Caring Conversation Framework to promote person centred care: synthesising qualitative findings from a multi- phase programme of research

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Abstract

Background

Little is known about how to support practitioners to enhance their interpersonal conversations to be more compassionate and relational with others. The Caring Conversations (CC) framework was empirically derived to address this issue and comprises seven attributes (be courageous, connect emotionally, be curious, consider other perspectives, collaborate, compromise and celebrate).

Objective

This paper synthesises the qualitative findings from a multi-phase programme of research, which implemented the CCF across a variety of health and social care settings (acute hospitals, community, and residential care). It explores the perceived impact of the CCF on staff and their practice.

Methods

Secondary analysis was conducted on the qualitative findings in the final reports of 5 studies, involved in the implementation of the CCF.

Results

The analysis showed consistent positive outcomes for staff in their interactions with patients, families and others; including greater self-awareness during interactions, development of stronger relationships, and more open dialogue that supports relational practice. The secondary analysis confirmed the applicability of the framework across a number of different settings, strengthened confidence in its value, generated fresh insights to inform further research, and developed a deeper insight into the attributes of the framework and its application.

Conclusions

Policy and research advocate compassionate care and relational practice, but do not state how this can be delivered in practice. By synthesising the findings from 5 studies undertaken in a variety of different settings, we can be more confident in the value of the CCF to ensure best practice.

250 words

Introduction

The Caring Conversations (CC) framework was developed in a study carried out in 2008 to explore compassionate care in an acute care setting caring for older people and has a relational focus [1]. Since then the empirically derived framework has been explored and further developed in a multi-phase programme of work comprising 4 further studies [2-5].

This paper reports on this multi-phase programme of work.

The CCF [1,6] comprises 7 key attributes (Table 1) that guide people to have conversations that are courageous, connect people emotionally, foster curiosity, consider other perspectives, facilitate collaboration, compromise and celebrate what works well. It supports the development of relational capacity [1,6] and a number of practice based conversation tools have been developed to help practitioners enact these attributes in practice (Table 2).

Table 1: Caring Conversations Framework

Key attribute	Dimensions	Key questions to ask others
Being Courageous	Courage to ask questions and hear responses. Feeling brave to take a risk. Persevering. Having courage to stand up for things.	What matters? Help me to understand what has happened? What would happen if we gave this a go?
Being Celebratory	Making a point of noticing what works well. Explicitly saying what works well and asking questions that get at 'the why'. Continually striving to reframe language to the affirmative.	What worked well here? Why did it work well? How can we help this to happen more of the time? If we had everything we needed what would be the ideal way to do this? What are our strengths in being able to achieve this? What is currently happening that we can draw on? I like when you……..
Connecting emotionally	Using 'windows of opportunity' to create openings for people to discuss emotional and personal issues in the context of ordinary conversations. Inviting people to share how they are feeling. Noticing how you are feeling and sharing this.	How did this make you feel? How would you like to feel?
Being Curious	Asking curious questions about even the smallest of happenings. Wondering in the moment about what you see, hear and feel. Using micro-	What strikes you about this? Help me to understand what is happening here? What prompted you to act in this way? What helped this to happen? What stopped you acting in the way you would have wanted to?

Key attribute	Dimensions	Key questions to ask others
	noticing practices by being attentive and open to what is happening. Questioning, weighing up this or that, hunting for meaning. Looking for the other side of something that's said, checking it out. Being receptive to be changed by what you hear.	
Considering other perspectives	Creating space to hear about another perspective. Recognising that we are not necessarily the expert. Checking out assumptions. Being open to hearing perspectives, recognizing that they may not be the same as your own and feeling comfortable to discuss this in an open way. To enlarge and expand my point of view.	Help me to understand where you are coming from? What do others think? What matters to you? What is real and possible? What would it look like if we did nothing?
Being Collaborative	Talking together, involving people in decisions, bringing people on board, and developing a shared responsibility for actions. Looking for the good in others to encourage participation and collaboration.	How can we work together to make this happen? What do you need to help to make this happen? How would you like to be involved? How would you like me to be involved? What would the success look like for you? What can each of us do to make this better?

Key attribute	Dimensions	Key questions to ask others
	Finding out about what we care about – our shared aspirations. Making connections and realising the relevance of these to help make choices.	
Compromise	Being open and real about expectations Working hard to suspend judgment and working with the idea of neutrality. Helping the person to articulate what they need and want and share what is possible. Talking together about ways in which we can get the best experience for all.	What matters most to you? What is real and possible? What could we let go of? How would we feel about letting go?

Table 2 – Tools to enhance use of Caring Conversations in practice

Positive Inquiry Tool	A flexible tool that asks two questions about what's working well and what could we do together to improve the experience. The questions are intended to be asked in the context of a conversation rather than a tool to be sent out and filled in.
Photo elicitation	Simple and flexible approaches to using images to help people articulate thoughts and feelings about a range of concepts that may remain hidden with verbal interview, including intangible aspects of culture. For example asking people to select an image that sums up what they feel about their care experience.
Emotional Touchpoints	A process where people are asked to select from a range of touchpoints (neutral points in an experience) and then to select from a range of emotional words how that part of the experience felt. The approach supports more in-depth exploration of emotions and brings a structure and clear parameters to potentially difficult conversations [7].

This paper reports on a secondary analysis of the qualitative findings from 5 studies that explored the use of the CCF in a variety of health and social care settings. It summarises the key messages from this substantial programme of research, which takes us beyond identifying ***what*** is needed to enhance compassionate and relational practice, to explain ***how*** this might be fostered.

Background

Compassion and person centred care is at the forefront of national and international policy and practice with educational debates [8-13] emphasising the importance of strengthening the climate for care, by promoting models of practice that centre around relationships [14] and the need to nurture and sustain core interpersonal skills [15].

Whilst effective interpersonal communication between health care provider and client is one of the most important factors for improving care experiences, client satisfaction, compliance, plus health and well-being outcomes [8-13]; it is sometimes misunderstood to be a linear process, led by the professional aimed at obtaining information from the client about their needs and imparting information that will help to achieve pre-specified health care goals. What is required is a more skilled action of inquiry that is dynamic and fluid, which supports the development of relational practice to help deliver person-centred outcomes that are meaningful to individuals [16]. Indeed, Fredrickson and Eriksson [17] argue that the development of strategies and knowledge about interpersonal interaction needs to shift its focus from communication to conversation, where there is a focus on the relationship. Doane and Doane and Varcoe [16,18] argue that if relational practice is to be supported we need to move beyond mechanistic models of teaching communication skills that focus on a set of sessions aimed at enactment of behavioural skills, to a model that is more about human relating through an appreciation of people's connectedness and emphasises being with people rather than doing things to them.

Over 20 years ago, Tresolini and the Pew-Fetzer Taskforce [19] highlighted that respectful collaborative relationships are a critical foundation for humane and effective health care and involve:

- willingness to negotiate and compromise;
- willingness to see another perspective;
- promoting and accepting the emotions of others;
- sharing personal information;
- openness to other ideas;
- sharing insights when things are not going so well; and
- recognising what people are good at.

However, these relational attributes are rarely addressed in other models of interpersonal practice [20]. Building on Tresolini and Pew-Fetzer Taskforce's work on 'Relationship-Centred Care', Nolan et al. [21] provided empirical evidence that all parties (users, carers, providers) need to feel a sense of security, belonging, continuity, purpose, achievement and significance to be in good relationship with each other. The Caring Conversations Framework (CCF) was empirically derived to support the enactment of these six senses in practice. The multiphase research programme that sought to develop and test out this framework in diverse health and social care settings is described below.

The Multi phase Programme of Research

Overview

A multi-method, multi-phase co-inquiry was conducted across a variety of health and social care settings (hospital, community and nursing homes) in relation to a range of different topics (compassionate care, dignity, relationship-centred care, inequality sensitive practice, quality of life) over a period of 8 years (2008 – 2016), involving multiple researchers (n=8) and multiple participants (n=313) (see Table 3). Across all studies there was a focus on "Caring Conversations".

Retrospectively the overall programme of work can be divided into two phases.

Phase 1 involved two in-depth, longitudinal, on-site studies [1,2,6] which generated and validated the CCF. Phase 2 comprised three in-depth, longitudinal, off-site studies [3-5] on leadership support, which were based on the CCF generated from Phase 1 and allowed for further testing of the applicability and value of the framework in other settings (acute, community and nursing homes) and at greater scale.

In Phase 1, the first study was undertaken by the Principle Investigator (BD) in a single site (hospital) involving 35 participants [1,6]. It was conducted longitudinally (3 years) and led to the generation of the CCF, through a co-inquiry process involving reflection on findings from interview and observation data collection methods. The learning from this study was fed into the second single site study involving 37 participants, which used the same co-inquiry process and methods over a shorter period (1 year) in a different setting (nursing home). This allowed the findings from the first study to be explored in a different context to assess the resonance and relevance of the CCF and to identify any gaps and further insights. This second study was conducted with both Registered Nurses (RN) (n=5) and non-RNs (support workers, n=35) and enabled reflection on the utility and outcomes of the CCF to practitioners working at a different level of professional development. The strength of these two substantial and in-depth studies was that they were conducted in real world contexts and involved a co-inquiry process that allowed findings to be authenticated by practitioners. The learning from these two studies informed the development of a leadership support programme that had the CCF at its core and enabled the framework to be further tested in Phase 2 for its resonance, relevance and any gaps (further insights) across settings (acute, community, nursing home).

The strength of this research programme lies in the outcomes of the CCF being generated from multiple researchers and the combined quantity and quality of the data. Whilst Phase 1 studies directly involved the Principle Investigator (BD), the Phase 2 studies additionally involved other researchers (n=6) and practitioners (n=241) and generated in-depth qualitative data (group interviews) from a highly-developed reflection process (action learning) conducted over a year.

The purpose of the secondary data analysis across the five studies was not to generate new findings by analysing old data from a new research context and/or lens [22,23] but to track how the CCF had evolved throughout its use in different settings and to explore its impact. Additionally, the secondary analysis was seen as important to make more of the combined qualitative findings, which are often under-utilised in single studies of qualitative research [24].

When carrying out a secondary analysis of primary datasets, Heaton, [25] recommends outlining the original study, the process of data collection and the analytical processes applied to the data. These aspects are summarised for each of the five studies in Table 3.

Objective

To synthesise the qualitative findings from a multi-phase programme of research, which implemented the CCF across a variety of health and social care settings (acute hospitals,

community, and residential care) and explore the perceived impact of the CCF on staff and their practice.

Methodology used across all studies

The five studies were participatory in nature and drew on Appreciative Inquiry that focuses on exploring what matters to people, what is working well and what could be enhanced to support these practices happen more of the time [26,27]. Central to this approach is the power of questions to stimulate a different dialogue that supports practitioners to explore possibilities and challenge assumptions. It asserts that through the language and discourse of day to day interactions people co-construct the organisations they inhabit and thus words create worlds. The approach recognises that the moment we ask a question we begin to create a change and that positive change occurs when the process used to create the change is a living model of the ideal future [27]. Thus, the role of the researcher and the approach used are inseparable from the intervention.

Participants and study settings

All staff participants (n=299, across 5 settings) volunteered to take part in the studies. Only staff interview data were included in this secondary analysis.

Data collection methods used across the studies

Data collection methods across the five studies are detailed in Table 3 and included interviews and group discussions with key stakeholders. Interviews were carried out by experienced researchers. In study 1, 2, 4 and 5 this was led by the first author and in study 3 this was led by the second author. These interviews were not transcribed but detailed notes were taken and fed back to participants to check for resonance. In studies 1 and 2 (Phase 1), observation of interactions was also carried out. Study 1 and 2 differed in that the researcher was present in the study environment over a period of time and thus had additional input in relation to modelling the CCF as part of their role as a researcher and practice developer. In the other studies (Phase 2) the research team met with participants as a group outside of the care setting. All studies included action learning or reflective groups to discuss using the CCF in practice. These group discussions were a source of data generation.

Studies 1, 2 and 5 obtained ethical approval from respective University Ethics Committees and studies 3 and 4 were assessed as practice development projects and ethical approval was not required. The analysis reported here did not have formal ethical approval as it was a ‘desk-based’ study using anonymised data reported in the findings chapters of the study reports.

Secondary data analysis

The original studies with the exception of study 2 had not analysed the data by mapping data to the CCF. In study 1 the attributes were developed from the analysis of the data, study 2 mapped the data to the attributes and studies 3-5 (Phase 2) analysed the data in relation to outcomes for the individuals taking part and changes made to practice. Thus the secondary analysis was a unique opportunity to examine the data and map specifically to the CCF.

An analysis and mapping approach to analyse qualitative data across the 5 studies was used. (Quantitative data from original studies was not subject to secondary analysis). The lead author read the findings chapters of each study several times using a process of ‘open reading’. The purpose was to get a sense of the meaning related to the findings. The next step was to use the theoretical framework of the Caring Conversations to categorise data extracts. A grid was developed with the seven attributes of Caring Conversation and

populated with data extracts and interpretive commentary. The final step was to look across the illustrative examples given for each of the attributes, in the 5 different settings, in order to develop a more in-depth understanding of the attributes in the CCF.

Table 3 -Studies carried out to develop and test the Caring Conversation framework

	Study	Setting	Aim and use of caring conversations in each study	Methodology	Participants	Overview of Findings related to the Caring Conversations framework
	Phase 1					
1.	Caring about caring: an appreciative inquiry about compassionate relationship centred care [6] 2008-2011	A 24 bedded acute medical ward in hospital caring for older people	To work collaboratively with staff, patients and families to explore the concept of compassionate care and develop strategies to enhance this in practice Caring conversations were identified as an outcome of this study	Design: Appreciative Inquiry, a collaborative approach, which focused on real time feedback, and reflection and evaluation on positive attributes to develop practice, were central to the methodology. Methods: 240 hours of observation of interactions between staff/staff; staff/patients; and staff/relatives carried out and over 32 interviews. Analysis: immersion/ crystallisation technique.	A range of participants including registered nurses, non-registered care staff, allied health care professionals and medical staff (n = 35)	Detailed analysis of the extensive data set identified the Caring Conversations framework. Positive data extracts all had evidence of at least some of the attributes of the framework. Engaging in this way helped people to: understand what mattered to people and how they felt. They were then able to use this knowledge to work with people to shape the way things were done experience a sense of learned hopefulness rather than learned helplessness have more confidence to defend practices they believed in listened more to develop stronger relationships with all groups.

	Study	Setting	Aim and use of caring conversations in each study	Methodology	Participants	Overview of Findings related to the Caring Conversations framework
2.	Enhancing dignity through Caring Conversations [2] 2013-2014	72 bedded care home for older people	To celebrate and develop excellent human interaction that promotes dignity between community nurses, residents and families in care homes. Caring conversations used as a mapping tool in the analysis of observed and reported interactions	Design: Appreciative Inquiry:co-designing, implementing and evaluating an educational intervention with and for people in a care home setting. Methods: Specific data generation methods involving residents, relatives and staff included; observation of interactions between staff, families and residents to identify when interactions worked well and enhanced the relationship; interviews with staff, residents and families about their experiences of interactions in the home. These data were mapped to the Caring Conversations framework to check for relevance.	Range of participants: registered nurses (n=8), care assistants (n=29)	The data mapped well to the Caring Conversations Framework. Courteous comments also occurred that were not part of the framework but is was felt that the concept of courtesy or politeness was not particularly related to inquiry and asking a question and therefore although important was more surface interaction rather than deep interaction that represented meaningful dialogue. Care assistants found many aspects of Caring Conversations challenging and felt that they needed further support to be able to feel truly comfortable with this aspect of their role. When staff engaged in Caring Conversations they felt able to develop stronger relationships with all, promote positive cultures of care through appreciating what was valued. The study also found that the approach of appreciative inquiry is the framework for the educational approach to develop Caring

	Study	Setting	Aim and use of caring conversations in each study	Methodology	Participants	Overview of Findings related to the Caring Conversations framework
				Analysis: Data analysis was a mapping process to existing framework.		Conversations. An educational resource was developed from this study and is available at www.myhomelifescotland.org.uk
	Phase 2					
3.	Caring to Ask: how to embed Caring Conversations into practice across North east Glasgow [3] 2013-2014	Three community practice sites: early years, homelessness and primary care mental health settings	To work collaboratively with frontline practitioners to explore the realities of inequalities sensitive practice and test appreciative Caring Conversations to develop this practice. Caring conversations used as intervention in small tests of change.	Design: Appreciative Inquiry. Methods: Three inquiry groups were set up and met on 5 occasions, plus a wider event across the three settings including other stakeholders. Field notes collected from inquiry group meetings. The groups explored the concept of inequalities sensitive practice and carried out small tests of change in the practice settings. Analysis: Thematic analysis.	22 registered nurses/health practitioners in community settings working in 3 inquiry groups.	The use of the Caring Conversations framework helped people to challenge existing assumptions, engage in a more open way during interactions, greater attention to building on strengths of individuals and a motivation to learn from each other.

	Study	Setting	Aim and use of caring conversations in each study	Methodology	Participants	Overview of Findings related to the Caring Conversations framework
4.	Developing compassion through a relationship centred leadership programme [4] 2012-2013	Acute hospital setting. Study involved staff across 24 acute in-patient settings.	To support staff to work together to develop a culture of inquiry that would enhance delivery of compassionate care through a 12 month leadership programme. Caring conversations used as educational intervention.	Design: Participatory evaluation. Pre and post evaluation of 12 month leadership programme based on relationship centred practice and Caring Conversations. Methods: Data generation included, group discussions, field notes, pre and post culture questionnaire and final interviews. Thematic analysis carried out on qualitative data.	Participants n= 86. Which comprised: 2 Associate Directors of Nursing 5 Clinical Nurse Managers 23 Charge nurses/ward managers 23 Senior staff/registered nurses 33 Staff/registered nurses.	Data demonstrated that staff felt teams were working more closely together by the end of the programme due to the development of trust, more open dialogue, being more sensitive to the needs of others, handling conflict in a confident manner, and rewarding others. Additional outcomes reported by staff included; enhanced self-awareness, better relationships, greater ability to reflect on practice, different conversations in the workplace that were more compassionate and respectful, and an ethos of continuing learning and improvement.
5.	Implementation of a complex intervention to support leadership development in	119 care homes across Scotland. 12 month leadership	To examine the learning and perceived difference that the intervention (leadership programme aimed at	Design: Action research. Methods: Collection of both quantitative and qualitative data.	119 nursing/care home managers from homes across Scotland.	The Caring Conversations framework and principles of participation and appreciation helped managers to encourage and sustain genuine curiosity for themselves and others, deepen

	Study	Setting	Aim and use of caring conversations in each study	Methodology	Participants	Overview of Findings related to the Caring Conversations framework
	nursing/care homes: a multi-method participatory study.[5] 2013-2015	programme	enhancing the quality of lives of those living, working and visiting care homes) made to leadership development and nursing home practice from the perspectives of the participating managers, and to understand how change is being enacted. Caring conversations used as educational intervention	Quantitative data were collected pre and post intervention via questionnaires whilst qualitative data in the form of discussion groups were collected throughout the study period. Thematic analysis.	Managers have a role in leading and managing a service for residents in nursing/care homes.	inquiry, explore values and acknowledge and express emotion without dispute or judgement. It helped them to acknowledge achievements, encourage better listening and so make room for more contributions. It supported a different attitude to risk-taking and devising new approaches to problems and ultimately to feel more confident in translating the evidence base into their local contexts in an authentic way that resonates with and gives voice to overlooked perspectives.

Results

We present the results of the analysis based on the attributes of the Caring Conversations Framework.

Being Courageous

Whilst the attributes are not designed to have any particular order, participants confirmed that being courageous could be seen as an overarching attribute that needs to be considered in order to enact all of the other attributes.

Across all studies participants talked about having the courage to engage in Caring Conversations.

> *What has really helped me to have courage is asking myself the question about what is the worst thing that could happen if I gave this a go. (*Study 4, group discussion)
> *It's hard because this feels like a whole different way of communicating.* (Study 2, interview)

This however was not always easy; at times, courage came from being part of a reflective group that helped to overcome fears.

> *It still feels awkward trying to talk to colleagues who are not part of the group using the appreciative questions, but it might actually be easier to talk to service users or patients than we first thought.* (Study 3, group discussion)

Having courage relates to willingness to take risks, feeling confident to ask questions, working with uncertainty and the ability to defend practices that people believed in without feeling that there would be a negative consequence. Staff identified many examples of their own 'courageous' behaviour:

> *The biggest thing… is feeling much more aware about how I behave, being braver to ask patients and families more direct questions, being stronger in sticking up for the things I believe in and being much clearer about what it is we do well around here.* (Study 1, interview)

> *I've been working with a young mother with post-natal depression, where I'd had to get social work involved. It was hard for her to admit that she needed help, but I asked her what had worked well and she said it was that I had not been judgemental – because of her age and inexperience. I had taken time to explain to her why social work were involved. I admit I was surprised that her feedback was positive.* (Study 3, group discussion)

Courage also involved asking people what matters to them and being able to hear the response, even when it might be something the practitioner would find difficult to provide. The following quote illustrates this point:

> *I feel able to ask and hear what others have to say – it may be different from what I think but I now don't go on the defensive.* (Study 5, group discussion)

Even the act of noticing something someone had done well and feeding this back to them took courage as one participant explained:

> *We are not used to hearing the positive. I fed back to one staff member that I liked the fact that he seemed confident and calm. He was embarrassed and I was embarrassed. It feels like I have to take a deep breath in before saying these things* (Study 2, interview)

In study 5, in particular, participants spoke about courage to be vulnerable:

> *I know now that I can show my vulnerability, I don't have to know everything and this does not mean that I don't know what I am doing. In fact, it helps develop stronger relationships; it brings people in.* (Study 5, group discussion)

Developing courage to engage in the Caring Conversations is something that seemed different and potentially difficult for participants, particularly in Study 2 where a range of more junior staff were involved.

Being Celebratory

Being celebratory, particularly in the moment and as a starting point for inquiry, was about asking questions to explore fully what is working well and why and making a deliberate effort to notice things that are valued and feedback these in the moment:

> *I try to commend people for good things more now. Before, I think when I thought people did things well; I didn't say anything because I just thought it was part of their job. I do try to say these things more to people.* (Study 1, interview)

For many participants this felt like a new way of working:

> *It is refreshing not to focus on the negative all the time but to look for possibilities.* (Study 4, interview)

> *It's interesting to hear the stories from each other. They're hopeful and show acknowledgement of our efforts, but usually they get lost. We should do this more!* (Study 3, group discussion)

Being celebratory as a deliberate part of the way in which participants communicated on a daily basis also seemed to have a positive effect on those that they communicated with:

> *I have changed my management style. I never used to comment about the things people did well just on what they were not doing well. This has changed — it has not been easy but I am trying, and it is making a difference to the atmosphere on the ward—people are more supportive of each other.* (Study 4, interview)

The act of deliberately celebrating during interactions was important as it helped people to bring to consciousness the things that were valued. Interestingly in study 3 participants commented on the final placing in the original 'list' of the attribute of celebrate. Celebrate is often seen as something to do at the end of an encounter where people are thanked for their contribution. Many of the participants commented how the act of celebrating during interactions was different and potentially disruptive, counter cultural and provocative. Deliberately noticing what one values and naming this within the interaction can happen at any point and indeed can help engagement so that other attributes can be enacted. The attribute of celebrate is now placed following 'be courageous' in order to emphasise the enactment of this attribute through all stages of the interaction.

Connecting Emotionally

Connecting emotionally involved asking people, in a meaningful way, how they felt about their experiences and being aware of personal feelings about, and responses to, the emotion of others.

Participants often used the structured approach of emotional touchpoints (Table 2) to specifically engage emotionally [7]. This approach enabled people to explore emotions together during interactions:

> *I used the emotional touchpoint technique to help me in a conversation I had with a person who was in the last few weeks of his life. I always dread these conversations and don't think that I have done them very well in the past. He picked words 'frightened' and 'angry' and talked about why he felt that way. I think having the negative words there gave him permission to use them. We talked together about how he would like to feel and he chose the word 'calm'. We then talked about what would help that to happen. I felt so much more confident and working with emotions in this way helped him to be heard. The family came up after he had died and spoke about the important conversations we had that helped him to die in a way that he would have wanted.* (Study 5, group discussion)

The invitation to express emotion in the touchpoint activity gave legitimacy to emotions, whether they were positive or negative, and permission to express them. As a result, many participants talked about being more conscious of tapping into emotions during everyday encounters:

> *It has made us more aware of the bonding with the patient. You are not just showering a patient, you are using the opportunity to be with them, to talk to them about how they feel, to help them to feel less embarrassed about being naked in front of you.* (Study 1, interview)

There was also some evidence that if staff role modelled Caring Conversations, then clients and families responded in similar ways.

> *I see a difference in how others respond to me now…. they are not just saying 'ok' and 'fine' when I ask them how they feel. I often ask them specifically what word they would use to describe how they feel.* (Study 4, interview)

Some staff became increasingly aware of their own emotions and felt more comfortable about sharing them. Others felt this was more difficult:

> *I feel a bit scared to share my emotions with others – I'm not there yet but am getting there. (*Study 2, interview*)*

Being Curious

Being curious was about really trying to understand experiences and perspectives. It involves actively digging deeper to explore in more depth. It involves 'holding' assumptions lightly, recognising these and being receptive to be changed by what you hear. The focus is on expanding breadth of understanding:

> *I don't rush in with giving information and saying what I think when talking to patients, I' m much more mindful of pressing that pause button and asking a question.* (Study 4, interview)

Being genuinely curious meant that staff felt better able to let go of their own solutions and hear ideas from others:

> *I see myself less as a fixer of problems and more as someone who will spend time finding out things and helping others to come up with solutions.* (Study 5, group discussion)

In addition, staff commented on the element of surprise elicited by curious questioning.

For instance, when asked what helped if she was feeling a bit low, a resident replied that she liked to be left alone, resulting in the staff member saying:

> *I thought I knew this lady well – we don't always ask about these kind of things – we just think we know.* (Study 2, group discussion)

Thus asking curious questions seemed to stretch thinking beyond familiar patterns and connections and generated the development of a culture of inquiry:

> *When asked what she could do to make things even better he replied, 'keep asking me! (*Study 3, group discussion*)*

Participants found it helpful to ask themselves 'what am I wondering about' to prompt them to genuinely focus on curious questions.

Considering other perspectives

Although similar to the attribute of being curious the data generated from the analysis helped to delineate this attribute further. The emphasis here is about width as opposed to depth. It focuses on seeking out and celebrating diversity, rather than considering other perspectives to see who has the answer or which perspective fits best. It is about enlarging and expanding on a point of view and challenging assumptions.

This attribute involves asking questions that genuinely sought to explore the feelings and experiences of others as a means of learning new knowledge, unpacking existing assumptions and celebrating alternative approaches. This involved both exploring and being open to another's point of view, acknowledging that they may not hold the same beliefs and feeling comfortable to discuss any differences in an open way.

> *This has helped me to improve a relationship with a client. I think I'm being emphatic, but I'm going in with an agenda – I know what we can offer. Instead, I asked 'how do you see things? and 'what leads you to that conclusion?' This has helped us put things on a better footing.* (Study 3, group discussion)

Participants talked about consciously pressing the 'pause button' and slowing down to become more mindful about their assumptions. This became a conscious act:

> *I consciously try to press the pause button. This has been a key thing for all of us in the group that has helped us to try to think and ask about what others think. (*Study 5, group discussion)

> *I am still a bit nervous when approaching relatives who are not happy but I press a pause button in my head now and give myself time so I don't come across nervous and they feel that I am listening to them.* (Study 2, interview)

Thus staff became accustomed to challenging in a curious and positive way from a place of support rather than criticism, and in a way that helped people to consider other perspectives.

> *I feel I am genuinely more interested in what others have to say. I also feel more comfortable to just 'be' if something is raised that I don't agree with. It is their*

*perspective. I think more about how that makes me feel and whether saying anything would help us (*Study 4, group discussion*)*

Being Collaborative

Collaboration has become an over- used term, that most people feel they are practicing but it can often focus purely on idea sharing and consultation. In the CCF collaboration is a deeply human and relational process. It is about sharing what we care about and hope for and strengthening the collective capacity rather than carving out our own individual identity and directing the group's efforts towards these goals.

Throughout the studies there seemed to be enhanced opportunities for collaboration (talking together, involving people in decisions, bringing others on board, and developing a shared responsibility for actions), not only between staff but also with service users and families:

> *We have not always asked patients and families what they think would be a good way forward – we tend to think that we have to have the answers to this. We don't have all the answers and have found that patients come up with things we might not have thought about. A patient was fed up with us saying we will be back in a minute – we asked him what we could say that would be better – he said – 'I'll be back as soon as I can.'* (Study 1, interview)

> *It's maybe much quicker to just do it all myself and make decisions but I realise now that involving others has a longer lasting effect and it makes people feel part of things and valued.* (Study 5, group discussion)

Moving from a position of fixer to enabler was a key theme that emerged across all studies.

Different actions demonstrating collaboration can be seen in Table 4. A key aspect of collaboration that was identified particularly in study 3 and 5 was finding out about people's strengths and using this to encourage involvement and participation. Participants used the questions of what works well for you and how can we work together to improve your experience. Reflecting on this one participant noted:

> *The questions are good. They show we care; they show that we're in partnership. For me, the 'we' in 'what have we done well?' means me and the client – people do assume it means the service.* (Study 3, group discussion)

Such collaboration inevitably meant that the perspectives of others were given greater attention and future possibilities explored.

Table 4 – Evidence of new collaborations with staff, clients and families across the studies

Study	Collaborative activity
Caring about caring: an appreciative inquiry about compassionate relationship centred care [6]	Staff routinely asked people what mattered to them and found out about patients, staff and families as people and discussed this to establish how these aspects influenced care giving. Learning from peoples experience prompted collaborative dialogue about improvement of care giving.
Enhancing dignity through Caring Conversations [2]	Relatives meetings changed so that there was a clear purpose which focused on updates, exploring what worked well and

	how these things could happen more of the time.
Caring to Ask: how to embed Caring Conversations into practice across North east Glasgow [3]	Changes to thinking about respective contributions that can be made; by bringing to light the positive things in a situation or relationship, staff and clients both felt more motivated and had a better basis for working together to seek solutions. Greater peer support within and across professional groups. Demonstrated the value of dialogue.
Developing compassion through a relationship centred leadership programme [4]	Patients more involved in shaping the service as part of routine dialogue rather than setting up special meetings for service user involvement.
Implementation of a complex intervention to support leadership development in nursing/care homes: a multi-method participatory study.[5]	When implementing a new initiative about promoting physical activity for residents, staff worked to find out what physical activity meant to residents and families before implementing a range of activities. This changed the nature of activity and included for example, more opportunities to integrate physical activity into day to day acts such as preparing meals, walking to the dining room, stroking pets.

Compromise

Where there was evidence of this attribute in data extracts, staff felt more positive about relationships if they could be open and honest about expressing their feelings, particularly if this was in relation to difficulties in providing care that people wanted or expected.

This openness and honesty took courage. In study 5 participants specifically noted how the increase in confidence to compromise in a skilful way enabled them to have a different attitude to risk-taking and devising new approaches to problems.

It was interesting that there were fewer illustrative examples of this attribute across the studies compared to other attributes of the framework. A quote from one participant gives some indication of why this might be the case:

> *We might have negotiated things with patients before, but we did not always say to others what we had done, possibly because we were a bit embarrassed that we had to compromise and not give the best care we could.* (Study 1, group discussion)

Thus, possible reasons for fewer reported data extracts related to this attribute may be related to discomfort people feel when ideals or aspirations cannot be met.

The original CCF was developed empirically from data in one acute care for older people setting. What emerged during subsequent studies was that the attributes of the framework were an important guide to support self-reflection as well as interactions with others. As a result questions were developed, aligned to the attributes of the CCF, that guided this self-reflection [28]. These are illustrated in Table 5. Interestingly, study 3, 4 and 5 were not facilitated in the actual care settings. The development of the self-reflective questions were seen as an important addition during these studies and have helped us to understand how to do 'Caring Conversations' at scale without direct facilitation in practice.

Table 5 – Caring conversations with self: Self-reflective questions, Roddy and Dewar [29]

Caring conversations attribute	Key Questions to ask yourself
Being Courageous	What might help me to feel able to take a risk? What question is begging to be asked? What story is longing to be told? What is the worst thing that could happen if I gave this a go?
Being Celebratory	What do I value? What do I do well? What mistakes might I like to celebrate? What new idea would I like to bring forward in to the future?
Connect Emotionally	How do I feel?

Caring conversations attribute	Key Questions to ask yourself
	When did I experience strong emotion? What if I told others how I was feeling? How would I like to feel?
Being Curious	What assumptions do I have that might be shaping how I relate to another? What caught my attention?-Where might it be leading us? When was I most energised? What assumptions or contradictions have come to light? What am I focusing my attention on and privileging?
Consider Other Perspectives	How might I express myself in a way that is considerate of others? How can I ensure that those who aren't present still feel included? What alternative views might I explore?
Collaborate	With whom do I feel heard? Who brings out the best in me? What might help us to come together more? What can I offer? What ideas/actions would I like to build on? How do I want to be involved?
Compromise	What do I hope for? What can I not let go of? What would I like to let go of? What promises feel possible?

In general there was recurrence of themes in relation to impact of using the CCF across the studies which included; feeling brave to celebrate and value the practice of others, challenging poor practice through curious questions, exploring what mattered to people and feeling calm if their response was different to what you expected or contrary to your beliefs and values, asking people more often what mattered them and how they felt, feeling more confident to share personally with another, development of stronger relationships and being clearer about the legitimacy of compromise in the health and social care context.

The additional outcome of being more confident in translating the evidence base into their local contexts in an authentic way that resonates with and gives voice to overlooked perspectives was evident in study 1 and 5. This may have been because the aim of these studies explicitly related to implementation of best practice.

Discussion

This paper brings together evidence for each of the attributes of Caring Conversations and contributes to a more in-depth understanding of the framework. The findings raise several important considerations for future development and application of the framework in practice. In particular, the findings highlight the complexity of interactions in health and social care and confirm the importance of relational practice. The analysis across the five studies highlighted a more nuanced understanding of the attributes in the CCF. Participants across the studies found all of the attributes relevant and saw the potential for each of them to be 'notched' up in their day to day practice. It seemed that some of the attributes were more 'disruptive' or provocative than others. For example, the attribute of collaboration or consider other perspectives tended to evoke the response of, 'yes we do this anyway', whereas others such as be courageous and compromise were rarely named in this way. The naming of these attributes of and in itself has value.

The framework explicitly acknowledges the emotional connection that is required to develop relational capacity, along with the need to appreciate what people are good at. Literature on emotion in healthcare has not only focused on emotions; but has viewed their expression negatively, as something that has to be carefully managed [29,30]. These writers emphasise emotions as potentially disruptive and interfering with a rational approach to situations, rather than viewing emotions as fundamental to human experience and enhanced understanding. By contrast, other authors have articulated their concern about ignoring emotions [30,31]. For example, Stickley and Freshwater [30] talk about 'rehabilitating' the emotions deemed to be inappropriate back into the practitioner patient relationship, so that we change from adopting a model of 'keeping your distance' to one of 'more meaningful engagement' This requires emotional honesty directed both inward toward acknowledging one's feelings and their implications and outward toward the expression of one's feelings and the recognition of the feelings of others [33].The addition to the framework of the self-reflective questions to ask oneself in interactions affirms the importance of recognising our own emotions within interactions (Table 5).

It became clear in the findings however that expression of emotion required a degree of vulnerability. Shildrick [34] suggests that recognizing shared vulnerability with those who suffer may be at once a more humane and a more realistic position from which connection with others is possible. Vulnerability is considered by some authors to be a central feature of transformational leadership that helps to sustain relationships [35,36]. Transformational leadership is advocated in the context of health and social care, where shared responsibilities require dialogue that influence new ways of knowing [35]. This vulnerability can bring with it an element of risk taking that in itself is a courageous act. Indeed, Brown [36] suggests that true leaders welcome the uncertainty, risk and emotional exposure that is normally associated with failure and achieve success by having the courage to be vulnerable. The attribute of being courageous in the Caring Conversation framework seems

to link explicitly to the concept of vulnerability. Further work that explores supporting people to 'be vulnerable' in the context of their relationships in care contexts is required.

The concept of vulnerability seemed evident across all of the attributes not just the capacity to engage emotionally. For example, the attribute of compromise requires a level of vulnerability, where there is openness and honesty. The findings suggest that the attribute of compromise was least evident in the data from the original studies.

We suggest a possible reason for this may be may be related to a sense of failure if ideals are not realised. It can be seen as having to accept something less than you would want.

There is increasing evidence in the literature that a key source of emotional distress is managing the dissonance generated by the co-existence of conflicting ideologies of practice [37,38]. This is further supported in the systematic review of nurses' experiences of caring in older people settings [39], where they report that if nurses were not able to meet their personal aspirations for care they experienced moral distress.

If we acknowledge the growing evidence that emotional distress can result from the dissonance experienced when care aspirations cannot be met [38-40], we may value and share the complexity of the skill of compromise within the context of health and social care.

This complexity is highlighted by Shapiro [43,p.7] who argues that human connections "need to support expressions of vulnerability, sharing mistakes, incorporating not knowing; awareness of and transparency of the emotional impact of health care work; and acknowledging the common bonds of humanity with patients, relatives and colleagues."

Explicit acknowledgement of this complexity would help to negotiate more realistic and achievable goals for care; along with more open approaches to risk taking, which in turn might lead to a greater sense of fulfilment and achievement for all those involved. Further research that examines what would support people to develop the skill of compromise in the context of caring is required.

A more detailed understanding of the attribute of considering other perspectives was developed through the analysis. The attribute emphasises discovering what we each care about, what are our strengths, and what can we learn together and joining that thinking and feeling to enable a breadth of understanding of an issue. It is a dialogic experience. This is in contrast to considering other perspectives when the purpose it to engage in debate. Bohm and Nichol [44] makes distinctions between the purpose of dialogue and debate where debate assumes there is a right answer and someone has it, in contrast to dialogue where the assumption is that many people have pieces of the answer and that together they can put them into a workable solution. This was evident in the data analysed across the studies. Self- reflection is also encouraged in dialogic approaches where dialogue causes introspection on one's own position and debate causes critique of the other position. Thus the additional questions in Table 5 that detail questions to ask self for each attribute are an important addition.

This attribute of collaborate involved more than working together. For example in Study 3, more explicit use was made of the positive inquiry tool, which asks firstly about what is working well and then about the possibilities for collaborative solutions to make things even better (Table 2). Thus people were co-creating solutions together in the moment, based on careful discussions about what matters, what is possible, and what are people's strengths and aspirations. This attribute is important and aligns with the growing body of work on the concept of co-production in health and social care. Co-production focuses on shared decision making requiring professionals to relinquish their roles as fixers of problems and embrace more facilitative roles to help clients and professionals work out solutions together

[45]. Co-production however may remain an elusive concept if we don't support practitioners to learn how to do this and Caring Conversations may help here.

The secondary analysis also led us to reconsider the 'I' in collaborate. Data presented recognises the interrelation and individuality in collaboration. The revised questions for self in Table 5 help to put the 'I' back into collaboration where we need to consider more about who am I in this collaboration, what do I bring, and what are my limits. Across the studies staff seemed to be drawn to the Caring Conversation framework and found it useful in developing more open conversations. Participants in study 2 expressed more hesitation than other groups in working with the framework. The group of participants in study 2 were less senior staff than in other studies. It may be that more guidance is required to support less experienced practitioners.

In acknowledging 'courage' as an overarching attribute that needs to be considered before all other attributes are enacted it is important to be aware that any attempt to introduce this framework, as a 'quick fix' without appropriate support, may have limited success. We caution against the usual approach of 'let's roll it out' and favour a more realistic and relational approach which focuses on nurturing and development. This was recognised in study 3.

All of the studies used appreciative and participatory research methodologies which in itself has the CCF at its core, in relation to modelling this way of communicating through the research. Evidence from Study 2 suggests that the approach of inquiring appreciatively is an appropriate educational and learning strategy to implement the CCF in practice. There is scope for further research to test this out.

It was clear that the CCF resonated with most staff and resulted in positive outcomes, such as challenging existing assumptions, engaging in a more open way during interactions, paying greater attention to building on strengths of individuals and providing motivation to learn from each other.

It is interesting that participants, in their accounts of development of these interpersonal skills, referred more to careful questioning and listening and rarely talked about the concepts of trust, respect and mutuality, often referred to in the literature as key concepts and processes that enhance relational caring [46]. Rather they referred to ways of being and relating that were about developing an openness to hear about experiences (being curious and collaborative), focusing less on saying the right thing and working with people based on what is said in the moment, and embracing ambiguity and uncertainty to shape the way things could be done together (being courageous and collaborative).

What was therefore clear from the analysis of the findings was the adaptability of the CCF. People felt able to adapt this to make it their own; it is not formulaic or a protocol, but requires improvisation. People developed their own questions based on a greater awareness of the attributes. The idea of doing something "in the moment" in response to one's immediate environment, inner feelings, without a script or step-by-step preparation seemed important. This finding will be important in developing further educational guidance on implementing the CCF. It also suggests the possibility of extending the application of the CCF to caring practices where verbal communication is limited. A recent ethnographic study [47] that adopted an appreciative stance when observing 'inter-embodied interactions' [48] in a care home setting enhances this potential, as our provisional review of study descriptions of observed interactions between care home staff and older people with advanced dementia uncovered instances of each of the seven attributes of caring conversations. This possibility merits further exploration.

The CCF articulated in this body of work identifies the ways of acting in conversation that can realise the knowledge, skills and values necessary to deliver and sustain Relationship-Centred Care as identified by Tresolini and Pew-Fetzer Taskforce [19] and enhance compassionate care, and thus make an important practical contribution to this knowledge base.

Conclusion

In this paper an analysis of the Caring Conversations across five studies in this multi-phase programme of work has helped to provide more illustrative detail of the attributes of these conversations in practice and supports an argument that the framework has application across a range of settings. In addition, the use of the framework has resulted in very similar outcomes for staff across these settings including, greater self- awareness during interactions, greater self-confidence, development of stronger relationships, and more open dialogue that supports relationship centred practice. Importantly the analysis has provided greater insight into the complexity of interactions and emphasised where more work needs to be undertaken to support guidance for education in the future.

The studies analysed are all conducted by the authors themselves. Heaton [24] highlight epistemological issues concerning the compatibility of secondary analysis with some of the key tenets of qualitative research, such as the importance of knowledge of the context in which data were collected. The authors had specific knowledge about the contexts of the studies and therefore this inside knowledge is seen as a strength of this analysis. It would be interesting in future work to locate other studies that have used the CCF as an intervention, but not involved the authors. To date there are none. Data used in the analysis of this paper is derived from self-reported outcomes from staff. Current development work is ongoing to capture outcomes for relatives and residents. While future research is required to explore the applicability of the CCF in caring situations that are more reliant on embodied and inter-embodied communication and interaction, the studies reported here go a long way towards addressing the challenge of how models of education and learning can support the development of interpersonal communication and relational capacity.

Practice and research implications

All of the five studies worked with frontline practitioners who were able to use the CCF in practice. Thus the framework has relevance and resonance as well as practical applicability. In addition, the findings have implications for how to support the development of skills aimed at enhancing relationship centred practice across health and social care settings. Further work is underway to develop linguistic markers of the attributes of Caring Conversations which could help to profile when these are happening and prompt areas for improvement.

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I confirm all patient/personal identifiers have been removed or disguised so the patient/person(s) described are not identifiable and cannot be identified through the details of the story.
The analysis reported here did not have formal ethical approval as it was a ‘desk-based’ study using anonymised data reported in the findings chapters of the study reports.

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