well and how can people be supported to develop further?	• One to one exit interviews with staff (n= 5 staff) • Photo elicitation (carried out at time of exit interview n=5 staff) • Development and refinement with staff of an educational programme for enhancing compassion through Caring Conversations.

The research team undertook observations of eight routine events (meetings, mealtimes and interactions in the sitting room), noticing interactions that worked well and others they were curious about. The role of participant observer was adopted where the researchers observed practices, taking part in the activity if appropriate. Observation was crucial in making the unconscious, conscious. People often used broad managerial or professional terms such as 'maintain a person's dignity' or 'team working' to explain concepts, finding it difficult to articulate real meaning.

Field notes were recorded during the observation, and feedback was provided to staff immediately after the observation to generate discussion about why particular interactions worked well. This process validated the interactions as positive and encouraged staff to consider what was important to becoming part of their everyday practice.

Discussions were carried out with staff, residents and relatives using two particular methods to enhance the inquiry process: photoelicitation and the positive inquiry tool.

Photoelicitation used image cards (NHS Education for Scotland, 2012) which included pictures of people, landscapes, abstracts, and everyday objects. Participants (staff n=6, residents n=6, families n=1) were asked to select an image that summed up the meaning of the term 'dignity' and how they felt when communication worked well. Photoelicitation helped open up conversations and gain more meaningful information than questioning alone. It helped contextualise individuals' experiences and promote participation with individuals who cannot always articulate ideas or express thoughts and feelings. The images appeared to help individuals connect with thoughts they may not have voiced before and articulate them clearly (Harper, 2002; Lorenz & Kolb, 2009; Dewar, 2012).

Discussions took place with residents (n=5), relatives (n=8) and staff (n=10) using the positive inquiry tool which poses two affirmative questions: 'what is working well for you here?' and 'how can your experience be improved?' This was used to understand people's experiences of interactions (Dewar, 2012).

The methods described above took place in the Discover phase of the study.

In addition to these methods field work and feedback sessions continued throughout the study and included informal observation and discussions. The researchers attended the care home one day a week throughout the study period.

Data Analysis

An iterative process of data analysis involved two researchers reading and re-reading data extracts and mapping these to the Caring Conversations framework, which was validated with the core participants. Data generated during the embed phase was mapped to the authenticity criteria (Nolan *et al.,* 2003).

Ethical considerations

Ethical approval was granted form the University Research Ethics Committee at the University of West of Scotland. Principles of informed consent, avoidance of personal harm and confidentiality, were adhered to. The act of gaining consent from participants was a continuous process, rather than an isolated event being checked out before and after any data generation activity.

Findings and Discussion

The findings of the study are presented and discussed using the AI phases.

Discover

The Discover phase identified a range of positive interactions that mattered to staff, residents and families which have been themed to the Caring Conversations framework (see Table 2). The positive interactions often fall under more than one 'C' but, to aid presentation, have been themed under the most applicable 'C' of the Caring Conversations Framework. The use of language was also a key finding in the Discover phase.

Table 2 – Examples of Caring Conversations mapped to the Caring Conversations framework

Caring conversation attribute	Examples gleaned from the discover phase of appreciative inquiry in the care home
Be courageous Being courageous relates to willingness to take risks, feeling confident to ask questions, working with uncertainty and an ability to stick up for practices that people believed in without feeling that there would be a negative consequence.	• Staff being able to challenge practice in a calm and confident manner when a staff member's mobile phone went off in the dining room. • Staff speaking to relatives to update them on a resident's condition rather than waiting to be approached by relatives.
Connect emotionally Connecting emotionally relates to staff asking others how they feel and sharing how they feel.	• A staff member noticed when one lady was a bit upset or agitated and quickly responding to her by touch and statements of reassurance. • Staff asking other staff how they were at the start of a shift. • Staff asking a relative what helps her if she is feeling a bit low • A student sharing how he felt on his first few days on placement with a senior member of staff • Staff member sharing that she felt sad that a resident expressed irritation at being in the home
Be curious	• Staff being humble and stating when they feel they do not carry out best

Caring conversation attribute	Examples gleaned from the discover phase of appreciative inquiry in the care home
Being curious relates to asking questions that genuinely seek to find out something. It is about trying to open up conversations and suspend preconceived ideas and assumptions one might have.	practice and asking questions about how to make things better. • Staff asking questions to find out more about the resident as a person, such as what did you used to do when you were working? What did you like about that?
Consider other perspectives This attribute involves exploring another's point of view, acknowledging that they may not hold the same beliefs as you and feeling comfortable to discuss any differences in an open way.	• Staff asking relatives for their expertise to understand their perspective on what might help a resident to remain more calm. • Staff having open discussions about their thoughts and feelings relating to a recent inspection report.
Collaborate Collaborate involves talking together, involving people in decisions, bringing others on board, and developing a shared responsibility.	• Staff and relatives working together to look out for residents well being 'The care home is like a family, everyone looks out for each other, they are supportive and work closely together, for example the residents will let staff know if another resident isn't well – staff appreciate this'. • Staff inviting a resident to help her to lay the table

Caring conversation attribute	Examples gleaned from the discover phase of appreciative inquiry in the care home
Compromise Compromise is about striving for consensus through discussion and reflection, and involves being prepared to 'give and take':	• Staff responding to immediate requests for help by being realistic about when they will be able to do this. For example saying 'I will help your mum to go back to bed as soon as I can - I just have to finish giving xxxx his medication. Are you able to wait till I finish?' • Staff and residents negotiating care - One resident during a photo-elicitation exercise told us: 'I like the fact that staff don't boss me about, have a nice approach, use my first name and you can 'bargain' with them'
Celebrate Celebrating involves making a conscious effort to explore what works well and understand why, and to let people know that their contribution is valued.	• Staff giving specific feedback to one another - one staff member gave feedback about working with another member of staff saying that he was good to work with because he knew his stuff, he was approachable, and always nice with the residents. • Taking the time to capture special moments of interaction, for example through photographs and sharing these with family when they visit • Staff thanking a resident for helping her to feel comfortable to put her hand in the budgie cage. • Staff contacting another care home to find out what they did to have an efficient laundry system where no clothes went missing

Positive interactions that mapped well to the Caring Conversations framework were fed back to staff during the Discover phase by the researchers and the core group. Key questions asked were: 'how do you feel about the quote/data extract?', 'What helps us interact in this way?', 'How could we feel confident to do this more of the time?', and 'What support might we need?' Through discussions, key learning emerged that related to some of the 'C's.

Connecting emotionally

Creating an environment where people were encouraged, and felt safe, to express emotions, was something staff had not necessarily considered appropriate before the study:

> I wouldn't always say how I feel about something – it doesn't feel professional. (S1)
> It is like you do have feelings but you are trying to hold them in. (S6)

Connecting emotionally did not always feel natural or comfortable for staff, suggesting an easy solution to enable staff to do this more of the time may be unrealistic. Sharing incidences when this happened and recognising that this could positively impact relationships, encouraged staff to try to connect emotionally more of the time. Firth-Cozens & Cornwell (2009) and Freshwater & Stickley (2004) recognise the importance of sharing emotions in developing effective and meaningful relationships.

Being Curious

Staff were surprised at a data extract from a resident who, when asked what helped when she was feeling low, said she liked to be left alone. A staff member said:

> I thought I knew this lady well – we don't always ask about these kind of things – we just think we know. (S6)

Being curious can result in new and surprising knowledge that challenges existing assumptions. The listener has to be able to really hear responses and intrigued to ask more. In this example, discussion prompted staff to develop a small test of change where residents were asked, more routinely, questions that probed deeper into what mattered to them, which older people value in the care setting (Bridges *et al.*, 2009).

Compromise

Compromises had to be made on a daily basis in the care home. Staff recognised this was a reality but found it challenging if they were unable to deliver what others wanted. Debating the concept of compromise in small groups, staff began to recognise they had 'rights' too and that compromising did not necessarily mean the other person would feel negative about this type of interaction. One relative said:

> The staff are always busy on here, they can't do everything. We try to help if we can. Staff thank us for this which is nice. (R4)

Freshwater & Cahill (2010) discuss the importance of compromise in enhancing the experience of individuals who use services, but also positively impacting on staff stress levels. However, it is recognised that compromise is a skilled interaction that people need support in developing and requires a level of vulnerability, where there is openness and honesty. Interestingly, the attribute of compromise was the least evident in examples across the data from the Discover phase.

Celebrate

Staff discussed being comfortable praising residents but less comfortable praising relatives and colleagues. One staff member said:

> It feels awkward – that you are just saying it to win them over or cos you want something. (S5)

Another staff member discussed when asking others why something has worked well, this could give the impression you lacked knowledge:

> I wouldn't feel comfortable ringing up another home to find out why their laundry system works – it would feel like you were admitting that your care home was rubbish. (S10)

These discussions highlighted that celebration did not always feel comfortable. During the study, celebration, in the form of noticing and valuing what worked well and asking curious questions to find out why, was a strong thread and staff became more comfortable hearing positive feedback. This in turn helped them model celebration in their day to day practice.

Although interactions mapped well to the Caring Conversations framework, further reflection and discussion highlighted the complexity of this way of interacting. This affirmed the overarching 'C' of being courageous as necessary to test out new ways of having dialogue in practice.

Focusing on the use of language

Focusing on the specific language people used during interactions was captured and discussed with participants during the Discover phase. Language is central to the approach of AI. How people use language in organisations is a sensitive indicator of the quality of a wide spectrum of relationships (Zandee & Vermaak, 2012).

Being curious about language, and 'playing around' with it, was a significant factor in helping people explore taken for granted assumptions. One support worker referred to a lady she was caring for as; 'The lady who likes to be on the move a lot of the time', which struck us as a positive statement. Discussing this with others prompted people to admit that they often referred to residents as 'wanderers', but this language was better as it did not label the resident, instead explicitly identifying what she liked doing. This dialogue was generative, prompting staff to engage in a whole process of inquiry about language they used. Using small tests of change they started noticing and sharing language they valued and language that could be developed. The 'generativity' power of AI has been argued by Bushe (2007), who states that AI is not just about the positive, but about generating new ideas.

Noticing excellent interactions in the Discover phase, feeding back, discussing and considering how these interactions could happen more of the time, was a phase in the research process, but also formed the basis of an educational intervention. This seems consistent with findings from a quasi-experimental study by Day & Holladay (2012), which showed AI training interventions achieved more positive results in people's confidence to demonstrate enhanced interaction skills than more traditional approaches to education.

Envision

Subsequent to discussions in the Discover phase, positive caring practice statements about Caring Conversations were developed, referred to as provocative propositions or possibility statements (Cooperrider *et al.*, 2008; Dewar & MacKay, 2010). These statements represented a shared vision of what participants valued and would like to happen more of the time. A shared vision is advocated as a crucial phase in improvement science and practice development literature (Langely *et al.*

2009; McCormack *et al.* 2006). This process of generating possibility statements from the Discover phase data had meaning and specificity that went beyond bland statements such as 'we strive to create person-centred cultures'. Such generic statements are often associated with shared visions based on discussions alone that lack the distinct ambitions detailed in positive caring practice statements. The researchers and core team developed 12 statements with two shown in Fig. 1.

Fig.1: Possibility Statements
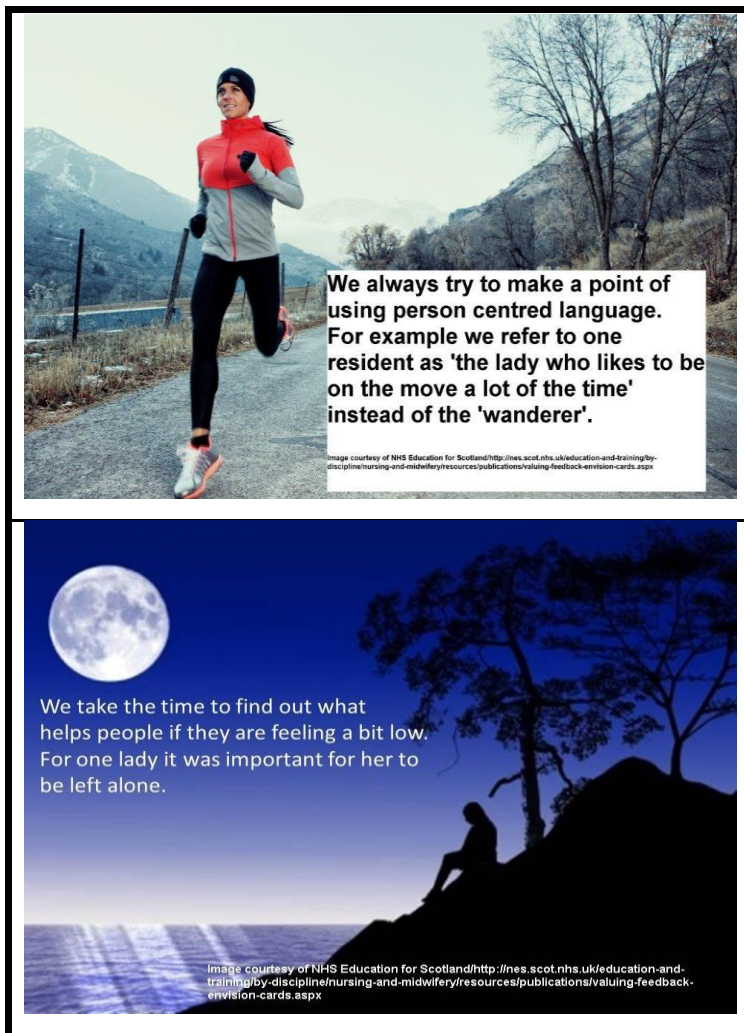
Original images by kind permission of NHS Education for Scotland (2012) adapted for the project by authors.

Co-create

Following discussions in the envision phase a number of small tests of change took place in the care home. It is important to note however, that the very act of noticing what worked well, and developing positive caring practice statements about Caring

Conversations itself, was an action that resulted in enhanced awareness of processes of skilled human interaction. This awareness led many staff to consciously engage in this 'new way' of interacting more of the time.

A range of staff took forward a number of tests of change, consistent with Bush & Kassam's (2005) idea of improvisation in AI as opposed to implementation. Bushe & Kassam (2005) warn against implementation – a specific tangible change agreed upon by assumed key decision makers. They prefer improvisation, where numerous diverse ideas for development are pursued by a range of actors linking to deeper fundamental transformation in how the organisation is perceived. Two of these developments/interventions are discussed in more detail. The first example of an intervention was raising awareness of language that promotes dignity through the development of a language poster and the second relates to the use of emotional touchpoints to explore feelings about particular issues.

Following discussions about using person-centred language, staff wanted to spend more time noticing language in their everyday work. They aimed to capture language they valued, and language that could be developed, by using a language poster (Fig. 2).

Fig. 2: Mind your language poster

Staff displayed their language poster for all to see and learn from - in itself a courageous act, as it openly stated to staff, relatives and residents, where they had perhaps used less person-centred language in the past.

Another small test of change focused on having Caring Conversations that helped people connect emotionally. Gaining confidence to engage in Caring Conversations, when relatives were concerned or upset, was a key aspiration for staff. Staff identified that this worked well when they had a positive relationship with families. However, they also described being 'out of their depth' when attempting to respond

to concerns in a way that did not feel defensive. When discussing with staff how they felt about interacting with relatives, they said they felt nervous, sometimes angry if they had taken personally what the relative had said, worried they would not know the answers and anxious that they may say something wrong. Using emotional touchpoints, which allows individuals to focus on their emotions in relation to an experience (Dewar *et al.* 2010), the study team, worked with staff at a relatives meeting to discuss how relatives felt when talking to staff. What was significant about this meeting was that staff encouraged relatives to engage emotionally which resulted in one relative mirroring this way of interacting and asking staff what it felt like talking to relatives. Staff were able to share their emotions for the first time. One member of staff used the word 'scared' to describe some of her experiences when interacting with relatives. This took courage but this resulted in more in-depth discussions during the meeting about relationships and what mattered to staff and relatives. Afterwards, staff spoke about their experience of engaging emotionally as a skilled interaction that would take time to develop. The focus on emotion is seen as crucial to the development of effective and meaningful relationships between service users and professionals (Firth-Cozens & Cornwell, 2009; Freshwater & Stickley, 2004) but how to support staff to engage in this way is complex. Emotional touchpoints could make a real contribution to our knowledge base about how to support such emotional engagement in practice (Dewar *et al.* 2010).

Embed

The embed phase of AI considers what we have done in the study, our learning, what we value now and what further support we need to continue to grow and develop. In effect this phase represents some of the outcomes of this study. It explores this from the perspective of staff where the core team were asked questions to assess the above and establish whether the study could be viewed as good participatory research. This was carried out using the authenticity criteria refined by Nolan *et al.* (2003) and adapted for this study with more user-friendly language (Table 3).

Table 3 - Authenticity Criteria

Criteria	Description
Knowing more about me	New insights into how I tend to see things, what I take for granted and how I typically act.
Knowing more about others	New insights about and amongst others on how they tend to see things, what they take for granted and how they typically act.
Ideas for what might change round here	Ideas for areas for positive change that each of us can do for ourselves and with each other.
Real change in the way we do things round here	New ways of working for ourselves and with each other that enhance significance, purpose, achievement, belonging, continuity and security in the home.

Knowing more about me

Staff spoke of how they had learnt more about themselves as people:

> I didn't realise that I don't like to ask questions. I feel uncomfortable doing this because I feel I am putting people on the spot – it's a bit of an interrogation and I don't want to do this. I have learnt how to ask questions that feel comfortable. (S3)
>
> I feel a bit scared to share my emotions with others – I'm not there yet but am getting there. (S5)

This relates to literature that emphasises the value of knowing yourself as an individual in the context of leadership (Day & Harrison, 2007; MacPhee *et al.* 2013).

Knowing more about others

Core staff on the study discussed how their confidence had increased, particularly in terms of asking questions that really heard the perspective of another:

> The study has encouraged me to listen more to residents and colleagues. I consider their point of view rather than my own. (S1)

They talked about being less defensive when talking to relatives, more curious rather than assuming their perspective was right, and taking time to explore things with people rather than trying to solve problems:

> I am still a bit nervous when approaching relatives who are not happy but I press a pause button in my head now and give myself time so I don't come across nervous and they feel that I am listening to them. (S5)

They also discussed making a more conscious effort to praise people and notice good practices:

> I do try to notice the things people are doing well and tell them – relatives and residents take it better from me than other staff. Other staff kind of look at me… (S3)

Learning and understanding about others from their perspective is a key aspect of relationship centred practice that enables creation of enriched care environments (Nolan *et al.* 2006).

Ideas for what might change round here

Core participants talked about using observation to notice what is working well as a starting point for future developments. They started to realise they were not always aware of what they did and how others felt about their actions. There was a renewed sense of hope in moving forward:

> I have learnt that even just changing a small thing in the way you talk can make a big difference. But you don't always know how you are coming across. I feel braver to ask. (S3)

Bushe (2007) asserts it is the notion of 'hope' that fosters action. When people realise that they share common values, hope kicks in and cynicism is replaced by generativity.

Real change in the way we do things around here

These new insights resulted in enhanced individual and team morale producing positive forward momentum, whereby different developments have been taken forward by a range of people in the care home. The core group highlighted they had new learning and had changed how they did things, although were not wholly confident that they could influence others. To do this, continued support from management was needed, with a shared vision of the value of Caring Conversations in the workplace and a commitment to embed the processes into routine practice.

Brown Wilson (2009), in her constructivist case study exploring factors that influence relationship centred practice, found leadership style as key to shaping the way things are done.

A key study outcome was the development of an educational programme to enhance Caring Conversations in practice using AI (http://myhomelife.uws.ac.uk/scotland/positive-caring-practices/).

Conclusions

The review of literature highlighted the need to develop more innovative models that support the development of human interaction skills in health and social care where the focus is on actively involving people in a way that is comfortable, and tapping into strengths and capacity. This study was successful in developing an appreciative participatory work based educational model with real time feedback as well as exploring the relevance of the Caring Conversations framework to the care home setting. The appreciative inquiry enabled the study team to explore experiences of Caring Conversations within the care home. Many examples of positive interactions mapped well to the Caring Conversations framework, demonstrating its relevance in the care home setting. The AI approach helped staff look closely at their conversations recognising those they valued, which had positive outcomes on future interactions. These practices were highlighted as positive caring practices and were shared more widely in the home, helping staff be more conscious of these positive ways of interacting. A number of methods were used to explore interactions, which became the methods that staff began using to develop Caring Conversations more within the home. Experiences shared by participants, methods tried and outcomes of this study have been developed into an educational resource. The process of AI is suggested as an appropriate model for the outcome of enhancing Caring Conversations in care homes relating to Bushe & Kassam's (2005) assertion of inquiry as intervention. AI, as an educational strategy for developing interactions in the care home setting, enabled a broader approach, enhancing human relating and emphasising being with people rather than doing for them. This research took place in one care home setting. Further work has embedded this approach in a National

Social Movement, called the My Home Life Programme (www.myhomelife.co.uk). The study was carried out by the researcher who developed the Caring Conversations framework. It would be interesting to report on research with the Caring Conversations framework carried out by other researchers in the field. A limitation of this study is that outcomes are primarily explored from the perspective of participating staff. Future work could explore in more depth the outcomes of specific interventions for relatives and residents.

Caring Conversations are crucial to developing relationships within care home settings, helping to promote a dignified and compassionate experience for all. Further development of these conversations requires commitment to their value in the overall vision of the home and commitment of senior leaders (Jeon *et al.* 2010). It is essential that this aspect of practice is given equal priority to other more closely monitored practices. The importance of effective leadership is highlighted by staff commenting that they found aspects of Caring Conversations challenging and needed support to feel comfortable with this aspect of their role. The priority Caring Conversations is given within the home, and the educational resource, may go some way to supporting staff, but further educational opportunities need to be considered in supporting staff with this complex and skilled area of practice.

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