The Humanising Care Toolkit

Sharing experiences and learning

Burdett Trust for Nursing

University of Hull

Hull and East Yorkshire Hospitals NHS Trust

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
The Humanising Care Toolkit

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The Humanising Care Toolkit
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Section 1: Introduction: About the toolkit

This toolkit is a resource to support health and social care practitioners to develop and sustain humanising care in their work setting. It has been developed and produced by a team of healthcare researchers, professionals and older users of NHS care who worked together on a research project, The Humanising Care Project. The project was funded by the Burdett Trust for Nursing and involved a collaboration between Bournemouth University, the University of Hull and 2 hospital settings, the stroke unit at the Royal Bournemouth Hospital and the dermatology outpatient unit at Hull Royal Infirmary. The study explored what really matters to older service users in relation to their experiences of dignity in healthcare. Working together with service users and service providers in Hull and Bournemouth we identified:

• What the service users really valued about the services they received
• What the service users and practitioners identified as important human aspects of care
• Ways service providers could practically support humanising care initiatives in their workplaces

Who the toolkit is for

We have developed the toolkit as a resource to support humanising care champions in different settings. A humanising care champion can be anyone who works in health and social care. Their main qualifications are:

• Feeling passionate about the human aspects of care and highlighting these on their unit
• Feeling able to notice, appreciate and raise awareness of humanising care when they see it
• Feeling confident to have conversations with colleagues and managers where they notice any dehumanising practices.

In this manual we will use ‘participants’ to refer to the colleagues or group members you are training or supporting in your role as humanising champions.
How to use the toolkit

We hope that humanising champions will either have participated in one of the Humanising Care workshops or have attended some humanising care sessions or special interest groups run by members of the Burdett research team. As humanising care champions, you will be able to use the toolkit in a range of flexible ways to support yourself and your colleagues to think about Humanising Care. Different approaches will suit different settings. Some of the ways you may want to use the toolkit are represented in figure 1.

Ways to use the toolkit

![Diagram showing ways to use the toolkit]

Figure 1

The toolkit encourages you to start by thinking about what being human and the human aspects of care mean to you. Each section of the toolkit contains ideas for practical activities and personal reflections. Try these out on yourself or with a colleague before you embark on using them to support others to develop their own thoughts and practices about humanising care.

What’s in the toolkit?

The toolkit has 7 key components:

- This manual for humanising care facilitators / champions
- A DVD containing 21 film clips illustrating stories of humanising care gathered from service users and service providers in the research sites (A)
✓ A start up set of images to support participants to reflect on being human (B)
✓ A set of downloadable powerpoint slides (on memory stick) (C)
✓ Useful handouts for group activities (on memory stick) (C)
✓ A set of laminated humanising care cards (D)
✓ Some start up creative materials for your personal kit – wool, stones, scissors (E)

For ease of portability, we have created a four-pocket canvas pochette to keep materials together. The pochette and core contents of the toolkit are illustrated below. We encourage humanising care champions to gradually develop your own personal toolkit, adding to, or replacing the start-up materials with images or creative materials such as wool, ribbons, buttons that fit with your own preferences.

**Contents of the toolkit manual**

There are **7 main sections** in this toolkit manual:

**Section 1** tells you about the toolkit and how to use it.

**Section 2** introduces some of the background and theory behind humanising care.

**Section 3** encourages you to think about what you want to achieve with the humanising care toolkit and how you might go about facilitating conversations or workshops about the human aspects of care.

**Section 4** focuses on tools, materials and activities that will help you explore humanising care initiatives with your colleagues in your work setting.
Section 5 offers some tips and examples for nurturing and sustaining humanising care initiatives.

Section 6 addresses issues of evaluating change and measuring the impact of your humanising care initiatives

Section 7 draws some threads of humanising care and practice together and offers some suggestions for further reading and resources

What the humanising care toolkit is and isn’t

We know how tempting it is to have a ready-made tool to help practitioners develop new skills and practices. The humanising care toolkit is not an off-the-shelf recipe book or a set of prescriptive exercises. Good humanising requires time and space for personal reflection and conversations about what makes people feel more human with others. So we ask you to view the toolkit more as a flexible set of resources to support personal reflection and conversations with others. As noted above, we also encourage you to develop your own set of creative materials and images as you become more familiar with facilitating sessions with and for others.

<table>
<thead>
<tr>
<th>The humanising care toolkit is….</th>
<th>The toolkit is not…</th>
</tr>
</thead>
<tbody>
<tr>
<td>A flexible resource</td>
<td>A recipe book</td>
</tr>
<tr>
<td>A set of principles</td>
<td>Prescriptive exercises</td>
</tr>
<tr>
<td>Organic, alive and open to your ideas and materials</td>
<td>Static with an unchanging set of activities and materials</td>
</tr>
<tr>
<td>Experience driven</td>
<td>Performance and target driven</td>
</tr>
<tr>
<td>Focused on human experience</td>
<td>Focused on organisational processes and systems</td>
</tr>
<tr>
<td>Concerned with who you are and ways of being</td>
<td>Concerned solely with service processes and the tasks of doing</td>
</tr>
</tbody>
</table>
Navigation

The icons below are designed to help you navigate your way through the different types of practical activity and core resources.

Getting ready

DVD clip

Groupwork

Personal reflection

Handout

Training slides

Humanising dimension

Cards

Creative materials

Images
Section 2: What is humanising care?

This section will introduce you to the eight dimensions of humanising care and the humanising care framework, which is the underpinning for the practical activities in the following sections. It will also support you to think a little more about what humanising care means to you. Our study showed that the best way to prepare to run sessions with others is to start with yourself and consider ways to raise your own awareness about what makes care humanising and dehumanising.

Thinking about humanising care

Watch part 1 of the DVD. In the first clip Professor Kathleen Galvin talks about why it is important to think about the human aspects of care when we are providing complex services to people with a complex range of health and social care needs. She argues that sometimes, unintentionally, the focus on the human aspects of care gets lost or obscured by the drive to achieve targets or produce statistics or deliver specialised services.

The humanising care framework is grounded in European philosophy and a lifeworld approach to understanding human experience. A lifeworld approach to care encourages us to think about who we are as humans in time, place, mood, in our body and in the way we relate to others around us. In other words, it aims to take account of who we are and how we experience life in ways that do not stereotype and simplify but allow a space for the depth and breadth of human experience.

Being Human

Reflection

Think of your own life: What does being human mean to you?

Group activity

Look at the greeting card and postcard images in the toolkit. Gather together your own set of diverse images. Greetings and postcards, cards from art galleries and places of interest, or scenes from old
calendars all work well. Make sure you have a range that includes different moods, different places, scenes from nature and scenes involving people and animals, works of art and images that may suggest metaphors about who we are and how we live, serious cards and images that convey humour. Spread out the images on a table. Ask participants to look at the set of images – then pick one or two in response to the question: ‘What does being human feel like for you?’

Tip: Don’t get involved in thinking about healthcare at this point. Keep it general and focussed on what resonates with different people in relation to everyday life and everyday experience.

The human aspects of health and social care

**Group activity**

Ask your participants think of a time when they or their close family members have used health and/or social care services. In pairs, share the following reflections:

• What did you really value about the human aspects of care?

• List some examples of when you felt met as a human being not just a ‘patient’ or a number

• What was it about what the care provider (eg GP, nurse, therapist, care staff) did or said or the way they behaved that made you feel more human

Feedback in the large group, generating together a list of what people valued, the impact good humanised care had on their experience (or that of their family member)

Do a similar exercise focussing on dehumanising experiences of healthcare. Some questions to ask:

• Does anyone have examples of when they did not feel met as a human in their health or social care experiences?
• What was it about the service or service provider that made you feel as if you were just a number or statistic or object going through a system?
• What words or behaviours or procedures made you feel neglected as a human? What was the impact on you of this experience?

The 8 dimensions of humanisation
Todres, Galvin and Holloway (2009) articulated 8 dimensions of humanisation to capture the depth and breadth of what it means to be a human and be met as a human in health and social care services. The 8 dimensions are represented in Table 1 with a short description of what the dimensions mean in relation to the human aspects of care.

Table 1 The human dimensions of care (from Todres et al, 2009)
See handout 1

<table>
<thead>
<tr>
<th>Forms of humanisation</th>
<th>Forms of dehumanisation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insiderness</strong></td>
<td><strong>Objectification</strong></td>
</tr>
<tr>
<td>Care takes account of your feelings and how things are for you on the inside; attends to feeling uncertain or scared</td>
<td>Care that labels you and treats you as a person as invisible; treated as an object, without thoughts or feelings</td>
</tr>
<tr>
<td><strong>Agency</strong></td>
<td><strong>Passivity</strong></td>
</tr>
<tr>
<td>Having a say and a sense of control; free to make choices and decisions; asked for your opinion and treated as knowledgeable about your health and wellbeing</td>
<td>Passive recipient of care; no say in decisions; others decide for you; little or no control over what happens</td>
</tr>
<tr>
<td><strong>Uniqueness</strong></td>
<td><strong>Homogenisation</strong></td>
</tr>
<tr>
<td>Treated as an individual with your own particular likes, dislikes, preferences and priorities</td>
<td>Categorised into a group; not treated as an individual but with a ‘one size fits all’ approach</td>
</tr>
<tr>
<td><strong>Togetherness</strong></td>
<td><strong>Isolation</strong></td>
</tr>
<tr>
<td>Feeling connected to other people who share your experiences and interests; a sense of belonging and community</td>
<td>Isolated and alone with your experience; no one to share what you are feeling and experiencing</td>
</tr>
<tr>
<td>Sense Making</td>
<td>Loss of meaning</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Understanding what’s happening; care that helps you make sense of your condition, treatments and recovery</td>
<td>Hard to make sense of your care, what’s happening and why; feeling lost and bewildered</td>
</tr>
<tr>
<td><strong>Personal Journey</strong></td>
<td><strong>Loss of Personal Journey</strong></td>
</tr>
<tr>
<td>Care and treatment that helps you find continuity; connecting your past with who you are now and future hopes and aspirations</td>
<td>A lack of continuity with who you are as an individual; care that is short term or feels disconnected from you and your life</td>
</tr>
<tr>
<td>Sense of Place</td>
<td>Dislocation</td>
</tr>
<tr>
<td>feeling familiar &amp; ‘at home’; Environments, surroundings, architecture, culture that help you feel relaxed and at ease</td>
<td>Feeling uncomfortable and alien; displaced; feeling out of place or in an alien context that doesn’t fit with or feel familiar to you</td>
</tr>
<tr>
<td>Embodiment</td>
<td>Reductionist Body</td>
</tr>
<tr>
<td>Care and treatment for you as a person and in your bodily connections with the world; attending to mind, body, mood, relationships. Being alive to the world and what your body is telling you.</td>
<td>The whole focus is on medical diagnostics and symptoms and the impact of your condition on your physical body. Geared towards fixing a body part.</td>
</tr>
</tbody>
</table>

The dimensions are not either / or concepts but represent dimensions with a spectrum of possibilities for humanising care. At any time, a person may be exposed to practices that are more humanising / or dehumanising along each dimension.

**Aren’t the human dimensions just a variation on person-centred care?**

Certainly good humanising care will have a lot of overlap with great person-centred care or compassionate care or humane, holistic care. However, humanising care based around the 8 humanising dimensions or values offers something additional and something distinctive.
Person-centred care can be quite generic and therefore it offers few suggestions for how to change practice. Because the 8 dimensions are clearly articulated they offer a vocabulary as well as a set of values to support change in practice. Both person-centred care and humanising care puts the patient at the very centre of the care experience. But because person-centred care channels all the focus to the ‘sick person’ it can fail to attend to the service provider as a human too. Humanised care is about human centred care, which values the service provider as well as the patient.

**Feeling human in the workplace**

**Reflection**

What enables healthcare providers to feel met as a human being in their workplace and in the care encounter?

**Using the 8 dimensions of humanisation in care and practice**

We hope that the framework with its 8 dimensions will act as a backdrop or a sensitising framework against which to think about humanising (or dehumanising) experiences of care in your practice and setting. They are not a checklist but a set of principles and values to hold in mind when you are looking at whether care is responding to people in human and humanising ways.

<table>
<thead>
<tr>
<th>A few tips when looking at the 8 dimensions for the first time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Don’t worry if you can’t remember all 8 dimensions</td>
</tr>
<tr>
<td>✓ Start with the dimensions that feel more familiar or most relevant in your practice</td>
</tr>
<tr>
<td>✓ Don’t be put off by the language. We have purposefully kept some of the original terminology so that you can explore the language and make it your own.</td>
</tr>
<tr>
<td>✓ Try to find stories and examples of the dimension rather than rushing to translate them into different language. It’s easy to come up with generic, clichés which don’t hold much meaning or sound familiar but mean different things to different people.</td>
</tr>
</tbody>
</table>
Don’t worry if the stories that your group share cover more than one dimension
The dimensions are not an either/or but an interactive set of concepts.

Getting Ready
Watch the film clip of Professor Les Todres (Part 1 - The 8 dimensions of humanisation) introducing and describing each of the dimensions.

- Do these dimensions make sense to you?
- Which dimension or dimensions really stood out for you ...as a patient / as a service provider?
- Can you think of any of any stories or examples from your work place and work practices that relate to one or more of the 8 dimensions?

Illustrating the humanising dimensions
Here are a few examples of stories and experiences that our project teams in Hull and Bournemouth shared when thinking about the different dimensions.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Illustration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insiderness</td>
<td>Staff ask how you are and care about how you are feeling on the inside</td>
</tr>
<tr>
<td></td>
<td>‘the fear never left me, until I had the team come to help at the flat, every day for two weeks, taking me for little walks. I thought I would never go out ever again on my own or the bus. It was their encouragement - took the fear away’</td>
</tr>
<tr>
<td></td>
<td>‘They knew I’d been feeling a bit down. And the next day they asked me ‘how are you feeling today, I hear you were a bit down yesterday’</td>
</tr>
<tr>
<td>Agency</td>
<td>Staff treat you as an expert in your condition and let you take the lead on solving some problems, e.g see Brian telling the nurses the best ways to secure an NG tube</td>
</tr>
<tr>
<td></td>
<td>‘I sit and look at the monitor that they monitor my blood’</td>
</tr>
</tbody>
</table>
and, say, I was this one doing and I was that one doing, it’s … you’re a partnership when you’re in there – patient and professional.’

### Uniqueness
Feeling special and that your own issues and preferences are attended to rather than just receiving what the system prescribes

‘I think they treat the patients here as people, equivalent to their own thing, rather than a number. You’re actually a person.’

I quite like that one [uniqueness] because I think every patient should be looked at individually … I want to be, you know, be a mum, a wife, that’s my individual thing

### Togetherness
Feeling connected to other patients or to staff members as human beings

‘It’s very reassuring, a smile’

‘I found it interesting to hear other people’s stories’

### Sense Making
The way staff don’t take it for granted that you know what’s happening. Gentle explanations repeated little and often.

‘then I saw Dr J, and his team, told me what would be happening, changed me to from an aspirin to something else which gave me a bit of confidence …then I met some of the team on the stroke unit who came to tell me that they would be coming to see me when I was at home, et cetera’

### Personal Journey
Continuity of care and staff who care about who you are not just what you have.

‘Its comforting knowing that you’re seeing the same specialist nurse, you’re not going over and over the story. You’re life story of psoriasis’

‘I really like it, they know exactly you, and they’ve known you for a long time’

### Sense of Place
People care about making you feel comfortable and welcome

‘you come in and everybody’s friendly and the nurse comes up and says, “Oh this way, please,” you know, “Have a seat, I won’t be a minute,” and you relax’

### Embodiment
Feeling alive to and connected to people and the world through your body. Experiencing and noticing bodily reactions e.g. excitement, passion, feeling lucky, feeling
troubled.
‘sitting and listening to other people I feel really lucky that I got off lightly’
‘I looked forward to seeing them [the early supported discharge team] I really did...it was like friends coming to visit’
‘this is when I was told I could go home [points to floating stone] so that reminded me of a boat and I felt I was sailing’

These first sections have been about the principles of humanisation and humanising care. It’s important to think about what these mean to you before you embark on training or experiential sessions with others. The next two sections of the toolkit will look at ways you can facilitate conversations or groups with others about the meaning of humanised care.
Section 3: Getting started

This section will help you think about what you want to do and what you are able to do with your colleagues. It will help you think through how to go about some of the groundwork before you embark on humanising care activities with your colleagues. For example, it will cover issues such as ways to recruit people to your session, the practicalities and principles of facilitating humanising care groups, and ways to engage with the experiences and stories of service users.

Running Humanising Care sessions in your workplace - Practicalities

In our research study we took a strategic approach to thinking about how we could start, continue and sustain conversations about humanising care in 2 discrete settings. Because we wanted to explore in depth what humanising care looked like in the two research sites we set up:

- Preliminary information meetings to tell the staff working in the site about the project and to start the process of looking for others who might want to join us in the study
- A series of 8 monthly group meetings with staff members and service users who joined the humanising care project group
- Follow up meetings to feedback to other staff who had not been directly involved

In follow up work in these and other settings we have run:

- Short taster sessions – 15-30 minutes to get a wider group of staff to think about the human aspects of care generally
- One-off 2 hour workshops – to run practical sessions introducing the 8 dimensions and beginning to think about what they mean to individual staff working in their clinical roles
- Education sessions (30 – 90 minutes) within nurse and Healthcare assistant induction training about what makes humanising care
- A series of workshops (3-6 90 minute sessions) for staff and staff members who become humanising champions
- A rolling programme of sessions on using the humanisation framework to support leadership in culture change
- One to one coaching sessions where one humanising champion supports someone new to be more aware of humanising care in the workplace

Ways to use the toolkit

So, as we described in figure 1, there are a range of different options to facilitating sessions in your setting about humanising care.

Planning your humanising care sessions

What are you hoping to achieve with your humanising care activity?

There is no hard and fast way to run the humanising care sessions. However, you might want to think about:

- What is motivating you to champion humanising care in your setting? Why is it relevant to your setting?
- The caring context – how does humanising care fit into a wider culture of supporting humanising care in your workplace – what are the current challenges and priorities?
- How does humanising care seem similar and or distinct from other improvement initiatives in your setting? For example, are there any connections with issues
raised in CQC inspections, culture change, person-centred care type quality improvements?

- If part of a training and / or induction programme what are the key learning outcomes relating to humanising care?
- If part of a programme of staff support and professional development what are the personal development goals for your peers and colleagues – what do they hope to gain personally by being involved in humanising care projects or support communities?

Some other questions to consider regarding the scope, scale and support for your plans:

- Are you targeting a ward, a particular setting or client group or are you hoping to have a wider impact on culture?
- Who is supporting your initiative – at a local level, at a managerial level
- What will help staff who sign up to your initiative to participate regularly and consistently e.g. occasional time out from clinical duties, flexibility with rotas, CPD incentives?
- Who will support you in your role as humanising champion?
- How will you access a network of support?
- How might you share interesting findings with your peers and managers?

Tip: It feels important in humanising care work to start with yourself and try to influence others simply and one person at a time. Once your own awareness of what makes care humanising or dehumanising is heightened start modelling and creating space for conversations about humanising care in different ways. So first steps are more about awareness and modelling rather than trying to change everyone and everything in the system.
More practicalities to consider:

- Will you be doing the humanising care work on a 1 to 1, small group or larger group basis?
- Do you have a budget to support your activities, e.g. paying for refreshments; funds to support service user involvement
- Where will you meet?
- How many people will the room hold comfortably?
- What’s the best lay out for the room?
- If you plan to use powerpoint/video where will this go?
- Who will make and confirm the room bookings and carry out other administrative tasks?
- If running workshop sessions, how many times will you meet and what is the schedule of meetings?
- Who will be facilitating the meeting(s)?
- How will you recruit people to participate?
- Will you be working with service providers only or providers and service users?
- How will people know where and when to come?
- If running one to one sessions or on site coaching...
- How often will you meet with your colleagues?
- What are the expectations and commitments of you and your coachee?
- How will you document or log your learning and examples in a flexible but efficient way?

Using stories

Encouraging service users and service providers to share stories about their health and social care interactions underpins all the different forms of humanising initiatives that you may want to undertake.
Why are stories important?

✓ They are real
✓ They provide the raw material from everyday lived experiences to think about what makes humanising (or dehumanising care)
✓ They embrace the rich diversity of experience that doesn’t over simplify or reduce the complexity of our human responses to illness and how to provide services

Stories don’t have to be all positive or all negative. In our study we chose to focus on stories that illustrated the human aspects of care that patients really valued. We asked:

• What did you really value about the service you received
• How could you get more of that good humanising care?

This is an approach called appreciative inquiry. Appreciative Inquiry is about noticing and valuing what’s good, and not taking it for granted. Highlighting humanising experiences and asking people to talk about what it was that someone did or said that demonstrated humanising care, how those human aspects of care felt to the patient, what it was that they really appreciated about the care and the person providing care are key to initiatives focused on humanising care.

**Stories of humanising care and practice**

Part 2 of the DVD has stories from service users and stories from service providers. Watch a selection of these as preparation for your sessions. Think about ways you and your team could build up a resource of your own humanising care stories.

**Involving service users in your session**

Taking time out to listen to first hand stories and experiences from service users was a key component of the success of our study. We strongly advise finding a way to recruit a handful of service users to participate in your humanising care project. If
you have time and an involvement budget you may be able to get service users to take part in your sessions. If not you may need to access and use their stories in different ways.

Finding different examples of patient experience

Your unit may have a user forum or access to people from local voluntary sector support groups.

If you are unable to invite patients and service users to your sessions, here are some good sources of material that provide access to patient stories:

- The Humanising Care toolkit DVD (Part 2 – Stories from service users)
  Healthtalk online – a website with video and audio stories of patients and their friends and relatives talking about their experience of different conditions and care. http://www.healthtalk.org/peoples-experiences
- Patients Voices – a series of short digital stories, where images, words and music support a person’s story of illness, disability and receiving healthcare.
  http://www.patientvoices.org.uk/stories.htm
- Patient groups websites – often a section of support group websites will be dedicated to personal stories and experiences.

How to involve service users

If you wish to involve patients and service users in your project we strongly advise that you look at the INVOLVE website (http://www.invo.org.uk). INVOLVE aims to help researchers and practitioners involve patients and service users ethically and responsibly in their projects and activities. The website has a wealth of resources looking at recruitment, resourcing and the practical issues you will need to think about to support lay people to be involved in authentic and productive ways.

In our study we chose to involve service users from the start and on equal terms with service providers. Questions we needed to ask ourselves included:

✔ How will we cover service user travel costs?
✔ How will we recompense service users for their time and expertise?
✔ What timings work well for both service users and service providers?
✓ How long can service users tolerate in a group and being sensitive to the particular impact of their condition?
✓ What criteria will we use when recruiting service users?
✓ How will we explain what the project is about and what it requires service users to do?

You can see an example of our recruitment materials in handout 3.

Tip: Photos and stories can be an important way to share your learning and experiences with others outside the group. If you are hoping to use stories, experiences, photos from your groups and conversations with service users and staff you will need to think about asking for their consent. It’s best to think about this at the start of your initiative. Check with your department or Trust if they have any particular requirements or consent forms that you can use. Think about how to keep the identity of your participants anonymised if required.

Benefits of involvement in humanising care groups

What might service users gain from being involved in humanising care project groups and initiatives?

In our research study we asked patients and service users what they felt they had gained from being involved. Here are some of their responses:

*It’s nice to meet everybody* (Brian)

*What stood out for me was having the nurses from the wards to hear their opinions as well as all of ours as well, that was really good and interesting for me... And I found that helpful because you understand from the other side* (Sandra)

*Yes, I’ve enjoyed it as well, I found it interesting to hear other people’s stories and... Yes, it’s good. I thought it might be boring but... (Laughter). I’m honest. It was far from that so* (Lynn)
What might staff members gain from being involved in humanising care project groups and initiatives?

Here are some of the benefits staff members involved in our humanising care project groups talked about:

*I like the discovering what... especially like with the patients, what their experience was like, because you don’t know that,... it’s something new... when you’re on the ward you try your hardest to like talk to people, I try hard to talk to people ... the patients on the ward, and find out how they feel, but erm you haven’t got really that amount of time to sit down and talk as much as you’d like to because you’re always conscious that you’ve got something else to do and someone else that needs your attention. (Andy)*

*what an interesting session today. I genuinely cannot think of a time recently that I have learned so much, so insightfully expressed, that has made so much sense. It was one of those sessions that, for me, completely rejuvenated what we are doing, and why we are doing it. ... to hear what a difference, in both good and bad ways, that has made is truly fascinating and thought-provoking. I feel very privileged to have been involved in that session: it really has brought back to me what it is all about (Chris)*

*It did feel really good to sort of sit down and use the materials to talk about it ...that felt almost therapeutic (Andy)*

*I’m feeling so much more confident now since coming to the group. Its helped me realise what I’m good at and that I’m not ‘just’ a healthcare assistant. (Jenny)*

*I’ll miss seeing the lovely ex-service users each month, it’s been a great reminder that life goes on and has influenced my practice greatly (Laura)*
Humanising care in your setting

Reflection
Before embarking on your humanising care initiative take time to reflect on some of the experiences you have witnessed or been involved in at work. Sometimes it’s hard to reflect on what’s happening when you are directly involved in an activity or are very used to the way things happen. Take 5 or 10 minutes just to sit quietly and observe what’s happening in an area of your clinical environment.

• What stands out?
• What are the sights and sounds and smells that you notice around you? Who is involved?
• What are people doing and saying?
• What do you think someone new to this environment might be thinking or feeling?
• Try to view an event (eg a medical procedure, a ward round, a family visit from the perspective of different people – what different stories might they tell of the same event?

Getting ready to run a group – Thinking about humanising groupwork
If you plan to get together a group of peers or colleagues to run a humanising care workshop or sessions you may want to think a little more about how to run your groups. There are lots of good resources to help you think about ways to facilitate groups. For example, Elwyn et al 2001 provide a rich resource of ideas for how to facilitate small groups in healthcare, education and research.

As with all good groupwork you will need to think a little about:
✓ The broad aims and boundaries of your group – what the group is and is not, what the focus of your conversations will be, responsibilities and reporting, aspects of confidentiality, ground rules
✓ Group process – how groups come together and go through a process of forming, norming, storming and performing; what can you do to ensure your group works well together
✓ Facilitation – what style of facilitation is appropriate to the aims of your group and what you hope to achieve; how can you introduce ideas and materials but encourage the group to take ownership of ideas and learning
✓ Group dynamics – developing some techniques to help manage tricky scenarios such as group members who dominate or are very quiet or hard to engage

A few props and materials that we have found useful in our groups

Ground rules

It is well worth just agreeing between you some basic ground rules, particularly where service users are involved and may have little experience of working in groups. Most often covering these in session 1 is sufficient. But if any tricky issues arrive you can quickly revisit the ground rules in future sessions.

Example of ground rules for humanising care groups – see also Handout 2

Listen – allow each person time to talk
One person at a time
Everyone is different - respect different points of view
No rights or wrongs
Avoid jargon – ask if you don’t understand
Confidentiality – keep what we share in the room in the room
Start and finish on time
Let [facilitator] know if you can’t make it
Other- Anything else you think we should add?

Forming, Storming, Norming, Performing and Adjourning/Ending

Tuckman (1965) describes 5 key phases in the life of a group. These can be useful to consider when planning group work. As group facilitator you will need to be aware of
what stage your group is at and the way the methods and activities you use can promote good team work so that the focus of your team’s energy and attention stays with the humanising care theme rather than being distracted by challenging group dynamics. See Elwyn et al (2001) for more ideas and reading around group work.

Table 3.1 The 5 stages of group process after Tuckman (1965) and some useful methods

<table>
<thead>
<tr>
<th>Stage</th>
<th>What’s happening in the group</th>
<th>Methods that help</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forming</td>
<td>Group comes together Tentatively getting to know each other</td>
<td>Allow good time for introductions Ground rules Identity focused ice breakers – who people are, likes/preferences</td>
</tr>
<tr>
<td>Storming</td>
<td>Differences and conflicts may surface in beliefs, values and behaviours</td>
<td>Facilitator acknowledges difference and makes space for different individuals. Use of small group work, pairs and triads as well as large group work. Consider who to pair with whom</td>
</tr>
<tr>
<td>Norming</td>
<td>Group members negotiate differences and behaviours settle so that group can address group aims</td>
<td>Facilitator validates the differences between people but ensures all views included. Clarification how different experiences fit the humanising care brief of the group. Reiterating purpose of the group.</td>
</tr>
<tr>
<td>Performing</td>
<td>Group members take on clear roles and shared ownership of work</td>
<td>Facilitator keeps overview of dynamics and performance, encouraging and supporting participation and co-ownership of ideas</td>
</tr>
<tr>
<td>Adjourning / Ending</td>
<td>Group ends but individuals may take on follow up roles</td>
<td>Clarify from outset when group will finish. Celebrate achievements</td>
</tr>
</tbody>
</table>
Being clear what the group is and is not

Sometimes it can be useful to spell out what the group is not as a way to keep the focus on humanising care and avoid drifting into other discussions. Table 3.1 shows an illustrative list you may want to use or amend.

Table 3.2 Focusing your humanising care sessions

<table>
<thead>
<tr>
<th>What the humanising care group aims to be ...</th>
<th>What the humanising care group is not ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>A group focused on the human aspects of care</td>
<td>A generic patient satisfaction group</td>
</tr>
<tr>
<td>A place to highlight specific features of humanising care and their impacts</td>
<td>A group to tell the staff how wonderful they are</td>
</tr>
<tr>
<td>A place for conversations about the human aspects of care</td>
<td>A general coffee and chat group</td>
</tr>
<tr>
<td>A place to appreciate what’s working well and why</td>
<td>A place to moan</td>
</tr>
<tr>
<td>A place to think about ways to get more of the good stuff</td>
<td>A monitoring or inspection group</td>
</tr>
<tr>
<td>An organic group where ideas spring from all participants</td>
<td>A group controlled by the service and a service agenda</td>
</tr>
<tr>
<td>A group where all participants have an equal say and valid expertise</td>
<td>A therapy group where the service providers are considered to hold most of the expertise</td>
</tr>
</tbody>
</table>

Lifeworld led facilitation

Before embarking on humanising care groupwork we ask potential facilitators to reflect on a particular style of group facilitation. Consistent with the underpinning philosophy of Humanising Care we call this lifeworld led facilitation.

Our lifeworld concerns everyday experience of life in relation to time, space, mood, our body and ways we interact with others. Lifeworld theory provides a context for making sense of human being and a methodology for reflecting on humanising health care (Todres et al, 2009). You can read more about this in Dahlberg et al 2009
or in the book Caring and Wellbeing – A lifeworld approach by Galvin and Todres, 2013.

Group facilitation in a lifeworld led style reflects the values of lifeworld led care. There are no rights or wrongs about what constitutes a lifeworld led facilitation style but it will aim to convey the following principles:

- **Sensitivity to identity** and the uniqueness of each of the individuals in the group
- Encouraging everyone, whether service provider or service user to participate equally
- Valuing the **expertise** of every individual not just professional expertise
- As a facilitator and as group participants, **being present** and able to hold a space to think about issues together, free from external pressures or the busy ward environment you have just left
- As a facilitator emphasising a **process of learning together** and making your own contribution rather than being on the outside
- Keeping a focus on **connectedness** and **aliveness** of the group
- Encouraging an atmosphere of **serious playfulness**, eg using creative materials to explore complex or taken for granted experiences; ensuring there is space for humour and light heartedness
- Experimenting with activities that encourage **understanding and expression through bodily rather than verbal means**, for example using visual or tactile materials
- Allowing participants the freedom to explore **how things feel on an emotional level** rather than always focussing on the rational
- An **openness to uncertainty** rather than a prescriptive approach to objectives and what the session might achieve
- An approach to fellow human beings underpinned by **curiosity and respect**
- A group process which reinforces **connectedness and kinship** in exploring healthcare whilst appreciating the rich diversity of individuals
Warm up group activities with a lifeworld-led style

In our Action Research Groups we aimed to start each group with an activity that:

- Focussed participants on the present
- Reinforced and modelled equality of everyone in the room
- Helped participants share something of their identity with the other people in the room – who they are not just what they do
- Set a light hearted but engaged and listening tone

Some activities you may find useful in getting everyone present and into the room:

- A favourite TV programme or film or book
- A highlight of the week
- Something that made you laugh or cry today
- Pick an image to represent...how you feel today, how you handle crises, your family dynamics (see Long and Wilson, 2014) for great collections of scenes and people

You could also use the cards and creative materials in the toolkit for a warm up centred on being in the present and being you. For example, you could ask group participants to:

- pick a card or image that represents how they are feeling right now
- use the stones to choose 3 significant people in their day so far
- use the wool and stones create an image of their week so far

Experiences of groupwork

Reflection

- Think of a group that you have participated in recently.
- What is it that helps the group feel productive and useful?
- Is there anything that stops the group feeling productive and useful?
- What is it that helps people participate readily and equally?
• What stops people participating readily and equally?
You may want to think about:
✓ The environment
✓ The remit or aims of the group
✓ The style of the facilitator
✓ The participants and their behaviours
✓ The group dynamics
✓ Any explicit or implicit tone and values that exist in the group
Take each of the above areas –
Can you identify something that works well in helping the group feel more creative, productive, supportive?

Facilitating groups

Reflection
Think about your natural style as a facilitator

• Do you tend to prefer more or less control over what happens in a group?
• Do you have any concerns and anxieties about facilitating groups?
• Can you think of anyone who you feel has a different style of facilitation? Are they more or less controlling in their facilitation than you? Are you aware of any particular techniques that they use?
• From your experience in work based groups and meetings, note down some styles of questioning which seem to open up discussion, and exemplify curiosity
• Where could you get support to develop your range of facilitation styles?

This section has been about preparing yourself to facilitate humanising care sessions and conversations with others. The next section will describe in more detail what you might actually do when working with others to develop awareness of the the human aspects of care and practice in your setting.
Section 4: Facilitating sessions and conversations about humanising care

This section contains a selection of activities and ideas for facilitating humanising care groups and conversations. Because different humanising care champions will have different needs and requirements, depending on how long you have with your colleagues and your ambition for your humanised care work, we have grouped the activities under three main headings:

1. Experiences of being human; experiences of illness and care
2. Understanding the human dimensions and what makes care human
3. Promoting and sustaining humanising care in your setting

These are the key building blocks for addressing humanising care and practice in different settings. Pick and choose from the activities in flexible ways but try to work out ways to build on and reinforce in some way each of these three core elements.

Materials

The activities and ideas in this section require a range of materials. Some are in your starter toolkit. Others you may want to start collecting as you undertake more humanising care workshops and/or training.
Table 4.1 lists the activities and resources and which of the core components of humanising care that they support

<table>
<thead>
<tr>
<th>Core component</th>
<th>Activity / Materials</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experiences of being human; experiences of illness and care</td>
<td>1. <strong>Images of being human</strong> (cards and postcards)</td>
<td>Share impressions of what being human means to different individuals</td>
</tr>
<tr>
<td></td>
<td>2. <strong>A day in my lifeworld</strong> (stones and wool)</td>
<td>Create and share your perspective on what you do/ how you feel</td>
</tr>
<tr>
<td></td>
<td>3. <strong>Journeys through care and illness</strong> (routemap and road signs)</td>
<td>Elicit stories of living with a condition or illness, the highs, lows, transitions and everyday impacts</td>
</tr>
<tr>
<td></td>
<td>4. <strong>Stories of suffering and wellbeing</strong> (personal stories from service users or story based resources such as healthtalkonline)</td>
<td>Highlighting what stood out about being met as a human in health and social care interactions</td>
</tr>
<tr>
<td>Understanding the human dimensions and what makes care human</td>
<td>5. <strong>Background to humanising care and the humanising care framework</strong> (Powerpoint slides and/ DVD Part 1)</td>
<td>Provide a quick overview of why humanising care is important and relevant in today's systems of care Provide an insight into the theoretical background to humanising care and why humanising care is distinctive</td>
</tr>
<tr>
<td></td>
<td>6. <strong>Introducing the 8 dimensions</strong> (DVD part 1)</td>
<td>Introduce each of the 8 dimensions and how to use them when listening to stories</td>
</tr>
<tr>
<td></td>
<td>7. <strong>Stories of humanising care</strong> (DVD part 2)</td>
<td>Gain inspiration from stories of humanising care as told by people using stroke care services and multi disciplinary professionals providing stroke rehabilitation</td>
</tr>
<tr>
<td></td>
<td>8 <strong>Mapping stories to dimensions</strong> (Humanising care framework)</td>
<td>Map short stories of giving and receiving care generated in your group to the 8 dimensions</td>
</tr>
<tr>
<td>Promoting and noticing</td>
<td>9. <strong>Evaluating humanising care in your setting</strong></td>
<td>Reflect on how well your unit or setting is doing in</td>
</tr>
</tbody>
</table>
humanising care in your setting  

<table>
<thead>
<tr>
<th>(Humanising Care cards or framework)</th>
<th>relation to each of the 8 humanising dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Appreciating what works well</td>
<td>Notice and raise awareness of good practice in humanising care; identify ways to get more of the good</td>
</tr>
<tr>
<td>11. Acknowledging and noticing – the humanising care tree (DVD part 3)</td>
<td>Inspire to develop local tools and initiatives for keeping humanising care alive in your setting</td>
</tr>
<tr>
<td>12. Initiatives in hospital settings (DVD part 3)</td>
<td>Provide ideas for small scale humanising care initiatives in busy clinical settings</td>
</tr>
</tbody>
</table>

**Getting to know the toolkit resources**

Familiarise yourself with the toolkit

Explore some of the resources on the memory stick, DVD and in the toolkit bag

Pick an activity from each of the 3 sections to do with yourself and/or with a colleague

- What worked well?
- Any parts that were confusing or that you didn’t understand?
- How confident would you feel to run the same activity with a small group of peers and colleagues?
- What might you need to think about if you were including patients and service users in your group as well as professional colleagues?

**Experiences of being human; experiences of illness and care**

These activities act well as warm ups and a way for participants to share something of their own experience as well as getting to know others in the room. Using the different visual and tactile materials can help get to different sides of people more
quickly and richly than just by using words. The more creative activities are also a good way of ensuring everyone in the group can participate equally.

Tip: Remember as facilitator or co-facilitator it is important that you participate and share your stories too as an equal member of the group.

**Activity 1  Being Human**

Spread out a range of cards and images on a table or any flat surface in the room. Ask everyone in the group to get up, look at and move around the cards and then pick one or two that represent something important about Being Human to them.

Sit back down and invite each person (or 4 or 5 individuals in a larger group) to show the image(s) they have chosen and why that image appeals to them in relation to being human. This activity should highlight the rich diversity in what it means to be human the different ways we each engage in life.

Tip: Make sure you have a good range of cards including representations of different moods, humour, nature, urban life, different places, people, animals, people, art, culture, indoor and outdoor interests such as reading and sport, unusual sights as well as the everyday.

**Activity 2  A day in my lifeworld**

Spread out on the table or a flat surface a selection of stones and/or buttons of different shapes, sizes and textures and a pile of wool and or ribbon in different colours and lengths. Leave some scissors in case people want to snip the wool and ribbon to different lengths. Ask participants to create an image that represents their experience of a day in their everyday life as
....a patient/ carer/ service provider. For example, for a healthcare assistant this may be a day in their life on the stroke unit; for a sister in the outpatient department it might be a day in her life of managing a service and delivering care; for a person with an acute medical condition it may be a day on the hospital ward; for a person with a long term condition it may be a day living with that condition in the community; for a relative it may be their everyday experience of caring for their relative at home.

Remind people there are no rights or wrongs its just about whatever that experience feels like to them.

Allow participants quiet time and space to create their own image – usually about 5-10 minutes. Then encourage people to talk you through their image either in pairs and threesomes or to the whole group. You may want to model asking questions such as : ‘And what does that big shiny stone there represent? What’s this big clump of wool here? Be sure to accept all responses in an appreciative, non-judgemental way.

This activity can be a great way for patients and service users to get a little more insight into the life and pressures of working in health and social care systems as well as a different way for service providers to hear about the things that stand out for patients and relatives.

Look at some of the examples below or watch the DVD clip of Brian – A day on the ward, to get a feeling for how different people do this.

Brian describes how each interaction (a different stone) represents a high point of a long day on the ward (the wool).

Jackie talked about loving her job (the heart stone). Coming onto the unit there are loads of issues to juggle and remember (the pile of stones).
A clear plan can quickly become entangled in the complex and busy life of the acute stroke unit (the mess of wool). And some times there are difficult and sad things that happen when patients are very sick (the black tangle).

**Tip:** Some people may feel a little uncomfortable or uncertain when engaging in the ‘serious play’ of this type of activity. Reassure people in the group that there is no right or wrong and that everyone does this differently. If people find it hard to get going just encourage them to see what materials their hands are drawn to and model reaching for materials and moving them around.

**Activity 3  Journeys through care**

Clinicians often talk about patient pathways as a way of attending to efficient ways of passing through a service and receiving good care. For patients the experiences of illness are often more complex and individual. This activity is a way to generate stories about illness and care that you may want to use later when you are talking about what makes care humanising or dehumanising. It is also a good way to highlight the moments and experiences that were really important, memorable and meaningful for patients and their relatives so it is another way of sharing deeper understanding about the experience of illness, suffering and wellbeing as people struggle to make sense of illness in the context of who they are and how they live their life.

Part 1 - Draw a twisting, winding road on a piece of flipchart. Starting with service users in the group ask them to indicate a point on the road, their experience of an illness or long term condition, that was significant or very memorable – either in a good or bad way. Ask them a few probing questions such as:

- What was it that made that moment particularly memorable?
- Why does it stand out?
- What was going through your head at that time?
- What were you feeling – physically and emotionally – at that time?
Ask service providers to add their thoughts on what they see as important moments in the experience of illness and care, also using the roadmap. The example in Figure 4.1 is from a group of people living with skin conditions.

Figure 4.1 Living with long term skin conditions

Part 2 – After everyone has shared some thoughts and experiences ask the group to look at a set of road signs (see Appendix x) and pick one or more that connects to the significant moments or events highlighted on the roadmap. For example, Figure 4.2 illustrates some of the comments that arose in one of our research groups discussing the experience of stroke.

Journeys through stroke and stroke care
Activity 4  Personal stories of suffering and wellbeing

If you don’t have patients and service users in your group you may want to look at some freely accessible stories of being in hospital and/or care settings and / or living with a particular condition. See the list of resources containing patient stories in section 7, for example has a fabulous range of audio and video clips linked to different conditions.

Remember you can also draw on practitioner stories about being on the other side of the fence, either personally or in healthcare interactions where they are with children, older parents, relatives and friends.

In pairs you can spend 5 minutes each talking about a personal experience of healthcare. Describe any points in your interaction where you felt someone really connected with you as a human being.

- What was it that they did or said that made you feel met as a human?
- Was there anything or any parts of the experience where you felt unmet as a human, or treated just as a number or statistic?

Understanding the human dimensions and what makes care human

This next group of activities focuses more closely on the eight humanising dimensions that make up the framework for humanising care and practice. Don’t feel you need to memorise or retain all of the dimensions all of the time. These activities are about understanding where the framework has come from, what each of the dimensions covers in relation to human experiences and how the framework is distinctive from other approaches to compassionate or person-centred care.

Activity 5  Background to humanising care

Watch the first clip in the toolkit DVD (Part 1 Introduction to Humanising Care). This segment and the overview presentation will help give you and your participants an introduction to humanising care, and the humanising framework.
In the film Professor Kathleen Galvin, co-author of the framework shares her thoughts about:

- Why the framework is necessary and relevant in today’s health and social care landscape
- Where it came from – its theoretical and philosophical roots
- How it is similar to and also distinct from other approaches to improving care

The powerpoint slides (see Presentation 1 and handout 4 Introduction to Humanising Care) present the same information as well as introducing, in overview the 8 dimensions of care. This presentation can be a useful way to introduce the idea of humanising care to colleagues, managers and commissioners.

Tip: Don’t worry too much about the language of some of the humanising dimensions. In the following activities you will be asked to explore what these words and dimensions mean to you (and your audience) in your experiences as patients and providers. Think of the unfamiliarity of some of the language as a way to encourage curiosity, exploration and ways of grappling with the meaning for you and your participants.

Activity 6  Introducing the 8 dimensions

Watch clip 2 of the toolkit DVD (Part 1 - The 8 dimensions of humanisation). In this section Professor Les Todres, Emeritus Professor of Health Philosophy at Bournemouth University guides us through the meaning of each of the humanising dimensions. He asks us to use the framework and the different dimensions as a way to think about and better understand the stories of humanising care and practice that we will use in the following activity.

Watch the dimensions 1 or 2 at a time. Look at them on the humanising care framework (Handout 1a/1b/1c). Discuss with participants what you
and they understand by each dimension. Can you think of any examples from your everyday practice or experience of illness? Do any examples from the stories elicited in the first set of stories and experiences come to mind as illustrations?

If you are all linked to a particular condition eg stroke, skin care, mental health, do any of the dimensions immediately stand out as salient to experiences of care and living well with that condition?

**Activity 7    Stories of humanising care**

Having elicited stories of being treated in human and possible less human ways, and looked at each of the 8 dimensions, now its time for some activities that try to bring together experiences of receiving and delivering care with the different dimensions.

Remember that the dimensions are not exclusive or separate but are interlinked and interacting. Therefore some stories and experiences are likely to relate to more than one dimension.

Start by listening to several of the stories of humanising care in part 2 of the video. Appendix 1 gives you an idea of the content and general themes of each short story. After the clip, stop the video and talk in small groups about what dimensions seem to be coming into play. You will need to have the framework in front of you. It may be more manageable to have 2 sets of 4 dimensions as presented in Handout 1c and to work in smaller groups. Each small group can focus on just 4 of the dimensions as a more gradual way to familiarise themselves with the different dimensions.

As the groups get more familiar with the 8 dimensions the group can listen and watch the story of humanising care and then discuss the best fit with one or more dimensions.
**Figure 4.3** The 8 dimensions of humanising care in 2 groups (Handout 1c)

<table>
<thead>
<tr>
<th>Dimensions of Humanisation</th>
<th>Forms of Dehumanisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment for you as a whole person: mind and body, thoughts and feelings and connection to the world through your body, being alive to the world</td>
<td>The whole focus is on medical symptoms and the way your illness/condition affects your body. Geared towards fixing a faulty part.</td>
</tr>
<tr>
<td>(Embody)</td>
<td>(Reductionist view of the body)</td>
</tr>
<tr>
<td>Understanding what’s happening, making sense of your condition, your treatment(s) and recovery</td>
<td>Loss hard to make sense of the events in your care: not understanding what’s happening and why.</td>
</tr>
<tr>
<td>Treatment and care that helps you make sense of your illness condition</td>
<td>(Loss of meaning)</td>
</tr>
<tr>
<td>(Sense-making)</td>
<td></td>
</tr>
<tr>
<td>Comfortable, relaxed, at ease; feeling that things are familiar, feeling at home and at peace with the environment and surroundings and culture</td>
<td>Displaced; feeling uncomfortable and alien, feeling out of place, or in an alien context that doesn’t fit with you.</td>
</tr>
<tr>
<td>(Sense of Place)</td>
<td>(Dislocation)</td>
</tr>
<tr>
<td>Feeling a say and a sense of control in your own healthcare: free to make choices; asked to your opinion in making decisions about your care.</td>
<td>Passive recipient: healthcare; no say in decisions; feeling ‘done to’; often decide and you have no control over what happens.</td>
</tr>
<tr>
<td>(Agency)</td>
<td>(Passivity)</td>
</tr>
</tbody>
</table>

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<th>Dimensions of Humanisation</th>
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<tr>
<td>Takes account of your feelings, interested in your mood, how things are for you or the inside of feeling uncertain or scared</td>
<td>As if you as a person are invisible; feeling labelled, just an object with or without thoughts or feelings</td>
</tr>
<tr>
<td>(Insideness)</td>
<td>(Objectification)</td>
</tr>
<tr>
<td>Treated as an individual, a person with your own particular likes, dislikes, fears and priorities: Congested into a group, not treated as an individual: everyone is assumed to be the same. Treated with a ‘one size fits all’ care plan</td>
<td></td>
</tr>
<tr>
<td>(Uniqueness)</td>
<td>(Homogenisation)</td>
</tr>
<tr>
<td>Treatment and care helps you find continuity; connecting you past, with who you are now and your future hopes. More than just a snapshot in time</td>
<td>There is no continuity or connection of care and planning to wish you are an individual. Care is short-term; may feel ‘rushed’, not moving forward.</td>
</tr>
<tr>
<td>(Personal Journey)</td>
<td>(Loss of Personal lounes)</td>
</tr>
<tr>
<td>Feeling connected to other people who share your experiences and interests; a sense of belonging, community and connection to others</td>
<td>Isolated and alone with your experience. No one to share what you are feeling and experiencing.</td>
</tr>
<tr>
<td>(Tangibility)</td>
<td>(Isolation)</td>
</tr>
</tbody>
</table>

**Activity 8** Mapping stories of care to the 8 dimensions

This is another way to match experiences and stories to the different dimensions but draws on the stories generated in your own groups and settings rather than those on the DVD.

In the toolkit you will find 8 coloured cards. Each card contains a description of the humanising end of the dimension and a brief, user friendly description of its meaning. These are reproducible in handout 1d in case you need to produce more coloured cards.

Produce some short vignettes of the stories that have come up in your discussions of illness and care experiences. Aim for a good range of vignettes including service user and service provider stories and illustrations of positive as well as less positive experiences. Have each vignette on a separate piece of paper so that you produce a pile of 10-15 stories. The vignettes should be recognisable to the original story teller, perhaps using some of their own words. You can find some examples of vignettes from the stroke unit in appendix 2.
Ask a group member to read out the vignette. Then ask others in the group to point to the dimension or dimensions it fits with. Ask someone to write the dimension(s) you decide on the back of the vignette as this may be useful to revisit later.

At the end of the activity you should end up with different vignettes grouped around different dimensions – as illustrated below.

Tip: Try to keep the writing up of the vignettes short but authentic. Don’t confuse the story with too many different ideas at once – if necessary make it into more than one vignette.

**Promoting and noticing humanising care in your setting**

These activities have a focus on small-scale initiatives that you can undertake in your own setting. They aim to support practitioners and care staff to go about their everyday work with heightened awareness about what makes care humanising and through noticing and gently drawing attention to small examples of the human aspects of care, ensure it has a more visible and alive presence.
**Activity 9  Evaluating humanising care in your setting**

In your humanising care group focus on your own particular care environment and setting. Think about the people who use and interact with your service, the procedures and treatments that happen there, the routines and rituals that take place, the environments and buildings and departments that your staff and patients/visitors use.

Look at the 8 dimensions of humanising care (use the coloured cards or the coloured framework). Take each of the 8 dimensions in turn or break into small groups with each group focusing on up to 4 dimensions. Discuss how well you think your unit does in delivering humanised care on this particular dimension. If you are giving yourself a very high self-evaluation, what are your reasons and examples. If you are rating your service(s) less highly on a particular dimension, what is it that detracts from fully humanising care, give examples and illustrations.

At the end of the activity can you identify your unit/setting’s relative strengths and weaknesses in relation to each of the human dimensions of care?

**Activity 10  Appreciating what works well**

In your group of service users and service providers generate a list of all the human aspects of care that participants have noticed and really value. You can do this in a group or give everyone 3 or 4 post its to generate a wall of post its. Think about people, spaces, attitudes, behaviours, activities, routines etc.

Do these really valued aspects, attitudes and behaviours group into different headings. Have a go at moving the post it notes around a bit to see if there are any common themes. In our research groups some common themes were:

- Friendly, consistent relationships
• Atmosphere and culture
• Places and spaces
• Knowing what’s going on
• Reassurance and kindness
• Taking your mind off your illness / condition
• Support for relatives and friends too

Select one or two areas.
✓ What would it take to get even more of the good stuff?
✓ Can you think of ways to raise awareness on your unit / care setting of how these small acts of humanising care are valued?
✓ How can you make sure they are modelled routinely by more staff?
✓ How can you make sure they are highlighted in induction programmes for new staff?

Activity 11  Acknowledging and noticing humanising care as individuals– the humanising care tree

Watch Lucy (Part 3 of the DVD) talk about and demonstrate the humanising care tree. This was a light touch way that the team of humanising champions in a stroke unit decided to bring ideas and illustrations of the human aspects of care to everyone’s attention. The tree has the 8 dimensions of care as its roots and a little box of write on/wipe off leaves to collect examples of humanising care they witness in their day-to-day work on the ward. The tree is also a way to encourage anyone on the ward to initiate conversations about humanising care or raise issues about occasions where care has failed to meet people as fully human.

Discuss different ways your team can notice, talk about and make visible moments of humanising care.

Tip: Try to think about ways your initiative will stay alive and remain interesting to and interactive with other staff, patients and visitors. For example at Christmas some of the leaves on the humanising tree changed shape to become Christmas baubles.
Activity 12  Humanising care team initiatives in busy clinical settings

Watch part 3 of the toolkit DVD. Practitioners from our 2 research sites talk about some of their humanising care initiatives. For example, Lucy talks about the humanising care tree on the stroke unit and how the humanising champions work to highlight and capture moments of great humanising care that they see on the ward or in the community work. Karen talks about a similar initiative in the Skin Care unit at Hull. Yvonne tells how the huddle helps staff to value and share specialist knowledge that keeps the human side of care at the forefront of a busy outpatient Dermatology unit. Abby talks about the very small things that staff can remember to do which make a big impact on patient experience. See Appendix 1 for a description of what the different stories on the Humanising Care DVD illustrate.

Discuss different ways your team can try small but significant ways to focus on or raise the profile of humanising care in your unit.

✓ What could you realistically do to humanise interactions and conversations with patients, relatives and peers?
✓ How could you find a regular team time to highlight or share top humanising moments of the week?

You may also want to run this activity as part of a presentation and/or workshop. See presentation 2 for some pre-prepared slides focusing on initiatives to develop and nurture humanising care in your setting.

This section has provided suggestions for activities and resources to help you and your local team to share experiences, thoughts and ideas about the human aspects of care and practice. The next section looks at different ways you can think about embedding raised awareness of humanising care and keeping the idea of humanising care alive and evolving in your setting.
Section 5: Keeping going: Sustaining and embedding humanising care in practice

The humanising care activities and initiatives you have addressed in previous sections have hopefully lit some small candles of humanising activity in your setting. In this section we encourage you to think about ways to keep these humanising care flames alive rather than be snuffed out by the everyday pressures and stresses of workplace activity. This section encourages you to think about ways to embed humanising care and practice and gently but stealthily spread the word.

Support for humanising care and cultures

Here are some questions to ask yourself:

• What is the level of support for the humanising care sessions – from your peers, your professional discipline, your care team, your managers, executive and non-executive directors, commissioners?

• Do you have a small budget or access to any funds that might resource follow-up sessions and activities?

• What are the opportunities to re run humanising care workshops?

• How can your setting embed attention to humanising care in the more routine aspects of your setting – e.g. induction and training processes; appraisal and CPD; patient and staff satisfaction surveys; in-service training

Activities that focus on sustaining humanising care in practice

Activity 1 – Spreading the word – humanising cultures and leadership

Think about the opportunities to introduce more humanising care in your work setting. For example, you may want to think about:

✔ Meetings where you discuss patient goals

✔ First interviews with patients

✔ Interactions with patients and relatives to discuss progress
✓ Routines that happen on the ward such as mealtimes, visiting times, ward rounds
✓ Settings where you review practice
✓ Ways you think about and respond to complaints and/or patient feedback
✓ Places where staff and patients interact

Take one of these examples – with the 8 dimension cards in front of you think about all the aspects of that setting/ activity/ process that ...
• Are valued by staff/patients/relatives/ visitors as humanising?
• Are there any aspects that are less humanising?

Focus on one activity and one positive example of humanising care. What would one small way to get more of this humanising aspect of care look like?

**Some examples of Humanising Leadership**

Following a session on what makes care and leadership in care humanising, we asked staff at a charity providing acute and long-term care to think about ways they could introduce a heightened focus on humanised care. Here are some of their thoughts:

✓ Introduce the set of humanising cards for 5 minutes at the end of operations meetings. Check whether the way staff have behaved together in the meeting has been consistent with the 8 humanising dimensions. Check whether a driving interest in the human experience of care is at the forefront of all agreed actions (Director of Operations)
✓ Introduce more humanising language in to the business plan and commissioning documents (Director of Commissioning)
✓ Review communications about the service with careful attention to language – avoid language that homogenises or strips away uniqueness (Communications and Fundraising)
✓ Reflect on how to be with, rather than ‘tell off’ or dehumanise colleagues. Consider how interactions between board members and staff support the staff who support the frontline workers (Board member)
Activity 2  Finding a space for reflection: humanisation and Continuous Professional Development

In our research study participants in both sites highlighted the importance of finding quiet, reflective space, away from the hurly burly of life on the unit, to reflect on what humanising care means to patients and staff. For some staff this was an important way of reconnecting with why they pursued a career in caring. Others talked about how using the creative activities with a focus on humanising care, with their peers and service users, enabled them to feel motivated and re-energised in their work role.

Watch the film clip of Abby (Part 3 - Pause and Reflect) talking about what she found useful from some of the creative activities.

Can you think of any ways to introduce creative reflections on humanising care into your own or your team’s CPD activity?

Activity 3  Embedding humanising practices in culture

Most care settings are overwhelmed with initiatives and inspections promoting better quality care and improved patient experience. It’s important that a spotlight on humanising care doesn’t feel like yet another new initiative. Much of our learning from the research study demonstrated that humanising care isn’t something brand new but more a way of remembering what’s important about being a human and meeting others as human beings in care settings. It may be helpful to think about the way humanising care interacts with other initiatives and interests directed at improved care and patient experience. A key point to remember though is how to keep care and attention on the human aspects of caring rather than tick box procedures that care more about systems and processes.

Watch the film clip of Catherine (Part 3 – Sustaining Change) talking about why she feels humanising care is important to improving patient experience for those who are particularly vulnerable within modern economies of health and social care.
Discuss how humanising care fits with current initiatives in your setting.
✓ How do you think humanised care might differ from these initiatives?
✓ How could these initiatives eg person-centred care, the 6 Cs, responses to Care Quality Commission reports, have a more humanised and humanising focus?

**Celebrating the human aspects of care and practice**

Another way of attending to sustainability of humanised care initiatives is to think about ways your setting can recognise and validate those individuals who are talented and exceptional at modelling humanising care and the initiatives that work well at bringing humanisation to the fore. In our research sites staff members who attended the humanising care workshops took on roles as humanising champions in their settings. In the Dermatology Unit the humanising champions and researchers gave a presentation to local commissioners to highlight the importance of truly humanising skin care to people living with long term skin conditions. In the stroke unit service managers recognised the important role of these staff members and facilitated them to take on new roles coaching peers as next generation humanising champions and supporting training initiatives across the hospital trust. The trust also recognised the achievement of the stroke unit as a Humanising Care model through presentations to the Trust Board, articles in hospital newsletters, and support to present at international conferences.

Watch the film clip of Jackie (Part 3 – The impact for staff) talking about the confidence she has gained both from becoming more aware of her own humanising care skills and from playing a more prominent role in championing great humanising practice in the stroke unit.

Think about ways you can shout about the success of your humanising care initiative. How can you advocate for humanising care across your team, unit, directorate?
Developing a support network for Humanising Champions

As other humanising care projects develop we hope to be able to establish a community of people engaged in humanising care work. We encourage all those with an interest in humanising care to stay in touch with us by sharing your stories, ideas and experience. See section 7, for further details about ways to stay in touch and our plans for a network of humanising care champions.

This section has focused on ways you and your team can think about sustaining and embedding humanising care initiatives. The next section will give an overview of ways of thinking about evaluating your initiatives and their impact.

The humanising care tree at the stroke unit, Royal Bournemouth Hospital
Section 6: Making a difference: tracking change in humanising care

This section offers some suggestions about ways to evaluate changes that may result from your humanising care initiatives. It describes briefly the humanising assessment tool, which we have developed and piloted as part of this research study. It also offers some more informal ways of gathering feedback and data about any changes that may result from being involved in and carrying out humanising care activities in your care setting. Finally, this section asks you to stay in touch and help us to create a network of humanising champions to share successes and learning about developing humanising care in your setting.

The Humanising Assessment Tool

As part of this study we wanted to pilot a quantitative measure for healthcare professionals to measure humanised care. We were aware of the challenge of producing a quantitative measure for a relatively new and little explored phenomenon. So the tool is currently undergoing face validity testing.

The Humanising Assessment Tool (HAT) aims to assess perceptions of humanised care behaviours as they relate to each of the 8 humanising questions. Developed from learning in the research project and 2 pilot sites the pilot version of the HAT consists of 98 items in a questionnaire format, spread across the 8 dimensions and including a series of dummy items. The stem question for each item is ‘My work environment enables me to ....’. participants are asked to reflect on their setting and practice and answer as honestly as possible on a 5 point likert scale, using the labels:1 : Always, 2: Most of the time, 3: Some of the time, 4: Rarely and 5: Never.

Items.

Items have undergone a first phase of face validity testing in the UK and Sweden
You can view the pilot version of the HAT in the full project report.
As the HAT evolves we hope to make it available to humanising champions so that they can use it in their settings both as a way of measuring change in humanising practice and as a way to help us further develop a vocabulary to talk about humanising care and the specific dimensions.

**Capturing change informally**

We also encourage humanising champions to capture and document change in more informal ways that link to your specific interventions and initiatives.

Many of the initiatives in our pilot sites aimed to bring about subtle shifts in perception and heightened awareness of or visibility of humanising care as a feature of the care culture. Here are some ideas that may demonstrate change in awareness:

- Increased evidence of conversations about humanising care in the care setting
  - Visible signs that staff and visitors are noticing aspects of humanising care eg comments on the humanising care tree or information board
  - Regular training and induction of new humanising champions and a growth in numbers of champions in specific wards, units and settings
  - Humanising care has a more visible presence within the meetings, routines, and quality initiatives that regularly take place in your care setting, eg Humanising Care as an item on staff meeting agendas, in service training, or within staff supervision and CPD activities

Another way of capturing the impact of your initiative is by collecting stories that illustrate how staff members have started to do something just a little differently as a result of participating in your humanising care workshops and coaching. Although humanising care can support service and culture change, it is also very much about individuals ‘being’ the change, becoming a little more aware of the human aspects of care and consistently modelling humanising behaviour for those around them.

At the end of sessions focussing on humanising care you can ask participants to comment on their own perceptions of change – in awareness, in behaviours, in the
ways they think and talk about the human aspects of care. For example, at the end of our action research groups we asked participants if they had noticed any changes in their everyday ways of being and working. Some of their paraphrased comments included the following:

✓ Smiling when I say hello to patients in the morning, even though I’m not really a morning person
✓ I take more time gently explaining what people might expect when they go home, even when they have a very mild stroke
✓ I’m more aware of some of the big emotions feel when they first go home and how new and scary it can all seem after you’ve had a stroke
✓ I feel more confident about talking to patients and sharing a little bit of myself so that we build a relationship
✓ I try to have more conversations with patients about everyday things, rather than always asking about their illness
✓ I’m more aware of the fear some patients experience while they are waiting for results – if I can I give them a ring
✓ I think more about humanising care in operational meetings – we try to ask how will this decision impact on keeping the service focused on the human aspects of care and practice

Developing the toolkit and a network of Humanising Champions

We are very keen to gather your comments and feedback on the tools and ideas in this toolkit. We hope to feed these into further iterations of the toolkits and future projects to support humanising care in health and social care settings. We encourage you to share your stories with us by email, through images and video (with participants consent) in Skype calls, or face to face conversations.

As other humanising care projects develop we also hope to be able to establish a community of people engaged in humanising care work and a network of humanising care champions. The aim of the network will be both to offer mutual
support and to share ideas relating to humanising initiatives and their impact on individuals, services and culture.

We encourage all those with an interest in humanising care to stay in touch with us by sharing your stories, ideas and experience.

The points of contact at the current time are:
Carole Pound cpound@bournemouth.ac.uk
Kathleen Galvin K.Galvin@brighton.ac.uk

We also invite anyone with an interest in Humanisation and care to join the Humanisation Special Interest Group which is hosted by the Centre for Qualitative Research at Bournemouth University. If you wish to be added to the contact list please email Caroline Ellis-Hill: cehill@bournemouth.ac.uk
Section 7 Reading and Resources

This section lists some of the reading, practical tools and resources that you may find helpful in developing your understanding of humanising care and running practical sessions for others. As we stated in section 1 we encourage you to develop your own examples and resources that will support you to explore humanising care for yourself and alongside others. Please let us know if you discover other tools and resources that you think we should share with other humanising champions.

Reading about humanising care and practice – articles and books

Cowdell, Fiona , Galvin, Kathleen (2016) Practice Question. Nursing Older People. (ISSN 14720795) v. 28. no. 2. 20160301. p. 14-15

This article presents some practical illustrations in answer to the question: ‘How can I care for older people in a more human way.’


This article illustrates key concepts of the lifeworld and the way lifeworld led practice differs from patient or person-centred practice.


Although this book is not specifically grounded in the theory of humanisation it examines why current healthcare delivery struggles to retain a strong focus on the human beings at the centre of the system. Margaret Hannah, a public health
consultant shares insights and hope for more humanised cultures of health and social care.


These three papers offer a short introduction to the humanising care framework and ways the framework is relevant to nursing education and care.


This paper provides examples of what older carers (relatives of people who have had strokes from Black and Minority Ethnic communities) perceive to be important components of humanising homecare.


This article introduces the humanisation framework and gives more detail on the background to and illustrations of the 8 dimensions of humanising care.

**Websites with an interest in humanising topics and practice**

The Daily Good website is a volunteer run website that delivers good news stories to you by email. Many of the stories have a focus on kindness, compassion, empathy, creativity and other themes that overlap with aspects of humanising care and practice. You can subscribe for free at: DailyGood.org <dg-news@servicespace.org>
Professor Belinda Dewar has developed a web resource for practitioners wanting to develop more compassionate conversations in care settings. Belinda’s website and academic articles also talk in more depth about appreciative inquiry as a method of working together to encourage more humanising experiences. A range of practice development tools and resources relating to caring conversations are available via MyHome Life Scotland

http://myhomelife.uws.ac.uk/scotland/resources/

Books and resources on group facilitation

Tuckman’s classic work describing the stages of groups coming together and learning to function effectively as a small group to achieve the group aims.

There are also some freely available online tools, for example Prendiville (2008) Available from:


A Ketso Kit is a commercially available resource designed to help you facilitate inclusive group work and offer creative ideas for engaging people in your projects
http://www.ketso.com

Collecting your own materials and resources
Most of the materials we use in sessions are things that we have gathered from everyday life.

Cards to illustrate what it means to be human. You can collect a set of cards from retailers or by collecting cards that people send you, images that are available in
places of art and culture or downloadable from the internet. You may also want to use images developed from your own photographs. The key thing is to ensure you have variety, covering different people, animals, relationships, places, cultures, moods etc

Evoke cards – a set of images conveying different landscapes, moods and activities. Available from: http://www.evokecards.com

A set of freely available cards has been produced by NES. These can be downloaded from: http://nes.scot.nhs.uk/education-and-training/by-discipline/nursing-and-midwifery/resources/publications/valuing-feedback-envision-cards.aspx

Wool, ribbon and stones and other material can generally be collected from left over party decorations, trips to the beach, relatives and friends who enjoy handicrafts, or local craft stores.

**Stories of care**

There are a range of freely available online resources in which people talk of their experiences of illness and care. Support groups will often have a section for patient or survivor stories where you can find video and audio material of people telling their stories.

Other good resources include:

**Healthtalkonline** – a resource of video and audio recordings of people talking about their experiences of different conditions and the care they received
http://www.healthtalk.org/peoples-experiences

**Patient voices** – a resource of digital stories which use audio, video, music and still images to tell short stories about the experiences of people living with different conditions and people who work in healthcare.
http://www.patientvoices.org.uk/stories.htm
## Appendices/Handouts

These appendices contain many of the materials referred to in the toolkit. They are downloadable in word, powerpoint and/or PDF form and may be freely photocopied for use in your humanising care sessions. Please acknowledge that they are part of the Humanising Care Toolkit and let us know about any changes and adaptations you want to make to suit your setting.

<table>
<thead>
<tr>
<th>Handout 1</th>
<th>1a - The 8 dimensions of humanising care</th>
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<tr>
<td></td>
<td>Version 1b – 8 dimensions on a page</td>
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<td></td>
<td>Version 1c – 4 dimensions on a page</td>
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<tr>
<td></td>
<td>Version 1d – 8 dimensions - 1 dimension to a card</td>
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<tr>
<td>Handout 2</td>
<td>Example of information and recruitment materials</td>
</tr>
<tr>
<td>Handout 3</td>
<td>Sample of ground rules</td>
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<td>Handout 4</td>
<td>Powerpoint slides – Introduction to Humanising Care (from Presentation 1)</td>
</tr>
<tr>
<td>Handout 5</td>
<td>Powerpoint slides – Developing and sustaining humanising care initiatives (from Presentation 2)</td>
</tr>
<tr>
<td>Appendix 1</td>
<td>Contents of the DVD – the 21 clips and descriptions of what they illustrate</td>
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<td>Examples of vignettes from the stroke service</td>
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The human dimensions of care (after Todres et al, 2009)

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<td><strong>Loss of Personal Journey</strong></td>
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<td>Care and treatment that helps you find continuity; connecting your past with who you are now and future hopes and aspirations</td>
<td>A lack of continuity with who you are as an individual; care that is short term or feels disconnected from you and your life</td>
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### Dimensions of humanisation - possibilities for humanising healthcare

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<td>Treatment for your mind, body and who you are in the social world. Linking mind &amp; body &amp; connection to the world <strong>(Embodiment)</strong></td>
<td>The whole focus on medical symptoms and the way stroke affects your body. Geared towards fixing a body part <strong>(Reductionist view of the body)</strong></td>
</tr>
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<td>Understanding what’s happening; making sense of stroke and your treatment and recovery. Care that helps you make sense of stroke <strong>(Sense-making)</strong></td>
<td>Loss; hard to make sense of the events in your care; not understanding what’s happening and why <strong>(Loss of meaning)</strong></td>
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<td>Comfortable, relaxed, at ease. Feeling that things are familiar, feeling ‘at home’ and at peace in the environment, surroundings and culture <strong>(Sense of Place)</strong></td>
<td>Displaced; feeling uncomfortable and alien. Feeling out of place, or in an alien context that doesn’t fit with you <strong>(Dislocation)</strong></td>
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<td>Having a say and a sense of control in your healthcare; free to make choices; asked for your opinion in making decisions <strong>(Agency)</strong></td>
<td>Passive recipient of healthcare; no say in decisions; feeling done to; others decide and you have no control over what happens <strong>(Passivity)</strong></td>
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<td>Takes account of your feelings, interested in your mood, how things are for you on the inside (eg feeling uncertain or scared) <strong>(Insideness)</strong></td>
<td>As if you as a person are invisible; labeled, just an object without thoughts or feelings <strong>(Objectification)</strong></td>
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<td>Treated as an individual, a person with your own particular likes, dislikes, fears and priorities <strong>(Uniqueness)</strong></td>
<td>Categorised into a group, like other stroke patients, not treated as an individual. Treated with a ‘one size fits all’ care plan <strong>(Homogenisation)</strong></td>
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<td>Finding continuity; connecting your past, with who you are now and future hopes. More than a snapshot in time <strong>(Personal Journey)</strong></td>
<td>Events and experiences are unfamiliar. No continuity or connection of care and planning to who you are as a person <strong>(Loss of Personal Journey)</strong></td>
</tr>
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<td>Feeling connected to other people who share your experiences and interests; a sense of belonging <strong>(Togetherness)</strong></td>
<td>Isolated and alone with your experience. No one to share what you are feeling and experiencing <strong>(Isolation)</strong></td>
</tr>
</tbody>
</table>
### Dimensions of Humanisation - Possibilities for Humanising Healthcare

<table>
<thead>
<tr>
<th>Forms of Humanisation</th>
<th>Forms of Dehumanisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment for you as a whole person - mind and body, thoughts and feelings and connection to the world through your body. Being alive to the world. (Embodiment)</td>
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<td>Understanding what’s happening; making sense of your condition, your treatment(s) and recovery. Treatment and care that helps you make sense of your illness/condition. (Sense-making)</td>
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<td>Treated as an individual, a person with your own particular likes, dislikes, fears and priorities. (Uniqueness)</td>
<td>Categorised into a group, not treated as an individual; everyone is assumed to be the same. Treated with a ‘one size fits all’ care plan. (Homogenisation)</td>
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<tr>
<td>Treatment and care helps you find continuity; connecting your past, with who you are now and your future hopes. More than just a snapshot in time. (Personal Journey)</td>
<td>There is no continuity or connection of care and planning to who you are as an individual. Care is short term. May feel ‘stuck’, not moving forward. (Loss of Personal Journey)</td>
</tr>
<tr>
<td>Feeling connected to other people who share your experiences and interests; a sense of belonging, community and connection to other (Togetherness)</td>
<td>Isolated and alone with your experience. No one to share what you are feeling and experiencing. (Isolation)</td>
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</table>
The Humanising Care Project

General Information Summary and Invitation to a Question and Answer session

The Humanising Care Project:

How older adults’ experiences of care can guide practice and enhance dignity.

What is the purpose of the Humanising Care Project/group?
This study aims to investigate what human aspects of care mean to older people accessing healthcare services. We want to explore:
• What makes older people feel human?
• What really matters to them in terms of the human aspects of care they receive?
• How can practitioners enhance human aspects of care and practice?

The study/group is particularly interested in the experiences of:
• People who receive treatment from the [insert name of your unit]
• People who work on the [insert name of your unit]

What do we plan to do?
Firstly, we will recruit:
• 5-6 service users [amend to suit your project]
• 3-4 clinicians [amend to suit your project]
Along with researchers these participants will form an Action Research Group.
This group will have a series of about 6 meetups at [insert name of your unit]

The Action Research Group will discuss how patients can be at the centre of health care and how practitioners can best support humanised care for older people. The group will talk about their own experiences. Members will discuss what makes people feel human (or not) (insert name of your unit). The Action Research group will help develop a plan to support some small changes to services and to enhance human aspects of care and practice. [Amend to suit your plans]
For example, these might include:
• Ways people can feel more in control
• Changes to the healthcare environment
• Having conversations that make people feel like staff really understand their individual needs

The Humanising Care Project

Please come to a question and answer session to find out more about the project. And decide if you want to be involved.

• This session will be on [date]
• Time [time]
• Venue [insert venue]

We do hope you can come

If you need more information or help with transport arrangements please contact: [name]
[Email address]
[telephone contact] [insert your photo]
Ground Rules

- Listen – allow each person time to talk
- One person at a time
- Everyone is different - respect different points of view
- No rights or wrongs
- Avoid jargon – ask if you don’t understand
- Confidentiality – keep what we share in the room in the room
- Start and finish on time
- Let [facilitator] know if you can’t make it

Other - anything else you think we should add?
The Humanising Care Toolkit Presentation 1
Introducing the human aspects of care

About the session
- Conversations and exploration about:
  - Being human – you in your life
  - Being met as a human... as a patient, relative, visitor, staff member in your setting
- Background to the human aspects of care and practice
- Introduction to the 8 humanising dimensions
- Your experience – exploring what the dimensions might mean for you

Remembering the human aspects
- Pick a card
- What does being human mean and feel like to you?

Buzz words in policy and practice
PERSON CENTRED CARE
Compassion
Dignity
Values-based care
6 CS

Why Humanising Care?
- Compassion
- Person-centred care
- Values-based care

What's distinctive about humanising care?
- Strong theoretical and philosophical underpinnings – European philosophy, lived experience
- Over 15 years of research at Bournemouth University about what it means to be human
- Well articulated dimensions - these offer directions for practice
- Beyond 'patient care' - humanisation relating to each other and the environment in human ways
- Methodology - reinforces higher sense of wellbeing for ALL concerned

For further information about the Humanising Care Toolkit
cpound@bournemouth.ac.uk
The Humanising Care Toolkit Presentation 1
Introducing the human aspects of care

<table>
<thead>
<tr>
<th>Dimensions of humanisation</th>
<th>Humanising healthcare (Todres et al, 2009)</th>
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<td>Forms of humanisation</td>
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<td>Homogenisation</td>
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<td>Personal Journey</td>
<td>Loss of Personal journey</td>
</tr>
<tr>
<td>Embodiment</td>
<td>Reductional body</td>
</tr>
</tbody>
</table>

Humanising Care – What’s different
- Not just a list of dos and don’ts
- Not about techniques
- About being not just doing tasks
- Emphasises relationships – patient experience, relative experience, staff experience
- Well articulated dimensions – not too generic
- Help capture depth and breadth of lived experience

Background to Humanising Care

1. You and your lifeworld
- Think of a day in your everyday experience of working or receiving care in this setting
- Use the materials to create an image of that experience – what it looks like, what it feels like
- Talk through your image in pairs/threes

What does it mean to be treated as a human being here?
- Think about the card exercise
- Think about your images
- Generate some words and phrases on post it notes that summarise ‘what it means to be treated as a human in this setting’

For further information about the Humanising Care Toolkit
cpound@bournemouth.ac.uk
The Humanising Care Toolkit Presentation 1
Introducing the human aspects of care

2. Humanising dimensions – meanings for you

Keeping your images in front of you ...

• Pick a humanising dimension that interests you or you would like to explore more
• Talk about this dimension in relation to your image and your experience (as a patient/relative/practitioner)?
• What sort of issues and examples come up? (Discuss in small groups)

2. Humanising dimensions – meanings for you

The 8 Dimensions of Humanising Care

The 8 Dimensions of Humanising Care

Humanising care and cultures – Why bother?

• Better patient experience
• Understanding complaints and challenges
• Better staff experience - motivated / energised/resilient staff – increased staff satisfaction & wellbeing
• Staff at all levels who demonstrate and embody humanising excellence are recognised and validated
• The negative impacts of de-humanising experiences and ways of working e.g. poorer patient, relative and staff wellbeing

References and further reading


Follow up thoughts, questions, reflections

cpound@bournemouth.ac.uk

[add own email ]

For further information about the Humanising Care Toolkit
cpound@bournemouth.ac.uk
Humanising Care Toolkit Presentation 2
Developing and Sustaining Humanising Care

The Humanising Care Project
What really matters to older people in relation to humanly sensitive care?

Stroke Unit
Bournemouth
Dermatology Unit
Hull

The Humanising Care Project

Service providers

Service users

Researchers

Dermatology Outpatient Service

The Humanising Care Project
What really matters to service users and providers?
What do they really value about the service?

Sense-making
Togetherness

Personal Journey
Sense of Place

Agency
Uniqueness

Embodiment
Insiderness

Stories of humanising stroke care

Examples from Hull
• If you come in and everybody's friendly and the nurse comes up and says, "Oh this way, please," you know, "Have a seat, I won't be a minute," and you relax...
• Its comforting knowing that you're seeing the same specialist nurse, you're not going over and over the story...You're life story of psoriasis
• they're very friendly, they seem to understand dermatology and especially psoriasis, can be embarrassing, and they put you at ease
• Stepping out of their profession to humanity.

Thinking about your service
• What do you (staff members/service users/visitors) really value about the human aspects of your service?
• Think about some key areas: relationships, environments and atmosphere of a place, knowing what's going on, feeling really met as a human being...
• Prioritise 3 valued things from your list – how could you get more of these human aspects of care?

Further information about the Humanising Care Toolkit:
cpound@bournemouth.ac.uk
Humanising Care Toolkit Presentation 2
Developing and Sustaining Humanising Care

Examples from other settings:

Often not big changes but about raising awareness more widely about the importance of human aspects of care (see DVD Abby Little things make a difference)

Championing and valuing humanising care (see DVD Lucy – the humanising tree)

Reflecting on ways staff can be more supportive of other team members (see DVD care teams in Hull)

Humanising care initiatives in Hull & Bournemouth

- Embedding humanising care in HCA training and HCA induction programmes

- Together time eg staff shadowing, morning huddles

- Humanising Champions & tree

Humanising care and cultures – opportunities and potential

- Better patient and family experience
- Positive approach to understanding and responding to complaints
- Motivated / energised / resilient staff – increased staff satisfaction & wellbeing
- Opportunity for staff development – e.g. staff at all levels who demonstrate and embody humanising excellence are recognised and rewarded
- Starting with the self, greater sense of shared responsibility
- A focus on being human not doing the checklists of care

Further information about the Humanising Care Toolkit:
cpound@bournemouth.ac.uk
### Handout 5: Content of the Humanising Care Toolkit DVD

<table>
<thead>
<tr>
<th>Section</th>
<th>Title / story</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part 1</strong></td>
<td><strong>Introducing humanising care</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Introduction to humanising care (Professor Kathleen Galvin)</td>
<td>Kate describes why attention to humanising care is important in today’s health and social care. She introduces the theoretical and philosophical underpinnings of humanising care.</td>
</tr>
<tr>
<td>2.</td>
<td>The 8 dimensions of humanisation (Emeritus Professor Les Todres)</td>
<td>Professor Todres asks us to consider what it takes to meet as a human in complex healthcare contexts. He sums up the meaning of each of the 8 dimensions of care and asks us to keep these in mind as we listen to service user and provider stories in the next section.</td>
</tr>
<tr>
<td><strong>Part 2</strong></td>
<td><strong>Stories of humanising care</strong></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Introduction to people who have experienced a stroke (Brian, Peter, Wynn, Sylvia and Leila)</td>
<td>Brian, Peter, Wynn, Sylvia and Leila, the service users who took part in the project in Dorset, introduce themselves.</td>
</tr>
<tr>
<td>4.</td>
<td>Peter – The breakfast club</td>
<td>Peter describes his confusion when he didn’t get his breakfast and also some of the benefits of being in a group. Key themes: Sense Making / loss of sense making; Togetherness</td>
</tr>
<tr>
<td>5.</td>
<td>Brian – Hard to swallow</td>
<td>Brian talks about finding his own solution for keeping his feeding tube in place. He describes his joy at feeling his swallow reflex returning and how he celebrated this with his nurse. Key themes: Agency; Embodiment; Togetherness</td>
</tr>
<tr>
<td>6.</td>
<td>Leila – A person not an illness</td>
<td>Leila describes the importance of conversations about who you are not what you’ve got. Key themes: Personal Journey; Uniqueness</td>
</tr>
<tr>
<td>7.</td>
<td>Sylvia – Going home</td>
<td>Sylvia talks about the fear and uncertainty on returning home after a stroke, and how helpful the Early Supported Discharge team were with their gentle guidance and reassurance. Key themes: Insiderness; Sense-Making; Personal Journey</td>
</tr>
<tr>
<td>8.</td>
<td>Wynn – Feeling special</td>
<td>Wynn also valued the Early Supportive Discharge team. She feels they cared about her, communicated about her and were almost like friends. Key themes: Uniqueness; Sense Making; Togetherness</td>
</tr>
<tr>
<td>9.</td>
<td>Sylvia – The power of tea</td>
<td>Sylvia describes how a nurse’s brusque response for a cup of tea after a long, stressful day on the ward affected her. Key themes: Isolation; Homogenisation; Passivity</td>
</tr>
<tr>
<td>10.</td>
<td>Brian – A day on the ward</td>
<td>Brian creates an image from wool and stones to represent a day on the ward. He highlights the importance of relationships and making sense in an alien environment. Key themes: Sense of Place; Sense Making</td>
</tr>
<tr>
<td>11.</td>
<td>Sylvia, Leila, Wynn – Human contact and connection</td>
<td>Sylvia, Leila and Wynn talk about what and who makes care more human for them. Key themes: Uniqueness; Personal Journey</td>
</tr>
<tr>
<td>Part 3 Impact &amp; sustainability; Embedding humanising care and culture</td>
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<tr>
<td>12. Jackie – Building humanising relationships</td>
<td>Jackie, a healthcare assistant working on the stroke unit, gives an example of building reciprocal relationships with patients and taking account of who we are as service providers. Key themes: Embodiment; Sense of Place</td>
<td></td>
</tr>
<tr>
<td>13. Lucy - Remembering the impact</td>
<td>Lucy, a physiotherapist, describes the impact for her of listening to patients’ stories. She was surprised at how vividly they remembered experiences on the ward and it highlighted for her how alien, unfamiliar and frightening these events can be for service users. Key themes: Insiderness; Sense Making; Sense of Place</td>
<td></td>
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<tr>
<td>14. Abby – Having a say</td>
<td>Abby, a speech and language therapist, describes the importance of noticing and not taking for granted great humanising care by others, for example taking a little more time to find out an individual’s preferences when they have communication difficulties. Key themes: Uniqueness; Agency</td>
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<tr>
<td>15. Abby – Little things make a difference</td>
<td>Abby highlights one of the key themes of the project, that little acts of humanising care like smiling or providing gentle explanations, can make a big difference to how both patients and service providers feel about care experiences. Key themes: Sense of Place; Sense Making</td>
<td></td>
</tr>
<tr>
<td>16. The humanising care tree</td>
<td>Lucy describes how the staff on the Stroke Unit are keeping humanising alive by championing and recording little acts of humanising care</td>
<td></td>
</tr>
<tr>
<td>17. The impact for staff</td>
<td>Jackie reflects on what she gained from being involved in the project and the importance of recognising and valuing those who are great at modelling the human aspects of care</td>
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</tr>
<tr>
<td>18. Pause and reflect</td>
<td>Abby reflects on the importance of finding time out and a quiet reflective space to have conversations about the human aspects of care</td>
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</tr>
<tr>
<td>19. Transferable benefits: Humanising care and care teams in Hull</td>
<td>Karen and Yvonne, specialist nurses in the Dermatology Outpatient unit in Hull talk about the meaning of humanising care in their setting. They discuss 2 service improvement initiatives: The Humanising Care board and the huddle</td>
<td></td>
</tr>
<tr>
<td>20. Sustaining change</td>
<td>Catherine, a stroke research nurse talks about the relevance of humanising care to quality of care and improved patient experience, particularly for more vulnerable patient groups. She talks about embedding humanising care within hospital culture and leadership.</td>
<td></td>
</tr>
<tr>
<td>21. Championing the dimensions in policy and practice</td>
<td>Les offers some final comments about using the humanising framework to support change in practice. He talks about the need for those within practice, management, training and policy making to use and champion the dimensions and vocabulary of humanising care.</td>
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</tbody>
</table>
Appendix 2 Examples of vignettes from a stroke service

Service User Experiences

Going home and feeling scared
The difficult feelings when you are all alone after coming home from hospital. Feeling scared about what might happen next, what's the best way to recover, will I have another stroke.

Reassurance from the Early Supported Discharge team visits
Feeling more confident to do things. Being told what to expect next. Lots of reassurance that you will be walking, talking, swallowing in x amount of time.

Night time on the ward
Bleeps going off, different staff, sometimes staff who are not so familiar or friendly.
As a patient feeling worried about asking for help when the ward is short staffed.

On the ward at weekends
Feels like a ‘dark tunnel’ and time drags slowly. Not much happening. No therapy, no visits from doctors. A different routine but less to break the monotony.

Importance of kindness and compassion
Feeling really grateful when a staff member is kind and comforting. A kind word, a gentle touch, feeling someone cares about you.

The importance of smiling staff
Interactions with staff can be the highlight of a boring morning or afternoon. The importance of a smile. Makes you feel better or feel like they really care.

The reactions of family members (cotton wool)
When you go home family members want to wrap you up in cotton wool. Treat you differently than before your stroke. So being at home can feel an unfamiliar environment.

Tiredness
Feeling tired a lot – and not being sure of how to deal with feeling tired.
Should I do more or should I do less?

Worries about the future
What will happen next?
How will my recovery be, and what’s most important
When will I be able to …
Will it happen again?

Feeling lucky
Feeling lucky compared to others.
Feeling grateful that it was only a mild stroke and not many long lasting effects
Feeling grateful for professional staff.
**Ending therapy and support**
Feelings when therapy or support visits (eg Home stroke team) stop
Feelings when therapist says ‘there’s nothing more we can do to help’

**Visitors**
Seeing a friendly and familiar face at visiting time.
Breaking the boredom

**Chatting to others**
Lunch group as a way to meet others
Positive experience of chatting to others in the same boat

**Service Provider Experiences**

**Strawberry Yogurt story**
Jacky’s story of remembering what flavour yogurt a patient really liked. Going to a little bit of trouble to get something special for them

**Headless chickens stories**
The organised chaos of the unit. The impact of always having lots to do and lots of people to see. Always in a rush.

**Working with families**
Struggling to meet the needs/wishes/expectations of patients and of family members – may be different
Hard to know if the family members are always putting the best interests of the patients at heart or prioritising their own needs and interests, eg not wanting someone to go to a different unit because its further for them (the relatives) to travel

**When people can’t talk**
Knowing what to do when people have impaired communication.
How to know what they want or think. Harder to involve them in decisions and discussions. Can end up having all decisions made for them.

**The speed of discharge**
A feeling that sometimes we ‘write people off too soon’

**Being part of the team**
Good team working – feeling a part of a good team.
Being valued for your role in the team
Knowing the team is doing a good job- a sense of pride.

**Difficult discharges**
Sometimes it’s hard to get the support in place that people need.
People who don’t improve and have to leave the Stroke Unit and go to another ward without specialist rehab.
Consistency and getting to know people
Hard to really get to know patients if you're part-time
Not knowing what happens to people when they go home

Expectations of decision making
Being expected to make decisions as a patient when being in hospital is all very new and disorientating

Ways to get to know people a little more
Seeing patients in their own homes as very helpful to hear about who they are.
Other experiences of getting to know patients as people
Eg Storytelling group, breakfast club

Make the experiences more vivid and recognisable by adding a short quote or a few verbatim phrases from the person who shared the experience with you/ your group