



Humanising Relational Knowing

An Appreciative Action Research Study on Relationship-centred Practice on Stroke Units

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Abstract

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Over the past two decades, NHS stroke services in England have improved the organisation of hospital-based stroke care, leading to improved outcomes after a stroke. However, this drive for improvement has not always been informed by a holistic view of stroke recovery and rehabilitation. Stroke survivors and their carers ask for individualised, person-centred care, with less focus on the physical aspects of their recovery (Stroke Association 2013; Luker et al. 2015). Despite a plethora of national recommendations on person-centred care, there is little actual 'know how' on achieving this within stroke services.

An appreciative action research (AAR) method was used to develop a relationship-centred care (RCC) approach within a stroke unit setting. It was a two-phase study conducted on two combined acute and rehabilitation stroke units in the south west of England over 20 months. The first phase objectives were to explore and describe participants' meaningful relational experiences and the processes that supported them. The objective of phase two was to take the processes learnt from phase one and explore whether these could be translated to a second stroke unit.

Data were generated from 17 interviews, 400 hours of observations, 10 staff discussion groups, and the researcher's reflective diary. Initial co-analysis using sense-making with participants was part of the AAR process, with this analysis informing the subsequent phases of the AAR cycles (Cooperrider et al. 2005). Further in-depth analysis was conducted using immersion crystallisation to confirm and broaden the original themes (Borkan 1999). Data analysis was informed by relational constructionist and humanising/lifeworld-led care perspectives (McNamee and Hosking 2012, Galvin & Todres 2013).

Data described that participants (patients, relatives and staff) all valued similar relational experiences around human connections to support existential well-being. The AAR process supported changes in self, and the culture on the stroke units, towards an increased value placed on human relationships, including colleague relationships among staff. The processes that supported human connections in practice included:

- i. sensitising to humanising relational knowing through appreciative noticing;
- ii. reflecting and sharing these experiences with others to co-create a relational discourse;
- iii. having the freedom to act, enabling human connections.

Developing processes to support humanising relational knowing revealed the complex, experiential and constantly changing nature of this way of knowing. Open reflective and reflexive spaces, created by animation and facilitation, were important to support staff to maintain sensitivity towards relational knowing within an acute care context. The outcomes from this study build on existing humanising/lifeworld-led care theories through: developing orientations for practice that support relational knowing, and; proposing development of the RCC model to include humanising values of embodiment, insiderness and agency.

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List of Abbreviations

AAR	Appreciative Action Research
AI	Appreciative Inquiry
AR	Action Research
MDT	Multidisciplinary Team
NHS	National Health Service
RCC	Relationship-Centred Care

Acknowledgements

This thesis is dedicated to my late father: I fondly remember our conversations in his study that inspired me as a young girl to do this. Thank you for nurturing my inquisitiveness, and being my continued inspiration to finally get this thesis completed. I'm sad that you will never share this with me. I am also forever grateful to my mum: for introducing me to the wonderful world of nursing, and being such an amazing role model.

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Chapter 1: Introduction

“Promise me you will not spend so much time treading water and trying to keep your head above the waves that you forget, truly forget, how much you have always loved to swim” Tyler Knott Gregson (2014).

1.1 Overview

This thesis explores meaningful relationship-focussed care experiences on specialist stroke units. The study within this thesis sought to describe and develop approaches that enrich the experience of human relationships for people with stroke, their families and health care workers on stroke units.

This chapter will give a short introduction to my personal values and beliefs shaping my worldview and influencing my research choices in this study. Then I will outline why research into relationships on stroke units is required within the current context of stroke services in the United Kingdom National Health Service (NHS). The chapter will conclude with an outline of the structure of this thesis.

1.2 My personal worldview

I have been a registered nurse for 21 years with my clinical experience predominately in hospital-based services. Although I remember wanting to be a nurse from the age of five, both my mother who was also a nurse, and my father, who I watched living with disabling arthritis and constant pain, had a big influence on my decision to become a nurse. I became interested in acquired brain injury in the first year of being a registered nurse, and have remained within this speciality ever since, working across the entire pathway from neuro-intensive care to inpatient rehabilitation. While working in a regional neurological unit in the late 1990s, I first came across the inequalities in care between stroke and other forms of brain injury, with stroke patients receiving non-specialist general medical care (there were no specialist stroke units at this time) while, I believed, they still

required specialist neurological nursing. This inequitable care, and the general negative status of stroke nursing among nurses, sparked my passion for stroke care and my career has remained within stroke care since. I have been fortunate to have been involved in strategic, organisational and clinical improvements at a national and local level that have radically changed the organisation of stroke care.

My professional roles have included being a nurse, leader, manager, educator, practice developer and novice researcher. I process information verbally, and therefore enjoy working in a team where I can bounce thoughts and ideas around. I find that this stimulates creativity in my practice, and I enjoy learning with others. I am also inherently pragmatist and will engage in projects that I perceive are grounded in 'real world' clinical practice.

Despite having increasingly less direct patient contact, the role that I still identify with the most is a nurse. I see a large part of my role as a supporter and enabler for my colleagues from all disciplines, to provide them with the resources to enable them to care. I highly value the reciprocal nature of caring, and the pleasure that a good caring experience can provide. Caring for others reinforces a sense of who I am. I think that this stems from my experience of caring for my father when I was a child. My motivation is not only a human element of relieving suffering, but also the desire to make a difference.

My previous research has included exploring the interactions between nurses and patients with communication disability after stroke (Gordon et al. 2009) and highlighted the lack of personal interactions that take place alongside inequality in control of the interaction that can exist between patient and nurse. Therefore including patients with communication difficulty in any further research that I

conducted was important for me to develop more knowledge to support this patient group.

In the last decade, I have had a growing concern that stroke services, through focussing on processes and outcomes to drive improvement, are unconsciously losing the holistic approach of caring for a person with stroke and their family. It is the combination of my interest in stroke; a desire to re-dress the balance between the organisational processes of care and providing holistic care to people; and also considering the needs of the health care team in the caring dynamic; that has led me to researching relationship-focussed care on stroke units.

1.3 A background of stroke and stroke services in the United Kingdom (UK)

A stroke is defined as,

“rapidly developing clinical signs of focal (or global) disturbance of cerebral function, lasting more than 24 hours or leading to death, with no apparent cause other than that of vascular origin” (World Health Organisation 1978).

Stroke is the fourth most common cause of death, with one in five strokes being fatal (Office for National Statistics 2016; Stroke Association 2017). In the UK there are approximately 1.2 million affected by stroke living in the UK, with more than 100,000 having a stroke each year (Stroke Association 2017). In 2016, England, Wales and Northern Ireland had 85,000 people admitted with stroke to over 5000 stroke unit beds (Royal College of Physicians 2016b). Stroke is the leading cause of disability worldwide, and causes a range of disabilities from visual disturbance and cognitive problems to paralysis and coma, depending on which vascular supply and extent of brain that has been affected (Department of Health 2007). A stroke can be hugely life-changing and challenges a person’s sense of identity, sense of self and their lived experience of being in the world (Parr et al. 1997; Ellis-Hill et al. 2008; Sunvisson et al. 2009), illustrated by the following quote,

“A blood vessel exploded in the left half of my brain. And in the course of four hours, I watched my brain completely deteriorate in its ability to process all information. On the morning of the haemorrhage, I could not walk, talk, read, write or recall any of my life...” (Bolte Taylor 2008).

1.3.1 Communication and cognitive difficulties after stroke

In the UK, approximately one third of people after stroke acquire a communication difficulty (Sellars et al. 2002; Engelter et al. 2006). Communication problems after stroke will have an impact on any language based activities, including building therapeutic relationships. Communication difficulties after stroke are commonly dysarthria or aphasia. Dysarthria is described as severe slurring of speech, and can vary in severity. It is defined as a,

“Neurologic motor speech impairment that is characterized by slow, weak, imprecise, and/or uncoordinated movements of the speech musculature and may involve respiration, phonation, resonance, and/or oral articulation” (Sellars et al. 2002, p.62).

Aphasia is defined as,

“Impairment, due to acquired and recent damage of the central nervous system, of the ability to comprehend and formulate language. It is a multimodality disorder represented by a variety of impairments in auditory comprehension, reading, oral-expressive language, and writing” (Rosenbek et al. 1989, p.53).

Other effects of stroke that can also result in communication difficulty include fluctuating levels of consciousness and disturbance of cognitive functioning.

Cognitive impairment after stroke is described as,

“Enduring difficulties in specific cognitive domains, such as attention and concentration; memory; spatial awareness; perception; praxis; and executive functioning. Although it is possible to have a deficit in one cognitive domain only, usually stroke survivors experience deficits across several domains” (Gillespie et al. 2014, p.121).

The prevalence of cognitive impairment is between 50 and 80% in the first months after stroke (Jokinen et al. 2015). It is not a clear picture, with patients often having a combination of types of communication difficulties and cognitive impairments. In the first days after stroke, these difficulties are often compounded further by fluctuating levels of consciousness.

The impact of communication and cognitive problems after stroke has been well-documented (Kauhanen et al. 2000; Nyström 2006; Pound 2013; Gillespie et al. 2014; Hallé and Le Dorze 2014). They can challenge a person's sense of identity and reduce social networks leading to isolation and poor mental health (Parr et al. 1997; Mitchell et al. 2010). In addition, this group is commonly excluded from studies, resulting in a lack of knowledge of their specific experiences and needs. The consequent inequalities in the knowledge base may in turn have led to inequalities in care (Brady et al. 2013; Jayes and Palmer 2014b).

Stroke services have focussed on staff training based on supported communication models to develop stroke clinicians' knowledge and skills to understand and interact more effectively with patients who have communication difficulty (McVicker et al. 2009; Murphy et al. 2016). However, studies highlight that this training does not always translate into practice, with a number describing patients with aphasia feeling distressed, objectified, isolated and staff avoiding contact with them (Gordon et al. 2009; Nyström 2009; Hersh et al. 2016; Clancy et al. 2018). There is also evidence of patients with communication difficulties feeling calm and secure when they feel clinicians recognise them as a person and are understood (Sundin and Jansson 2003; Nyström 2006). It is unsurprising therefore that researchers recommend that stroke clinicians (with the exception of speech therapists) need to improve communication with, and getting to know, the individual person with stroke related communication problems (Anderson and Marlett 2004; Gordon et al. 2009; McVicker et al. 2009; Brady et al. 2013).

1.3.2 *Stroke service development in the UK*

Stroke services, along with the NHS as a whole, have seen a continued increase in demand alongside a drive to improve quality, productivity, safety and reduce costs (NHS England 2013, 2019). Since the publication of the National Stroke Strategy (Department of Health 2007) 12 years ago, stroke care has been transformed by: improved organisational processes; the creation of specialist stroke units with specialist multidisciplinary teams in every hospital in England and Wales and; developing the evidence-base for clinical care promoted through the UK Clinical Research Network (Royal College of Physicians 2017). Combined, these have brought improved outcomes for stroke survivors, with reductions in mortality, disability, and patients more likely to be living at home one year after stroke (Stroke Unit Trialists Collaboration 2013; Royal College of Physicians 2014; Seminog et al. 2019).

Stroke services are monitored through the Sentinel Stroke National Audit Programme (SSNAP) that aims to measure the quality and organisation of stroke care in the NHS (Royal College of Physicians 2017). It provides quarterly reports on the performance of every stroke unit in England and Wales. The dataset for SSNAP focusses on systems, processes, completion of key clinical assessments, and core medical treatments. One ethnographic study has described how SSNAP influenced the prioritisation and delivery of therapy; and that contextual, human factors and experience of care or rehabilitation tend to be overlooked in favour of achieving SSNAP measures (Taylor et al. 2018).

The impetus for organisational change has not slowed, with services reorganising into hyper-acute 'hubs' to deliver new acute stroke treatments, and more patients being discharged earlier from stroke units to community rehabilitation (Royal College of Physicians 2017; NHS England 2019). However, there are starting to

emerge caveats to the major contribution of organised stroke care to improving recovery after stroke. Newer models of centralising acute services into hyper-acute ‘hubs’ with patients staying a few days at a ‘hub’ before repatriation to local stroke units (‘spokes’), and earlier discharge home with Early Supported Discharge services, has the potential to fragment care. ‘Hub-and-spoke’ models create fewer opportunities for clinicians to be with patients and their family before moving onto the next phase in the stroke service pathway. Recent studies that explored the experience of stroke unit care have started to describe the impact of these newer models of stroke service organisation on the capacity of patients, family members and staff to build relationships (Ryan et al. 2017; Suddick et al. 2019). Professionals describe the pressures of meeting targets and the need to expedite discharges undermining the quality that they are able to provide (Jones et al. 1997; Ryan et al. 2017). Patients ask for care and rehabilitation that meets **all** their needs as a human person, broadening the focus from their physical needs (Satink et al. 2013). Finally, family and carer needs continue to be highlighted as unmet by current stroke services, leading to a heightened sense of burden among family and carers (Morris et al. 2007; Stroke Association 2012, 2013).

The implications of a heavy focus on rational and process-orientated care were starkly highlighted in the horrific accounts of dehumanised practices at Mid-Staffordshire and Winterbourne View Hospitals (Morris et al. 2007; Department of Health 2012; Francis 2013; Hesselink et al. 2013; The Patients Association 2015). Humanising and relational approaches have the potential to provide a counter-balance to rational and process-orientated care (Galvin and Todres 2013). Tresolini et al. (1994) recognise the value of a relational focus within healthcare,

“although relationships may be difficult in the short run because of turmoil and turnover in the health-care system, in the long run it may be the one way of possibly affecting quality of care” (Tresolini and The Pew-Fetzer Task Force 1994, p.6).

Knowledge on relationship-focussed approaches specifically within the context of stroke services in the UK is lacking, and it is this area that this thesis seeks to explore.

1.4 Outline of Thesis

The overall aim of this thesis is to explore valued care experiences on stroke units and identify approaches to support these experiences in everyday clinical practice. This chapter has described my personal worldview that I bring to this research; it presented an introduction to stroke and communication problems after stroke; and it described the current context of stroke services in the United Kingdom National Health Service (NHS). Finally, this chapter has outlined the current agenda and challenges of a relationship focus to healthcare within stroke services and the wider NHS.

The thesis includes seven more chapters. Chapter 2 is a narrative review of the literature. The review aims to summarise and critique the existing evidence on experiences of stroke unit care for patients with stroke, their families and stroke unit staff and will include:

- An exploration of current policy, guidance and research on care quality and health care staff/patient/family relationships.
- A summary of the current evidence on:
 - How people with stroke and their families describe their care and rehabilitation experiences after stroke, in particular whilst on a stroke unit.
 - How stroke unit staff describe their therapeutic relationships with patients and their families to support stroke recovery and rehabilitation.

- Suggest where further service development and research are required, to address the current gaps in knowledge and service provision.

Chapter 3 (An invitation to a process) will discuss the research worldviews that framed this thesis, and introduce the reader to the research method and relational process of appreciative action research. I will provide a rationale for this particular approach in respect of this study. This chapter will also debate the aims and outcomes of the study.

Chapter 4 (Orientating towards human relationships) will present the research design, the participants and recruitment process; and finally how data were generated and analysed within the research worldviews that framed the study.

In Chapters 5 to 7, I will present the analysis of the data. Chapters 5 and 6 will describe the experiences of patients, relatives and staff and their meaningful relational experiences on the stroke units, with a specific emphasis on experiences relating to patients with communication problems after stroke. Chapter 7 will describe the processes that supported human relationships on stroke units, and propose orientating themes that could support human relationships on other stroke units.

In Chapter 8 (Possibilities for the future) the data and proposed orientations to relational practice will be discussed in the context of current theory about developing therapeutic relationships in stroke care. Finally, the implications of these new possibilities will be considered for policy, practice, education and research.

Chapter 2: Literature review

2.1 Introduction

This chapter will review the current discourse in the literature on relationships in healthcare. Firstly, I will provide a conceptual overview of the healthcare literature on relationships. The contribution of lifeworld-led and humanising care theories towards alternative perspectives to current theory will be considered. Secondly, the impact of UK policy, organisational and practice drivers, intended to support the quality of healthcare relationships, will be critiqued. The final section of this chapter will be a critical review of the current evidence for relationships specifically within stroke services, highlighting gaps in evidence that this thesis seeks to address.

2.2 Search strategy

An initial search was conducted in September 2015 and updated after completion of data collection in November 2019. Research papers from the second search (September 2015 to November 2019) included in this literature review were not available to me prior to data collection, and did not therefore shape the nature of the study. Due to my ongoing clinical practice alongside my research, I was aware of changes to healthcare policy and guidance during data collection and this may have influenced my fieldwork.

The search was conducted using the databases listed in Table 1.

Database	Number of papers
Scopus	250
CINAHL	18
MEDLINE	19
AMED	0
PsychINFO	1
PubMed	0
Web of Science	375
Cochrane Library	2

Table 1: Search results by database

The search process is summarised in Figure 1. Searches were saved in order that there was a clear record of how I conducted the searches and to enable me to update searches throughout my studies. References were followed up by ‘berry picking’ (for example, related citations tracking and manually searching of reference lists of finally selected articles). Grey literature was found through professional networks, websites such as Department of Health, The King’s Fund and Stroke Association websites and through discussions with supervisors and clinical colleagues.

Early searches revealed that there was limited use of the newer term RCC, and that I was missing valuable literature that used related terms of patient-, person-, family- or client-centred care; therapeutic relationship/alliance and compassionate care. I checked my key search words in retrieved articles to ensure inclusion of all relevant terms. It was at this point that I decided to add compassionate care and therapeutic relationship/alliance as search terms. There was a vast body of literature on patient-, person-, family- or client-centred care, compassionate care and therapeutic relationship/alliance, therefore the search was divided to comprise of two separate areas: (i) conceptual literature on centredness, compassionate care and therapeutic relationships/alliance; (ii) relational experiences on stroke units.

The following search terms were used. They included the use of key words and Boolean operators:

Relationship-cent*

(stroke OR cerebrovascular accident OR cva) AND (patient-centred care OR client-centred care OR person-centred care OR family-centred care)

(stroke OR cerebrovascular accident OR cva) AND compassion*

(stroke OR cerebrovascular accident OR cva) AND (multidisciplinary OR interdisciplinary) AND relation*

(stroke OR cerebrovascular accident OR cva) AND (therapeutic alliance OR therapeutic relationship)

Papers published before 1990 were excluded because the changing healthcare context resulted in earlier papers being less relevant. Any seminal papers cited and written before 1990 were included. Papers unavailable in English and from non-Western countries were excluded. The rationale for this was that the culture of healthcare relationships within professional groups, and between service users and professionals, can differ, in particular concerning power dynamics within relationships and Western countries are most likely to have similar healthcare cultures to the UK. Opinion papers were not included in the review but they were included in the search in case they provided key references.

Repeated searches revealed a body of core literature that provided evidence on patient-centred care in stroke, and RCC in the UK. Key contributors emerged and included Mike Nolan on RCC in the UK (1996; 2001; 2002; 2004; 2006); and Chris Burton (2000; 2008) and Alison Kitson (2013a; 2013b) on experiences of stroke care.

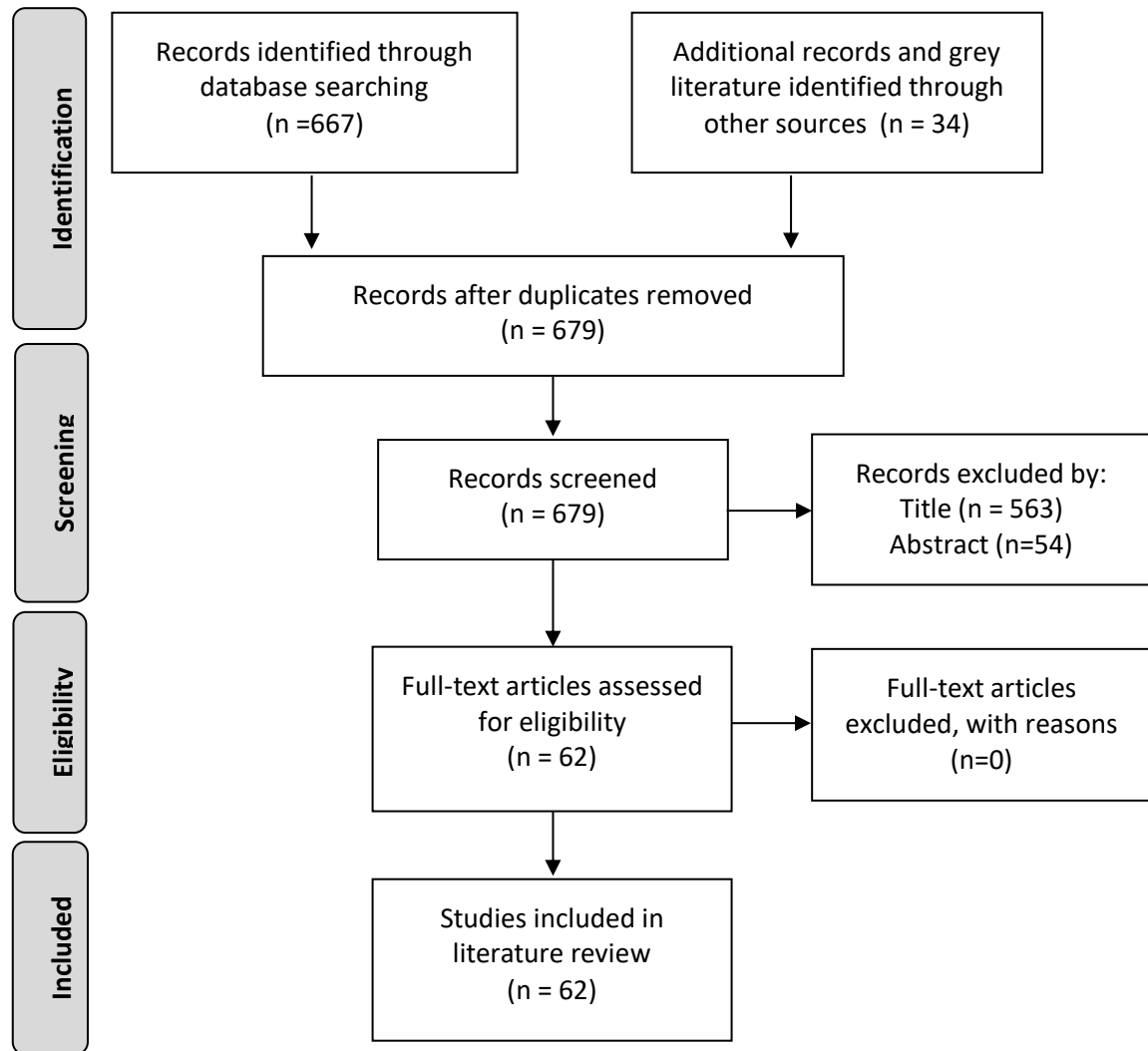


Figure 1: PRISMA diagram of the literature search process

2.3 Conceptual overview of relationships in healthcare

There are various terms in the literature for relationships within healthcare practice, each with slightly different theoretical perspectives and discipline behind their conceptualisation. Terms include connectedness, therapeutic relationships, relational practice, patient-, person-, client-, family- and relationship-centredness (see Table 2). It is not uncommon for these terms to be used interchangeably, with different terms in vogue at different times over the last 30 years.

The origins of person-centredness started in the 1950s from Carl Rogers' humanistic psychotherapy and client-centred therapy (Rogers 1965). The nursing literature pre-1990s focussed on individualised care and, by the late 1990s, had developed into patient-centred care. The major contributors to the patient-centredness concept were Balint (1955) and Gerteis et al. (1993) in medicine, and McCormack and McCance (2006) in nursing. The original discipline that developed each centredness term impacted the conceptual emphasis in practice. For example, Kitson et al. (2013a) found nursing texts on patient-centred care tended to focus on the relationship component, whereas medical texts lacked consideration of the care context. Recently in UK healthcare research, practice, policy and education, the dominant discourse has been around patient- or person-centred relationships. They are considered to represent high quality healthcare (Department of Health 2010; de Silva 2014; Eaton et al. 2015; Tee and Newman 2015; Care Quality Commission 2017; Fagan et al. 2017; National Voices 2017).

"Patient-centredness and related concepts have become important for ideological and structural reasons as well as for professional and ethical ones. They are part of the body of ideas through which professionals and others make sense of their work and attribute moral meaning and value to it" (Hughes et al. 2008, p.456).

Concept	Origin	Key concepts in addition to common themes
Person-centred	Psychotherapy and dementia care	Humanising health care, the person at the centre of care delivery, self-esteem, self-efficacy (Department of Health 2010; McCormack et al. 2015) (Department of Health 2010; McCormack et al. 2015)
Patient-centred	General practice and medicine	Patient autonomy, consumerism, coordination and continuity of care (Gerteis et al. 1993; Department of Health 2001; Dwamena et al. 2012; The King's Fund 2014b)
Client-centred	Psychiatry, social care and occupational therapy	Focus on power in relationships, informed decision making, autonomy and choice (Hughes et al. 2008; Whalley Hammell 2013)
Family-centred	Child health, midwifery	Treating the person in the context of the family as a social unit; collaborative relationships (MacKean et al. 2005; Bamm and Rosenbaum 2008)
Relationship-centred	Health education and Chronic disease management	Reciprocity of relationships (learning, well-being) and importance of reflective practice (Manning-Walsh et al. 2004; Wyer et al. 2014)
Therapeutic relationship/alliance	Nursing, Psychotherapy, psychiatry and mental health	Positive interpersonal attachment between the clinician and patient: mutual trust, empathy, confidence, acceptance and being genuine (Lambert and Barley 2001; O'Brien 2001)
Relational practice	Psychology, psychotherapy, social work, nursing, social construction	Collaboration, partnership, collective capacities of teams, connection & belonging (Suchman 2006; Konrad and Browning 2012)
Connectedness	Family psychology, Eastern cultures, counselling psychology	Interpersonal relationships with attributes of intimacy, sense of belonging, caring, empathy, respect, trust and reciprocity (Peplau 1988; Phillips-Salimi et al. 2012). Closely linked to therapeutic relationship/alliance.

Table 2: Summary of origins and differences between main concepts linked to relationships in healthcare

The drivers behind development of all the centredness concepts listed in Table 2 were in response to inadequacies in what were considered to be disempowering, reductionist, and biomedical attitudes to healthcare (Balint 1955; Gerteis et al. 1993; McCormack and McCance 2006). Centredness approaches aimed to move healthcare practice towards a more humanistic view, increasing the significance placed on the person situated in the context of relationships (Hughes et al. 2008; McCormack et al. 2015; Jesus et al. 2016). Although most concepts do not refer to

‘relationships’ in their title, all re-centre relations in the clinical encounter (Hughes et al. 2008). For example, Tom Kitwood’s definition of person-centredness is,

*“a standing or status bestowed upon one human being by others in the context of a **relationship**” (Kitwood 1997, p.8).*

Several authors have identified the common concepts and themes of centredness approaches that are summarised in Table 3.

Theme	Description
Respect for individuality	Valuing people as individuals and includes the right to dignity and privacy.
Uniqueness	Accepts the unique perspective of the person, reflecting the subjective nature of their experiences, and meaning of well-being.
Communication	Open dialogue with active listening.
Decision-making	Recognition of a person’s ability to make their own decisions within the principles of self-determination. Acknowledging expert lay knowledge. Shared power and responsibility with healthcare professionals.
Holism	Focus on well-being, and a balance of medical with psychosocial needs. Emphasises a holistic understanding of the person.
Relationships	Non-judgemental relationships. The importance of recognising an individual’s network of meaningful relationships – for patients, their family and healthcare professionals.
Context of care	Policy, supportive organisational systems, language used, therapeutic environment.

Table 3: Main themes common to centredness concepts (Hughes et al. 2008; McCormack et al. 2010; Kitson et al. 2013a; de Silva 2014; Waters and Buchanan 2017)

Despite a unifying aim to increase the significance of the person within healthcare practice, numerous terms developed from different theoretical perspectives and disciplines has resulted in little conceptual clarity or agreement in the literature (McCormack et al. 2010; Hebblethwaite 2013; Waters and Buchanan 2017). Some authors advocate the need for a common framework for healthcare relationships (Constand et al. 2014; Waters and Buchanan 2017). Others challenge the universality of frameworks, encouraging the recognition of the complexity of individual personal values and beliefs alongside the unique context in which the relationship is being created, that a ‘one-size-fits-all’ model or framework cannot

achieve (Doane and Varcoe 2007; Rider et al. 2014; Bennett et al. 2015; van Lieshout et al. 2015). The multiplicity in conceptualising healthcare relationships has had an impact on research and building an evidence-base to inform relational healthcare practice when current evidence-based practice tends to be grounded within positivist worldviews that value certainty and uniformity (Ashcroft and ter Meulen 2004).

2.4 Towards a relational focus

“In terms of importance, relationships in person-centred approaches should take as much priority as care tasks” (Waters and Buchanan 2017, p.1034).

Recently there has been a conceptual change in direction in the literature towards a relational focus rather than the individual (be that the client, patient, person etc.), that also reflects a shift in wider societal values. Relational concepts de-emphasise individualism, autonomy and independence that is untenable in the context of chronic disease, disability and care for older people (Nolan et al. 2004). Instead, a relational focus, *“recognises the uniqueness of each individual, but also the interdependence that shapes our lives”* (Nolan et al. 2004, p.47). It emphasises genuine complementary and symmetrical healthcare relationships in which both parties’ values and beliefs are made explicit in negotiating a reciprocal relationship. (Nolan et al. 2004). This has led to new ways of conceptualising clinical care in which healthcare practitioners acknowledge and value not only the patient voice, but multiple voices with the network of caring relationships (Bridges et al. 2010; Wyer et al. 2014; Soklaridis et al. 2016). The most recent relational concepts in the literature are relationship-centred care (RCC), relational practice and connectedness (Table 2).

2.4.1 Relationship-centredness

The term ‘relationship-centredness’ was coined in the 1990s by the Pew-Fetzer Task Force (Tresolini and The Pew-Fetzer Task Force 1994) in the United States. It was an

attempt to put relationships at the centre of medical education to support the increasing complexity of chronic healthcare needs.

“Practitioners’ relationships with their patients, their patients’ communities, and other practitioners are central to health care and are the vehicle for putting into action a paradigm of health that integrates caring, healing, and community. These relationships form the context within which people are helped to maintain their functioning and grow in the face of changes within themselves and their environments” (Tresolini and The Pew-Fetzer Task Force 1994, p.24)

Although relationship-centredness and other centredness concepts described above (Table 2) are inter-related, it is a distinctly different concept.

Firstly, it emphasises the view of human beings living within a network of social relationships, thereby widening the traditional patient-practitioner therapeutic to include:

- Family members;
- Health and social care workers;
- The patients’ wider social context;
- Team relationships among healthcare colleagues;
- The relationship of the clinician with his or herself (Tresolini and The Pew-Fetzer Task Force 1994; Beach et al. 2006; Suchman 2006).

This community of relationships values all persons in the health and well-being of others, and moves away from a hierarchical and ‘power-over’ bio-medical model to reflect a more biomedical-psychosocial perspective (Wylie and Wagenfeld-Heintz 2004). Relationship-centredness views the *quality* of a person’s network of relationships as ensuring a positive experience of healthcare (Beach et al. 2006).

“Relationship-centred care moves caring one step further and emphasises the importance of relating and interactions among people as foundational to therapeutic or healing activities” (Manning-Walsh et al. 2004, p.27).

In this aspect, relationship-centredness differs to other centredness concepts; elevating human relational principles (being with one other, connectedness, inter-

relatedness, mutuality and reciprocity); and the importance of practitioner-practitioner relationships and community-practitioner relationships along with those with patients and relatives (Wyer et al. 2014).

Secondly, relationship-centredness affirms individual personhood for all involved, not only on the patient's personhood, but also the unique experiences, values and perspectives of clinicians' and the wider community of relationships. Relationship-centredness makes explicit the giving of essential self of **both** persons within healthcare relationships, which is underdeveloped in other centredness concepts (Nolan et al. 2004; Brander et al. 2012).

Thirdly, consistent with their aim to develop medical education, Tresolini et al. (1994) embraced the need to develop relational consciousness in professional practice. They recommended education to develop self-awareness and self-care through reflection, improvisation, and developing dynamic relationships (Wyer et al. 2014). Often de-valued in medical education, Tresolini et al. (1994) placed significant value on the subjective, tacit, affective and humanising dimensions in clinical relationships that aimed to support more holistic, interconnected experiences.

In the UK the Senses Framework was developed to support relationship-centredness in practice and captures the experience and interpersonal processes involved in giving and receiving care (Nolan 2002; Nolan et al. 2006; Brown et al. 2008). The Senses Framework is based on the experience of relationships that encompass six senses of: security, belonging, continuity, purpose, achievement and significance (Table 4). It notably involves clinicians, as well as patients and family members, experiencing these senses for themselves (Nolan 1996; Nolan et al. 2006).

The Senses Framework	
Sense of purpose	Sense of continuity
Ability to pursue own goals and challenges, engage in purposeful activity.	Value placed on personal biography. Knowledge of past to help contextualise present and future.
Sense of significance	Sense of security
To be recognised and valued, that your work matters.	To be safe, free from threat or pain. Have essential biomedical needs met. Have a supportive work culture.
Sense of belonging	Sense of fulfilment/achievement
Opportunities to form meaningful relationships, feel part of a community or group.	To feel satisfied with ones efforts. Opportunities to meet meaningful and valued goals.

Table 4: The Senses Framework supporting relationship-centred care (Nolan et al. 2006)

The Senses Framework was developed over a number of years from relationship-centredness conceptual foundations and a large longitudinal study into older persons' long-term institutional settings (Davies 2000; Nolan et al. 2002; Brown 2005; Nolan et al. 2006). The initial study collected data through focus groups, questionnaires and observation visits from older people, family carers, practitioners and student nurses on their experiences and perceptions of older people living in the UK. It is notable that the study involved a wide range of institutional settings and hundreds of older people (some with dementia). However, the study's main limitation was that the most detailed data were collected from student nurses, and the least data from older people and family carers (Nolan et al. 2006).

Since the original research to develop the Senses Framework, the Framework has been used in studies on relationship-centredness in many different settings including older people (acute and longer-term settings), dementia care, undergraduate nursing students, and community drug services, demonstrating its relevance to many different care contexts (Anstey 2003; Aveyard and Davies 2006; Faulkner et al. 2006; Ryan et al. 2008; Davies-Quarrell et al. 2010; Andrew et al. 2011; Brown Wilson et al. 2013; Cooper et al. 2013; Dewar and Nolan 2013; Orr et

al. 2014; Ross et al. 2014; Watson 2016). These studies are summarised in Appendix 1 (Table A - 1). Most researchers have used the Senses Framework as an analytic framework to highlight and understand the Senses in practice. Only two studies (Aveyard and Davies 2006; Brown Wilson et al. 2013) explicitly described using the Senses Framework as a tool to support relationship-centredness practice.

Dewar's Caring Conversations Framework (Table 5) has been developed to further support operationalising relationship-centredness and the Senses Framework. The Caring Conversations Framework outlines key attributes in compassionate, relationship-centred interactions.

It has been demonstrated to effectively support interactions for clinicians and leaders in hospitals and care homes and as a framework for reflexivity within a relationship-centred approach (Dewar 2011; Dewar and Nolan 2013; Dewar and Cook 2014; Roddy and Dewar 2016; Dewar et al. 2017a; Dewar and MacBride 2017). The studies implemented Caring Conversations with Appreciative Inquiry methods and further evaluation using alternative methods may provide alternative perspectives on its implementation in practice.

Caring Conversations Framework	
Be Courageous	What matters? What would happen if we gave this a go? What is the worst that could happen if you do this?
Connect Emotionally	How did this make you feel? I feel You made a difference to my day because.....
Be Curious	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 that you wanted to?
Consider other Perspectives	Help me understand where you are coming from? What do others think? What do you expect to happen? What is real and possible?
Collaborate	How can we work together to make this happen? What do you need to help you to make this happen? How would you like to be involved? How would you like me to be involved? What would the desired goal/success look like for you?
Compromise	What is important to you? What would you like to happen? How can we work together to make this happen? What do you feel you can do to help us get there? What would you like me to do?
Celebrate	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....

Table 5: 7Cs Caring Conversations Framework supporting compassionate relationship-centre care (Dewar 2011)

Both the Senses and Caring Conversations Frameworks provide further clarity to realise relationship-centredness in clinical practice. Within the studies described above, there are three main gaps in evidence that are specifically relevant to stroke care. Firstly, although most studies recruited practitioners from many disciplines, the majority of data was from the discipline of nursing and more evidence of relationship-centredness within multidisciplinary teams would be of benefit. Secondly, there is limited evidence of the application of relationship-centredness for rehabilitation settings, with only one stroke unit recruited within a large study of 27 different inpatient settings (Leadership in Compassionate Care Team 2012); and thirdly, people with communication difficulties who are not able to interact with

practitioners in the 'usual way' have not been included. Although there may be some overlap with the evidence from people with dementia, this has yet to be confirmed.

Bridges et al.'s (2010) systematic review of qualitative studies on older people's and relatives' experiences of acute healthcare supported calls that relationship-centred approaches can enhance the experience of care and wellbeing of older people, staff and relatives. Unfortunately, relationship-centredness has not had the same uptake by healthcare practice compared with patient- or person-centredness (Hebblethwaite 2013; Wyer et al. 2014). Ongoing tensions between philosophy and practice and the highly regulated, technical, target-based model that dominates current healthcare is challenging for relationship-centred approaches (Bridges et al. 2010; Hebblethwaite 2013). There is recognition that organisational and service-wide commitment with clear leadership is required to create a culture in which relationship-centredness can flourish (Bridges et al. 2010; Dewar 2011; Hebblethwaite 2013). Dewar and colleagues have demonstrated that this can be achieved in the acute care context (Dewar and Mackay 2010; Dewar 2011; Leadership in Compassionate Care Team 2012; Dewar and Cook 2014) or institutional care.

In summary, there is an emerging conceptual shift in the literature away from individualism and autonomy associated with patient- or person-centredness towards a relational focus and relationship-centredness. A relational approach to healthcare practice has been identified as supporting a positive experience of care for all involved (patients, relatives, staff and the wider community). RCC appears to be gaining ground particularly in dementia and care home contexts, but has not yet had similar uptake in acute care settings and beyond the discipline of nursing. Other terms in the literature have been also used to conceptualise a relational (rather than individual) orientation to practice that reflect slight differences in their underpinning philosophies, which will be introduced in the next section.

2.4.2 Re-conceptualisation of relationship-centredness

“In knowing how to relate to their clients, the good practitioners gain insight in their motives, their moods, their problems, their disappointments, their sorrows, their expectations and their hopes. Without being connected in this way, they will not gain the same level and intensity of insight, which lowers their ability of making the right judgment in quite complex situations in which their clients usually find themselves” (Reinders 2010, p.31).

Some authors have disassociated with the term ‘centredness’ in their conceptualisation of healthcare relationships and have used other terms, for example, ‘connectedness’, ‘relational practice’ and ‘relational thinking’, summarised in Table 2 (Doane 2002; Parker 2002; Entwistle et al. 2010; Phillips-Salimi et al. 2012; Bright et al. 2015; Feo et al. 2017; Montgomery et al. 2017; Sharp et al. 2018). These terms appear to be used when authors wish to capture the largely intangible, (i) *tacit knowing and experience* of (ii) deeply meaningful *human* connections, also a pivotal element described in centredness practice (see Table 3).

“Patients appear to value a process of human connectedness above and beyond formal aspects of taking part and feeling activated and capable” (Wolf et al. 2017, p.7).

(i) Tacit knowing in relationship construction

The experience of human connectedness is often referred to as a ‘tacit knowing’ that conveys the human body’s inherent ability to acquire and convey meaning – a pre-reflective or pre-cognitive embodied level of selfhood (Kitwood 1997; Kontos and Naglie 2009). It is using one’s pre-reflective intentional body to inform the process of relationship construction and human connectedness, described by Merleau Ponty (1945/2013) as a powerful nexus connecting individuals. Tacit knowledge is well recognised in the nursing literature (Carlsson et al. 2002; Kontos and Naglie 2009), with much of it based on Polanyi (1967) and Benner’s (2000) conceptualisation of embodied knowledge. Tacit knowing and embodied selfhood have had a lot of attention in the dementia field to explore a pre-cognitive level of selfhood that persists despite cognitive impairment (Kontos and Martin 2013;

Watson 2015). Watson's (2015) ethnographic study into relationship-centred palliative dementia care suggested expanding the Senses Framework (Nolan et al. 2006) to incorporate embodied selfhood.

Discourse on relationships supporting recovery after stroke rarely describe tacit or embodied meanings of experiences. Literature searches on 'embodied' and 'stroke' reflect the dominance of a pathological and bio-medical discourse related to neuro-plasticity or to an altered sense of the physical body in space after stroke. There are two key contributors of evidence on tacit or embodied experiences in stroke care: Sundin (2000; Sundin et al. 2001; Sundin et al. 2002; Sundin and Jansson 2003) explored the embodied and silent narratives of nurses caring for people with aphasia ; and Galvin and colleagues developed stroke practitioners' embodied ways of knowing to develop humanising care on a stroke unit, and introduced an embodied interpretation of previous phenomenological studies of people living with stroke (Todres et al. 2014; Galvin et al. 2016; Galvin et al. 2018).

(ii) Human experience of connectedness

With regards to the human experience of connectedness, authors often cite a humanistic stance originating from psychotherapy (Maslow 1958; Rogers 1965) as a guiding principle (Tresolini and The Pew-Fetzer Task Force 1994; Hughes et al. 2008; McCormack et al. 2010; van Lieshout et al. 2015; Soklaridis et al. 2016). Several synthesis papers that examined factors influencing nurse-patient relationships across a range of clinical contexts refer to human connectedness, and the underpinning humanistic values or behaviours for example; openness, empathy and acceptance (Bridges et al. 2013; Wiechula et al. 2016; Feo et al. 2017). However, Maslow's (1958) and Roger's (1965) humanistic theories do not seem to capture the tacit, embodied experience of connectedness described by some qualitative studies into healthcare relationships.

A lifeworld perspective may provide an alternative conceptual basis to humanistic theory on the *human experience* and *process* of meaningful healthcare relationships. It has similar concerns to relationship-centredness and relational practice and further conceptualises the, “*holistic humanness*” (Waters and Buchanan 2017, p.1036) of healthcare relationships, including being explicit on embodied knowing informing relationships. The next section will explore the contribution of a lifeworld perspective towards relational practice.

2.4.3 Lifeworld-led/humanising approach to relationality

Lifeworld-led care draws on the work of many different phenomenologists including Husserl's (1936/1970) notion of lifeworld, Heidegger's writings on human freedom and being with others (Dahlberg et al. 2009; Hemingway et al. 2012), and Merleau-Ponty's (1945/2013) phenomenology of perception and embodiment. The lifeworld-led care approach was developed from people's experiences of the *meaning* of care, well-being and suffering (Dahlberg et al 2009). In contrast, RCC and many of the other centredness concepts have been conceptualised in response to the medical model, professional authority and the need to improve relationships in clinical practice by promoting patient agency, empowerment and choice (Gerteis et al. 1993; Tresolini and The Pew-Fetzer Task Force 1994; McCormack and McCance 2006; Nolan et al. 2006).

Lifeworld is described as,

“The beginning place-flow from which we divide up our experiences into more abstract categories and names. It is a world that appears meaningfully to consciousness in its qualitative, flowing given-ness; not an objective world ‘out there’, but a humanly relational world, full of meanings”(Todres et al. 2007, p.55).

A lifeworld-led approach to care is able to support the founding aspirations and values of the centredness concepts, and also brings new phenomenological and humanising perspectives to healthcare relationship theory. Borbasi et al. (2013)

described how lifeworld-led care theory contributes towards the emerging literature on relationships in healthcare, with lifeworld-led care theory being,

“a deeply relational ontology and epistemology that acknowledges both the socially embedded qualities of being human and an acknowledgement of vast sources of subjectivity and personal organisation beyond any simple deterministic framework” (Borbasi et al. 2013, p.882).

A key concept of the lifeworld is the removal of the subject-object divide, the internal and external. A person’s relation to the world is both interpretive and relational – always situated in context. Therefore, relationships are seen as wider than just between people and, for example, language, culture, history and space are all, *“interrelated horizons”* (Galvin and Todres 2013, p.26). The lifeworld dimensions of temporality, spatiality, intersubjectivity, embodiment and mood (Table 6) articulate the intertwined meanings which go to make up human existence (Dahlberg et al. 2009; Galvin and Todres 2013).

Lifeworld dimension	Description of dimension
Temporality	The continuities and discontinuities of time that are personally experienced. For example, time is sometimes described as 'standing still'.
Spatiality (being in relation with others)	People's relationship/significance to a world of places and things. How spaces can provide opportunities for socialisation and purpose. For example how art, sport or the natural environment impacts on well-being, or feeling alone in a crowded room.
Intersubjectivity	Human lives happen in a social world. People exist with others in a meaningful way. Language helps share meanings with others. For example, who I am close to? Who am I worried about? What am I looking forward to doing?
Embodiment (felt sense)	How people's bodies live and function meaningfully in relation to others and the world around them. For example, a body tenses up with fear.
Mood	Mood is a potent messenger of the meaning of our situation. Experiences are coloured by mood.

Table 6: Dimensions of lifeworld (Galvin and Todres 2013, pp.26-30; Galvin et al. 2018)

Galvin and Todres (2013) contend that these interrelated dimensions of lifeworld remain underrepresented in healthcare practice, and this can be illustrated through the concept of RCC in which relationships with objects and the environment are acknowledged but they are not fully conceptualised.

A Humanising Value Framework (Table 7), informed by Husserl's notion of lifeworld, was developed by Todres, Galvin & Holloway (2009) to support operationalisation in healthcare practice, education and research of what it means to be human (Hemingway et al. 2012). The Humanising Value Framework describes eight dimensions along a spectrum of possibility (instead of either/or) which can be used to explore practice.

Forms of humanisation	Forms of dehumanisation
Agency	Passivity
Freedom within health and social contexts to make choices that we are accountable for.	An excessive emphasis on attitudes and practices where one's dignity is stripped away.
Uniqueness	Homogenisation
Each of us are unique in terms of our relationships and context.	A de-emphasis of a person's uniqueness in favour of how they fit into a group.
Togetherness	Isolation
To be human is to be part of a community.	To feel separated from our sense of belonging with others.
Personal journey	Loss of personal journey
People move through time in a meaningful way, positioning themselves in terms of past, present and future.	No attention paid to a person's history and future possibility in life. Little consideration of a sense of continuity.
Sense of place	Dislocation
To be human is to come from a place that offers familiarity, comfort, safety.	A sense of place is lost or obscured, alien norms and routines.
Sense making	Loss of meaning
To care about the meaningfulness of events or experiences – not just a statistic.	To be counted as a statistic that does not connect with individual human experience.
Insiderness	Objectification
To be human is to experience life in relation to how you are.	To be made into objects or labelled in a way that does not fully recognise their insiderness.
Embodiment	Reductionist body
Experiencing the world and how we relate to the world through our bodies.	Over-emphasis on the body as separate from its broader contexts. A neglect of a relational view of the body.

Table 7: Humanising Value Framework of the dimensions of humanisation of care (Todres et al. 2009; Galvin and Todres 2013)

Several authors have published theoretical papers with examples of its potential application and contribution in healthcare practice and education (Hemingway 2011; Hemingway et al. 2012; Borbasi et al. 2013; Rees 2013; Todres et al. 2014; Norton 2015; Way and Scammell 2015; Pound and Jensen 2018; White et al. 2018). However, just one study has conducted a study to evaluate lifeworld-led care and

humanising theory in practice. Galvin et al.'s (2016; 2018) participatory action research study involved two participant groups from two clinical settings (outpatient department and a stroke unit). Participants comprised of service users (n=10), healthcare staff (n=8) and academics (n=4). The Humanising Value Framework supported participants to develop self-awareness and new insights into humanising practices in their clinical settings, and enabled assessment of current practices to identify humanising and dehumanising practices in the two clinical areas. The study developed a Humanising Care Assessment Tool in the form of a questionnaire (Galvin et al. 2016; Galvin et al. 2018).

As already mentioned, the intentions of a lifeworld-led care approach are similar to many of the centredness and related concepts. For example, there are several dimensions from the Humanising Value Framework that align with dimensions of RCC identified through the Nolan et al.'s (2006) Senses Framework (Table 4). These are illustrated in Figure 2 below by the dimensions within overlapping branches.

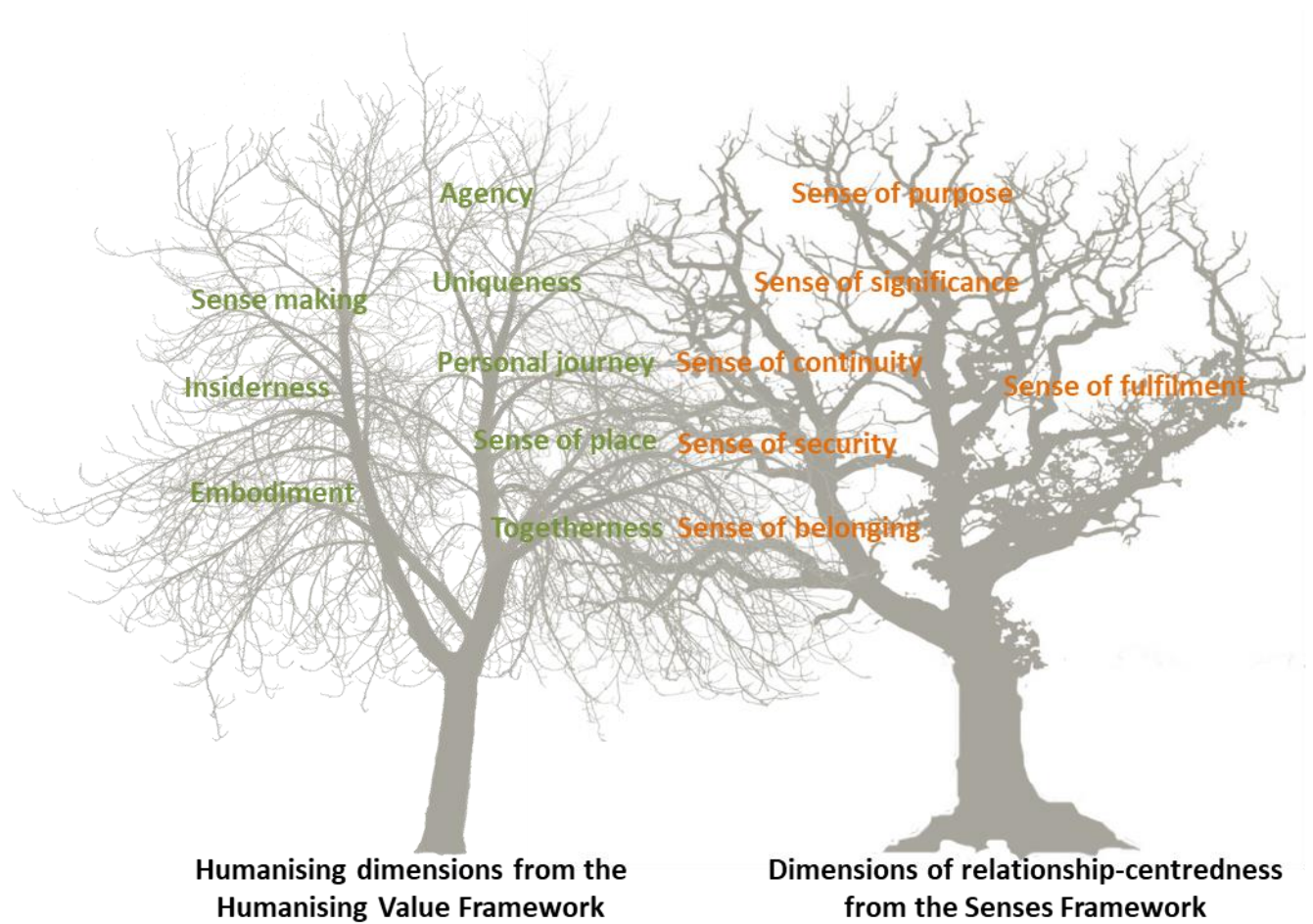


Figure 2: Illustration of the similarities and differences in the Humanising Value and Senses Frameworks (Nolan et al. 2006; Todres et al. 2009; Galvin and Todres 2013)

Notably the illustration above also highlights key conceptual differences that reflect their different development, with the humanising dimensions of sense making, insiderness and embodiment not explicitly mentioned in the Senses Framework. Therefore a lifeworld-led approach and the Humanising Value Framework may offer further contributions to theory on healthcare relationships, in particular related to the interrelated and embodied meaning of being human within the context of illness and healthcare relationships.

2.4.4 *Summary of the conceptual and theoretical development of relationships in healthcare*

In summary, this narrative review of the literature on the conceptual and theoretical development of relationships in healthcare practice has shown many different concepts emerging from different philosophical foundations with some overlap between dimensions, for example, compassion, dignity, empathy, human connections and mutuality in positive relationships. The variety of concepts reflects the complexity and uniqueness of relational practice but may impact on the ease of translation into current healthcare contexts that have a regulated, bio-medical focus that often favours conceptual and theoretical consensus to develop practice.

Conceptual development of healthcare relationships appears to be moving towards a relational (rather than individualistic) emphasis, which has mostly been realised in practice through a model of RCC. A lifeworld-led approach brings another perspective to conceptual development that embraces what it means to be human, and is more explicit on the nuanced, tacit and embodied experience of human connections.

2.5 Research into healthcare relationships in clinical practice

This section will provide an overview of the current evidence for person-centredness and related concepts in in-patient settings. The evidence specifically related to stroke care will be discussed in more detail later in this chapter.

2.5.1 *The impact of centredness approaches on patients' healthcare outcomes*

Several systematic reviews into the empirical evidence around centredness approaches and therapeutic relationships on healthcare outcomes are generally positive. A Cochrane review on patient-centredness consultations, in which patient-centred interventions mainly focussed on improved communication and shared decision-making, found that the effects on patient satisfaction, health behaviour

and health status were mixed (Dwamena et al. 2012). A meta-analysis by Kelley et al. (2014) of 13 randomised controlled trials in which some aspect of the patient-clinician relationship was manipulated, showed a small but significant ($p=0.02$) positive effect on objective (e.g. blood pressure, weight loss) and validated subjective (e.g. pain scores, anxiety) outcomes. Both reviews identified that the majority of studies had bias through lack of blinding to the intervention - a significant challenge for this particular research area.

An earlier systematic review (Rathert et al. 2012) of 40 qualitative and quantitative studies into patient-centred care (PCC) approaches supported Kelley et al. (2014) findings, describing a general positive empirical relationship between PCC, patient satisfaction and well-being. Rathert et al. (2012) found that longitudinal non-randomised studies had more positive relationships between PCC and clinical outcomes. In contrast to Kelley et al.'s (2014) concerns of bias, Rathert et al. (2012) advocated the strengths of a longitudinal study design that they suggested was more likely to account for variability of PCC from professionals, and capture a broader patient experience. The studies included in all three systematic reviews above predominately focussed on the patient-professional dyad, suggesting that evidence on the impact of the wider relational aspects of PCC and other centredness approaches described in the conceptual literature (e.g. patient/relative/staff individual networks of meaningful relationships) is lacking, particularly in quantitative studies.

A meta-ethnography of 48 qualitative studies into the experiences of older people and their relatives in acute hospital settings found that relational aspects of their care were described as the most important (Bridges et al. 2010). Patients and relatives wanted reciprocal relationships, in which they were actively involved in shaping their care experiences (Bridges et al. 2010).

Difficulties with communication and how this affects the capacity to create therapeutic relationships has had little attention in the literature. Bridges et al. (2010) highlighted people with dementia, delirium and communication difficulties were at particular risk of negative care experiences. Jesus et al. (2016) suggested that the meaning and practice of PCC may have unique peculiarities in certain contexts, in particular when the patient has cognitive and communication problems which may change the participation dynamic. Both suggest that generalist models of PCC may not apply when communication problems are present, and that this needs to be researched further (Bridges et al. 2010; Jesus et al. 2016). Qualitative studies within dementia care and brain injury have explored this particular aspect. Several studies described the role of the embodied dimension of selfhood, in which patients use their bodies rather than words, and a pre-cognitive, pre-verbal sense of human connection in their relationships (Kontos 2004; Hydén and Antelius 2011; Kontos and Martin 2013; Watson 2016). Other studies highlighted the importance of staff developing personal knowledge of their patients through listening to stories about the person's life from those with the patient's personal network of relationships. This personal knowledge then enabled personalisation of, and more meaningful, care routines (Brown Wilson et al. 2013; Scerri et al. 2015; Dupuis et al. 2016). Supporting staff to develop personal knowledge about their patients, and a focus on embodied dimensions of selfhood and relationships, broadens the scope and opportunities for relationships with people who have cognitive and communication problems (Kontos and Martin 2013). How this is achieved in practice is lacking in the literature.

2.5.2 *The impact of PCC on healthcare workers*

For healthcare workers, two systematic reviews have shown centredness approaches can have a positive effect on job satisfaction (van den Pol-Grevelink et al. 2012; Bridges et al. 2013). Bridges et al.'s (2013) meta-ethnography of 16 studies on acute hospital settings and the experiences of nurses in nurse-patient relationships, found that if nurses were able to create and maintain therapeutic

relationships that aligned with their values, nurses experienced feelings of gratification, privilege and personal enrichment. Nurses' capacity to build relationships was strongly influenced by organisational cultures, e.g. team dynamics or workload (Bridges et al. 2013). Organisational influences on developing relationships were also confirmed by Haesler et al. (2007) systematic review of 32 studies of staff-patient-family relationships in older people care settings. Both reviews recommended a focus on organisational cultures that visibly support and value collaborative and therapeutic relationships (Haesler et al. 2007; Bridges et al. 2013).

Compassion fatigue, burnout, poor motivation, lack of attention to cultures of care, organisational pressures, and lack of time have all been cited as major barriers to providing PCC (Finfgeld-Connett 2008; Coetzee and Klopper 2010; Pearcey 2010; Sabo 2011; McCormack et al. 2015). Encouragingly, a large mixed-methods study to seek evidence from staff and patients of culture and behaviour in hundreds of NHS Trusts found the majority of staff remained committed to providing the best possible care. The study included seven sub-studies with interviews, surveys, focus groups, performance data and ethnographic observations and found that when staff had access to resources, adequate staffing and effective systems, they could explore new ways to improve quality and could develop reflective practices (Dixon-Woods et al. 2014).

2.5.3 *Measuring PCC and healthcare relationships*

Two scoping reviews have identified and evaluated measures for patient-centred care (PCC) and healthcare relationships (de Silva 2014; Santana et al. 2019). Both reviews included studies researching different concepts of centredness but they appeared to have an individualistic view of PCC, focussing on individual responsibility, rather than relational co-constructed dynamics of healthcare relationships. De Silva et al.'s (2014) review, conducted for the Health Foundation, included 23,000 studies about measuring PCC or its components. Surveys or

structured observation tools were most often used to measure common behaviours or experiences, for example interpersonal skills, involvement in care, or emotional support. A plethora of different measures have been developed, with de Silva et al. (2014) finding over 200 different survey tools to measure PCC. The main limitations of these measures were difficulties in translating perceptions and subjective experiences into standardised objective indicators, and they did not reflect all the conceptual domains in PCC and healthcare relationships. The reviewers' conclusions reflect the conceptual literature on centredness: heterogeneity of definitions and outcomes that may limit the strength of evidence (as not comparing like-with-like) to inform policy, education and practice; recommendations for measurement strategies to reflect the dynamic, multifaceted perceptions and experiences of healthcare relationships and; further evidence of the implementation of PCC approaches in clinical practice (de Silva 2014; Santana et al. 2019).

Another recent systematic review, specifically on doctor-patient relationships in oncology, provided an alternative perspective. Palmer Kelley et al.'s (2019) review included 13 studies, one of which is qualitative. The reviewers came to similar conclusions to de Silva et al. (2014) and Santana et al. (2019) around heterogeneity of measures and outcomes. Additionally, they suggested that future study design may benefit from a relational lens to move the measurement focus away from individuals, and their discrete behaviours or attitudes, towards an emphasis on the patterns and dynamics of interactions among all those involved in supporting the patient (Palmer Kelly et al. 2019). Dewar et al. (2011) in their study used a relational lens for measuring compassion. Feedback, instead of measurement, was used to describe and measure compassion. The characteristics of feedback, which is context dependent, self-determined, evolving and dynamic, were aligned more with the qualities of centredness and relational practice than compared to measurement with imposed external criteria in which control, stability and outcomes are valued over process (Wheatley and Kellner-Rogers 1999; Wasserman and McNamee 2010; Dewar et al. 2011).

2.5.4 *Facilitating relationships in practice*

Evidence on how to best to facilitate centredness and therapeutic relationships in practice is starting to emerge. Many authors refer to tasks or skills synonymous with a cognitive or technical model of PCC. For example, a systematic review of PCC described common behaviours focussed on information-giving, emotional support, empowerment and involvement in care (Scholl et al. 2014). The most common intervention for PCC in research studies is training of healthcare staff in person-centredness communication and behaviours (Blomberg et al. 2016; Santana et al. 2019). Yet researchers do not describe healthcare workers' knowledge deficits being linked to poor quality relationships. Instead, whole-team approaches to PCC, alongside organisational cultures and leadership that value and support PCC, rather than training, are cited as most significant for developing practice (The King's Fund 2013; Blomberg et al. 2016; Moore et al. 2017; Santana et al. 2019).

The challenges to facilitating relationships in practice may be overcome by attending to the subjective and experiential aspects required for relational practice (Wyer and Alves da Silva 2015; Thompson et al. 2018). Facilitation, reflection, reflexivity, appreciating what is valued, and having an approach of PCC with colleagues and oneself, patients and relatives, have all been shown to facilitate relational practice (Dewar and Mackay 2010; Wasserman and McNamee 2010; Dewar and Nolan 2013; Ferguson et al. 2013; van Lieshout and Cardiff 2015; Roddy and Dewar 2016; Dewar and MacBride 2017; Feo et al. 2017; Moore et al. 2017).

Waters and Buchanan's (2017) thematic analysis of person-centred concepts concluded that a lack of common understanding and value-base has led to relational practice being highly influenced by the context and culture in which care is provided. Dahlberg et al. (2009) reinforced the need for a philosophical understanding of humanising and relational aspects to underpin person-centred practice,

“The kind of knowledge base that is required to lead care is then more than just political or technical but describes a philosophical understanding of how well-being and illness is intimately bound up in the human condition” (Dahlberg et al. 2009, p.267).

Therefore investing time in both personal and cultural aspects of relationships underpinned by common values that refer to the complexity of being human are required (Polkinghorne 2004). These aspects are in contrast to the current focus on skills, knowledge and service improvement ‘quick fixes’ (Department of Health 2010, 2012; Wyer et al. 2014).

Jesus et al. (2016) recommended action research, intervention mapping, theory of changes and co-design with stakeholders as research designs that have the potential to strengthen the emerging evidence on developing team-approaches, cultures and leadership to support PCC. One study that has achieved this is the Leadership in Compassionate Care Programme (2012). It is one of the largest UK studies to date on embedding compassionate, RCC in nursing practice. It was a three-year appreciative action research study covering 24 in-patient areas in one acute NHS Trust. A wide range of methods were used to embed a compassionate culture, for example, a compassionate leadership programme for staff, using story-telling to connect with the experience and emotions in giving and receiving care; creating space to engage in caring conversations and reflecting on how care is provided (Leadership in Compassionate Care Team 2012).

2.5.5 Summary of current evidence of relationships in practice

In summary, the evidence suggests a small significant positive effect of PCC on healthcare outcomes. The positive effect of PCC is also supported by qualitative evidence that describes quality healthcare relationships supporting meaningful care experiences for staff, patients and relatives.

Most studies have focussed on the impact of the patient-professional dyad and have yet to fully evaluate the impact of patients' wider network of relationships on healthcare outcomes and quality of experience. Patients with communication and cognitive problems may require alternative approaches to support creating relationships that do not rely on verbal communication. There is a limited evidence-base from small qualitative studies around patients with dementia and brain injury (including stroke) in which embodied dimensions of self appear to be significant in creating relationships when there is communication impairment. Further research is required to explore its relevance in stroke care.

Measuring PCC approaches is challenging considering the constantly changing, multifaceted and personal experience of relationships. This is reflected in the development of a plethora of measures, each of which tends to focus on one particular aspect of PCC, for example informed decision making or effective communication. These forms of measures have the potential to reinforce the cognitive aspects of PCC and individual healthcare worker responsibility for the success of developing therapeutic relationships. This does not align with the conceptual literature on the mutuality and co-creation in healthcare relationships. More recently, some researchers have used collaborative research designs, such as action or participatory research, to address this issue. The strengths of these research designs are that they align more closely with the relational, organisational and cultural aspects of facilitating PCC and therapeutic relationships in practice.

Relational practice is highly influenced by the context and culture of care. There is an emerging evidence-base on the processes that can facilitate relational practice. More studies are required in different healthcare contexts with differing organisational pressures and models of care including stroke services.

2.6 UK Policy and guidance to improve the quality of healthcare relationships

This section will provide an overview of the context of care in the National Health Service (NHS), UK policy and guidance related to care experiences and healthcare relationships. In the last two decades there has been increasing concern that human relationships in healthcare are under threat, summarised as a timeline in Figure 3. There have been numerous reports in media and healthcare organisations of dehumanising care with significant variations in care experiences, even within the same NHS organisations (Beckford 2012; Campbell; Care Quality Commission 2012, 2016; National Voices 2017). Avoidable extreme failures of care have been uncovered in many NHS organisations, most recently at the Gosport War Memorial Hospital, Shrewsbury and Telford NHS Trust (Gosport Independent Panel 2018). This occurred not only in the UK, but in many Western countries across the globe (Cole and Carlin; Feo and Kitson 2016). These concerns have grown alongside significant changes in healthcare needs, with more elderly populations who have increasingly complex and long term conditions, and a squeeze in healthcare funding (Maruthappu et al. 2014). The Francis Inquiry (Francis 2013) into Mid-Staffordshire Hospital was a pivotal moment in NHS policy. The Inquiry found an unhealthy and dangerous culture, lacking clinical leadership, driven by targets, and lacking focus on patient care. Francis warned that NHS Trusts across the country have aspects of this negative culture impacting (Francis 2013; The King's Fund 2013, 2014a).

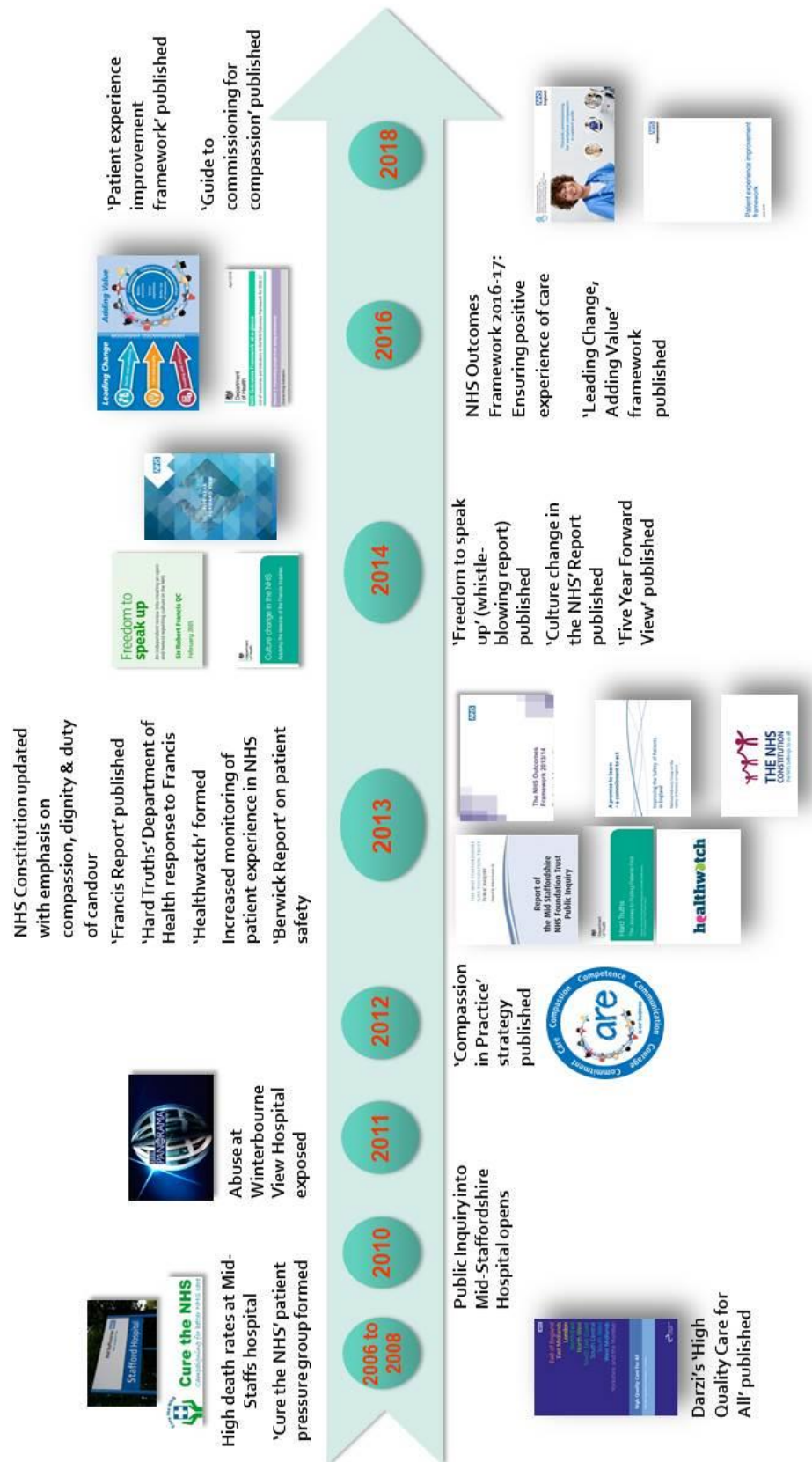


Figure 3 Timeline of major reports and policy on English NHS healthcare quality 2006-2018

2.6.1 National NHS policy

In response to these failures, all devolved countries in the UK wrote, and continue to update, quality improvement and delivery frameworks for NHS hospitals. They all have similar objectives of delivering dignified, compassionate and individualised person-centred care that involves patients in service evaluation and improvement (Department of Health 2006; NHS England 2014; NHS Wales 2015; The Scottish Government 2017; NHS England 2019).

The Department of Health in England responded with a plethora of papers intended to drive up care quality. ‘High quality care for all’ and ‘Hard Truths: the journey to putting patients first’ (Department of Health 2008, 2014), the NHS strategy ‘Five Year Forward View’ launched in 2014, updated in 2017 (NHS England et al. 2014; NHS England 2017) and the Government’s mandate for NHS England 2017/18 (Department of Health 2018) consistently focus on patient experience (Figure 3). Strategies include targets; financial incentives to reward care quality; the strengthening of professional regulation and inspectorates; and performance outcomes frameworks to monitor quality including the publication of performance data (Department of Health 2016b, 2018).

NHS England’s most recent strategy ‘The NHS Long Term Plan’ (NHS England 2019) is less explicit about a culture of person-centredness, instead, in a climate of austerity and scarce resource, it is moving towards a personalised care agenda which focusses on behavioural change and patient activation. The notion of person-centredness has changed its focus to control, empowerment and what is to be delivered – tailored and individualised support. The strengths of the Plan are that it views the person in the context of their entire life and community, drawing on primary prevention and initiatives to support self-management. Unfortunately, apart from developing patient empowerment, there is less emphasis on the *experience* of NHS care for patients, family and staff, and how care is delivered, for

example, in a person-centred way (The King's Fund 2019). None of the strategies completely address the priorities of culture, leadership and excessive performance monitoring outlined by Robert Francis (2013).

All UK countries evaluate the experience of care in the NHS through patient, family and staff satisfaction surveys. This enables each organisation to produce quantifiable data for national performance reporting. For example, the NHS Friends and Family Test (NHS England 2015) was developed as a simple metric to drive change and improve quality by asking one Likert scale question: how likely would you be to recommend the service to friends or family; and a free text box for individual responses. Unfortunately, it may not have realised its intentions. Criticism includes the Test providing little insight for practitioners as it does not capture care experiences, and that it has come another metric for organisations (Goodrich and Cornwall 2008; Manacorda et al. 2017; Robert et al. 2018). Although the space for free text allows for individual feedback, it is well known that it can be difficult for service users to freely express how they feel about their care (Coyle and Williams 2001; Dewar et al. 2010).

The patient group National Voices (2017) drew on patient experience data from multiple surveys (e.g. Adult Inpatient Survey, National Cancer Patient Experience Survey). They reported that person-centred care remains inadequately measured and a small but significant deterioration in the person-centred domains of 'getting information' and 'involvement in decision-making' in hospitals.

There are conflicting opinions in the literature on the value of measuring experience and care cultures (Watson and Lea 1997; Scott et al. 2003; Hesselink et al. 2013; National Voices 2017). Most authors expressed concerns similar to that summarised by Rafferty et al. (2015),

“Evidence suggests that major failures are not usually brought to light by the systems for quality assurance or improvement that are part of most healthcare organisations in developed countries - such as incidence reporting, mortality and morbidity reviews, inspections, accreditations, clinical profiling and risk and claim management. Since these cultural attributes are not picked up in the measures of quality and performance currently in use; metrics fail to capture the meaning and reality of care culture for patients or staff” (Rafferty et al. 2015, p.6).

2.6.2 Care policy and guidance

In the aftermath of the Francis Inquiry (2013), the state of NHS nursing care was particularly scrutinised. It shook the nursing profession, and destabilised the long held view of nursing as caring, compassionate and acting as advocates for patients (Nursing and Midwifery Council 2013). Consequently, NHS England and nursing professional bodies have published many reviews and guidance focussed on reporting concerns, monitoring and regulation (Royal College of Nursing 2013; General Medical Council and Nursing and Midwifery Council 2015; Nursing and Midwifery Council 2015; Nursing Midwifery and Allied Health Professions Policy Unit 2015). NHS England’s current guidance for nursing is the ‘Leading Change, Adding Value’ (LCAV) framework (NHS England 2016). It is based on the ‘6Cs’ values of compassionate care : care, compassion, competence, communication, courage and commitment (Department of Health 2012). The ‘6Cs’ and LCAV framework have similar criticisms to the Friends and Family Test and other satisfaction surveys on care experience as overly simplistic and reductionist, turning virtues into commodities that has even been classed as dehumanising (Dewar and Christley 2013; Bradshaw 2016). One mixed methods study of 36 NHS Trusts in England to assess the impact of the 6Cs described it as a ‘top down’ initiative, predominately engaging senior nurses and managers; and failing to impact on practice of front-line nurses by not recognising constraints on caring practice (O'Driscoll et al. 2018).

2.6.3 Drivers to improve care quality through cultural change

There are alternative perspectives in the grey literature that challenge metrics, regulation and 'top down' improvement initiatives. Rafferty et al.'s (2015) 'Culture of Care Barometer' provided recommendations for assessment of organisational cultures that aimed to move beyond the usual quality metrics and 'quick fix' improvements. Authors of the 'Patient & Family Centred Care Toolkit' (The King's Fund 2014b) highlighted the co-dependent relationship of healthcare staff and patients, moving responsibility of the quality of the experience solely from staff. Hence the toolkit focusses on processes and relational aspects of care, highlighting the power of patient and relative stories. It challenged previous policy and guidance which focussed on reductionist and individualistic approaches, but still advocated a traditional 'top down' hierarchical approach to change. Don Berwick's report (National Advisory Group on Safety of Patients in England 2013) concurred with The King's Fund (2014b) on the need to listen and empower the patient voice at all times. In contrast to The King's Fund, Berwick rejected a 'top down' hierarchical, regulatory approach and prioritised investment in the growth and ability of staff (both individually and collaboratively). He advocated a culture of learning and improvement through collective leadership to improve care quality and safety, and to use quantitative targets with caution.

More recently, in response to UK NHS Policy, initiatives have recommended transforming NHS cultures towards shared responsibility, person- and community-centred approaches that empower people to take an active role in their health and care, for example, peer support, health coaching, and asset-based approaches (Hibbard and Gilburt 2014; Finnis et al. 2016). Although the focus is on tailored and individualised approaches to self-management, Ham et al. (2018) highlight that the quality of relationships remains imperative,

"The most important cultural change is in the relationship between patients and the health care professionals who care for them. For this to happen, all involved must fundamentally change their behaviours and attitudes by

moving to genuine partnerships in which patients and professionals engage with each other as equals”(Ham et al. 2018, p.1).

2.6.4 Summary of UK policy and guidance on quality of care experiences

Person-centred, compassionate and dignified care is firmly embedded into UK NHS policy (Department of Health 2016a; Spencer and Puntoni 2016; NHS England 2019; NHS Scotland 2019). Policies and supporting guidance regarding the quality and experience of care have been described as bewildering, overwhelming and lacking any consistent priorities, which may be due to competing beliefs on how best to improve quality (Dewar and Christley 2013; Ham et al. 2016). Key organisational drivers for improving care quality have been outlined at micro, meso and macro levels, summarised in Table 8 (Brown et al. 2014; Scholl et al. 2014; The King's Fund 2014b; Wyer et al. 2014; Rafferty et al. 2015).

Micro, Meso and Macro drivers for improving care quality	
Micro level (Frontline healthcare staff, individual interactions)	Relationships with colleagues Recognising job constraints (time, staffing, skill mix) Equal patient-clinician relationships Valuing of the clinician and patient as unique people Patient empowerment, activation and self-management
Meso level (Healthcare organisation, resources)	Teamwork and team building Organisational culture Co-ordination and dilution of care
Macro level (Policy, regulation)	Specialisation and centralisation of services National health policy Financial constraints

Table 8: Organisational drivers for improving care quality (Brown et al. 2014; Scholl et al. 2014; Wyer et al. 2014; Rafferty et al. 2015)

UK governments have prioritised policy and regulation at macro level and meso levels (The Scottish Government 2016; Welsh Government 2019). Benefits of these policies include efforts by NHS organisations to ensure that the patient experience is brought into service improvement and evaluation; organisational support for

healthcare workers to deliver compassionate and dignified care; and emerging initiatives to develop healthcare workers skills in empowering patients.

Critics highlight that current policies fall short of implementing its aspirations, with the main reasons for this as follows:

- There is lack of a consistent theoretical base to the various initiatives, which can lead to services and policy using the same language, but with different meaning and interpretation (Bradshaw 2016; Waters and Buchanan 2017).
- Cultural changes have been implemented by hierarchy, regulation, inspection, and performance monitoring (McCormack et al. 2012).
- A heavy focus on objective measurement is unable to fully capture the highly variable meaning and experience of care for patients, family or staff (Rafferty et al. 2015).
- Policy focus has been on the care receiver, on communication and empowerment rather than human relating, and with less acknowledgement of the wider context of relationships between practitioners, families and patients (Dewar and Christley 2013; Ham et al. 2018).
- The practical and ethical tensions that arise when being person-centred in day-to-day interactions has not been addressed in policy (Entwistle et al. 2018).
- Financial and workforce pressures across the NHS has inevitably led to the rationalisation of resources (The Scottish Government 2016; NHS England 2019). This can favour a utilitarian view to achieve benefit for the greatest number, which further compromises aspirations to focus on personal care experiences and the unique context of the relationship construction (Woodward 1997; Royal College of Nursing 2013).

2.7 The current state of relationships in stroke services

“We’re not just legs and arms and a mouth...we are human beings with a mixture of emotions. All these feelings...self esteem, self worth, confidence, identity ...they’re all under attack after a stroke...you can feel vulnerable, frightened and you can lose yourself” (Stroke survivor Harry Clarke, cited in Gillham and Clarke (2011, p.4).

Previous sections in this chapter have summarised the conceptual literature on healthcare relationships, in particular PCC, and evidence on the impact of PCC approaches. Current policy and guidance that inform the delivery of PCC and healthcare relationships have been summarised. This final part of the literature review will focus on the experiences of relationships within the context inpatient stroke unit care. To get a comprehensive picture, it is important to understand different perspectives of stroke unit care experience; therefore this section will explore evidence from patients with stroke, their relatives or informal carers, and staff.

2.7.1 Patients’ experiences on stroke units

“We both had a terrible night’s sleep and we shed tears as whatever was happening was not a good thing. I didn’t know if I was going to wake up the next morning and believe me that makes you stay awake as long as possible. Here endeth day 1 of my stroke life. Words to summarize are: scared, confused but thankful for being alive” (Excerpt from R.Swales (2016) blog).

Three systematic reviews of qualitative studies on patients’ experiences on stroke units have been published since 2011 (Peoples et al. 2011; Hole et al. 2014; Luker et al. 2015). The three papers all focussed on stroke rehabilitation rather than the entire stroke unit experience. Many of the same studies were included in all three reviews. Luker et al (2015) had the most comprehensive search strategy, including 31 papers over 20 years all from the Western world (with the exception of one paper). Subsequent to these reviews, several relevant papers have been published and will also be referred to in this section. A common theme in the literature was the importance placed on the type of relationship between patients and stroke unit staff to support recovery and rehabilitation after stroke. Four important aspects of

the relationship type were cited in the literature: (i) patients' perceptions of power and vulnerability; (ii) the staff members' focus within the relationships; (iii) attending to their emotional and existential challenges after stroke and; (iv) the verbal communication ability of the patient.

(i) Patients' perception of power

Patients' perspectives on the perceived power in relationships with staff impacted on the quality of experience for patients, with widely variable experiences from participatory to hierarchical in nature (Jones et al. 1997; Peoples et al. 2011; Luker et al. 2015; Lawton et al. 2016). For example, stroke rehabilitation was described by some patients as purgatory with restrictive and authoritarian staff attitudes (Peoples et al. 2011; Rosewilliam et al. 2011; Kitson et al. 2013b; Brown et al. 2014; Luker et al. 2015). Associated with the power dynamic in relationships, vulnerability was another key theme. This sense of vulnerability appears to be twofold: firstly, a sense of vulnerability in reliance on others for personal care (Kitson et al. 2013b; Hole et al. 2014; Lawton et al. 2016); and secondly, a sense of feeling less capable and in control than prior to their stroke (Peoples et al. 2011; Kitson et al. 2013b; Ryan et al. 2017). For patients in a position of vulnerability, a humanising approach that was dignified, attentive and acknowledged the individual person led them to feeling valued and also strengthened relationships (Lawton et al. 2016).

(ii) The focus or intention of the relationship

There was an overwhelming consensus in the literature of patients describing themselves as being seen purely as a medical condition with impairments, and not as a person (Morris et al. 2007; Lawrence and Kinn 2011; Peoples et al. 2011; Stroke Association 2012; Brown et al. 2014; Ryan et al. 2017). Physical recovery was important for patients (Kitson et al. 2013b; Luker et al. 2015). However, an overly strong focus on physical needs led to a, "resigned passivity" (Lawrence and Kinn 2011, p.320) by patients due to individual, emotional and psychological needs being overlooked by staff (McKevitt et al. 2004; Lawrence and Kinn 2011; Stroke Association 2012; Kitson et al. 2013b; Kirkevold et al. 2014; Bennett et al. 2016).

(iii) Attention to emotional and existential challenges after stroke

In Kitson et al.'s (2013b) study, people with stroke, *"saw the whole hospital process as a battlefield where they were in danger of losing their identity and dignity"* (Kitson et al. 2013b, p.400). Patients described feelings of loss, shock and humiliation as they watched their bodies not working as they should, and were worried about changes in their self (Ellis-Hill and Horn 2000; Åndersson and Hansebo 2009; Tutton et al. 2012; Kitson et al. 2013b; Ryan et al. 2017). These emotional and existential aspects of life after stroke are cited as largely unmet by stroke services (Ellis-Hill et al. 2008; Stroke Association 2012; Brown et al. 2014; Ryan et al. 2017).

(iv) Communication ability of the patient with stroke

Impaired cognitive and communication function after stroke impacts the ability of those affected to use conventional language to build relationships (Gjermestad 2017). Bridges et al. (2010), in their meta-synthesis of studies into experiences of acute care setting, found that people with cognitive or communication difficulties were at a particular risk of negative experiences of care. Patients with aphasia experienced existential loneliness when communication affected interpersonal relationships (Nyström 2006). The challenges of building relationships after stroke appear to be accentuated further by communication or cognitive difficulties (Sundin et al. 2001; Pound and Jensen 2018), illustrated in the following quote,

"She [the nurse's aid] put the newspaper on my bed, but didn't say anything. After my aphasia she never talked to me again and avoided eye contact. I understood that she was afraid. Therefore I also became scared" (Nyström 2009, p.2506).

(v) Positive relational experiences

The literature was not all negative, with patients describing mixed views about their experiences (Morris et al. 2007; Kitson et al. 2013b; Lawton et al. 2016), summarised by a patient quote,

For every caring, intelligent, supportive member of hospital staff. . . for every one of those who is good and supportive at their, at their profession, I would also say that there's probably an equal number who don't take the same pride in their job and who don't care very much about the feeling, sensitivities and ultimate condition of their patients. . . (Kitson et al. 2013b, p.400)

Collaborative, inter-dependent relationships that saw patients as uniquely human, and that attended to their wider network of relationships with fellow patients, family and friends were important (Nordehn et al. 2006; Åndersson and Hansebo 2009; Tutton et al. 2012; Kitson et al. 2013b; Brown et al. 2014; Östlund et al. 2016).

"Many studies reported that participants could have empowering relationships with staff that helped to foster their autonomy. This could involve the development of trust in staff, but did not necessarily mean a one-sided power relationship. An increasingly collaborative and collegial relationship and communication style between the treating team and patients was associated with stroke recovery" (Luker et al. 2015, p.8).

When this was experienced, patients reported that it supported their wellbeing and sense of hope after stroke, and enhanced their overall recovery (Luker et al. 2015; Bennett 2016; Lawton et al. 2016).

"So through gaining autonomy participants were better able to reconcile their sense of "self " and this acted as a primary way to move on from the current self towards evolving the self" (Hole et al. 2014, p.8).

Finally, it is worth noting that the majority of studies in the literature studied relationships in the rehabilitation phase of stroke services, with only two recent studies including patients in the acute or combined stroke units (Bennett 2016; Ryan et al. 2017). Additionally, the majority of studies excluded patients with severe cognitive or communication problems. This may reflect the difficulties of

conducting these type of studies (McKevitt et al. 2004; Lawrence and Kinn 2011; Brady et al. 2013; Catangui and Roberts 2014; Jayes and Palmer 2014b). Patients with cognitive and communication problems have been highlighted as particularly vulnerable to negative relational experiences in hospital (Bridges et al. 2010), with 20-80% having some form of cognitive or communication difficulty after stroke (Sellars et al. 2002; Sun et al. 2014). Therefore there is a gap in the evidence concerning the experience of relationships in acute stroke units, and especially concerning patients with communication or cognitive problems after stroke.

2.7.2 *Relative and carer experience on stroke units*

In comparison to the patient literature, there is little consideration of informal carers/relatives needs in the stroke literature (Han and Haley 1999; Luker et al. 2017). There have been several quantitative (Han and Haley 1999; Low et al. 1999) and qualitative (Greenwood et al. 2009; Greenwood and Mackenzie 2010; Luker et al. 2017) literature reviews of stroke informal carers' and relatives' experiences. Most research has focussed on informal carer/relative experience at the transition from hospital to home, or in the longer term after leaving hospital. Luker et al.'s (2017) was the only review that looked specifically at the inpatient setting, and similar to the patient literature, had a therapy focus on rehabilitation experience rather than the entire stroke unit experience.

With regard to informal carer/relative relationships on stroke units, there were two main themes arising from the literature: (i) a feeling of being on the periphery of relationships with staff and; (ii) a change in role, responsibilities and relationship with the person affected by stroke.

(i) Being on the periphery

Relatives/informal carers described a distant relationship with stroke unit staff and felt that their lives in context with the person with stroke were poorly understood

(Morris et al. 2007). They perceived that rehabilitation was for the patient and did not expect the stroke service to support their own needs (Michallet et al. 2001; Hallé and Le Dorze 2014; Luker et al. 2017). The stroke unit environment and routines were described by relatives/informal carers as alien to them and therefore they felt on the periphery of stroke unit support when compared to the person with stroke (Low et al. 1999; Luker et al. 2017). This led to some feeling frustrated by the relationships with staff (Luker et al. 2017). They described not meeting with the stroke multidisciplinary team, not being recognised as partners in care and suggested a failure of the stroke team to draw on their knowledge and expertise (Brereton and Nolan 2002; Simon and Kumar 2002; Morris et al. 2007; Stroke Association 2013; Hewitt et al. 2015; Lynch et al. 2017). Several authors have cited that relatives/informal carers had to fight for dignified care, increased therapy and were often relied on to be the patient's voice (Wallengren et al. 2010; Stroke Association 2012; Luker et al. 2017).

(ii) Changes in role, responsibilities and relationships

"The experience of caring for stroke survivors centres on change and loss. Change includes changes in roles, relationships, responsibilities. Loss includes losses of former relationships, loss of autonomy and loss of taken-for-granted futures" (Greenwood and Mackenzie 2010, p.271).

In the first weeks of admission to hospital after a stroke, relatives/ informal carers described overwhelming emotions (Luker et al. 2017). A heightened sense of attachment and responsibility towards the patient with stroke was associated with the perceived vulnerability of the patient (Greenwood and Mackenzie 2010; Luker et al. 2017). In particular for patients who had communication disability after stroke, relatives/informal carers felt a responsibility to connect the patient to other people while they were in hospital (Bäckström et al. 2010). Relatives/informal carers found responding to the patient's needs at this time challenging for them (Kitson et al. 2013b).

Uncertainty and confusion about being a carer and, in particular preparing for discharge from the stroke unit, were common themes (Brereton and Nolan 2002; Hewitt et al. 2015; Chen et al. 2016; Lutz et al. 2017; Ryan et al. 2017). Relatives/informal carers described being surprised and unprepared when told that the patient was going to be discharged from the stroke unit (Luker et al. 2017; Ryan et al. 2017). Adequate preparedness, uncertainty and confusion may be exacerbated by short lengths of stay on stroke units (Bennett 2016; Chen et al. 2016), and could also be a reflection of the quality of relationships and support from stroke unit staff.

A significant concern expressed by relatives/informal carers was how they balanced their carer responsibility within their own lives. A meta-ethnography concluded that relatives/informal carers experienced a biographical disruption where normal rules of mutual support and plans or hopes for the future are put on hold (Greenwood and Mackenzie 2010). They expressed concerns over role overload and how they would maintain their own relationships and identity (Brereton and Nolan 2002; Brereton et al. 2007; Bäckström et al. 2010; Greenwood and Mackenzie 2010; Bastawrous et al. 2015). The responsibility of relatives/informal carers sometimes led to emotional and psychological problems including stress, anxiety and depression (Han and Haley 1999; Low et al. 1999; Stroke Association 2013). The quality of the carers' relationship with the person with stroke played an important role in maintaining carers' psychological well-being (Low et al. 1999). They concluded,

“Carers who had a poor relationship often perceiving their role to be more of a burden and having a more negative interpretation of their situation” (Low et al. 1999, p.713).

Positive relationships that supported the concerns of relatives/informal carers was another common theme, although not as often as negative experiences. Positive relational approaches included: establishing open communication; staff

understanding the social context of relatives; an open, relaxed attitude and; using humour to connect with relatives/informal carers (Low et al. 1999; van der Smagt-Duijnsteet et al. 2000; Burton and Payne 2010; Bennett 2012; Bennett 2016). Many papers recognised that stroke unit teams could do more to support relatives/informal carers (Greenwood and Mackenzie 2010; Hallé and Le Dorze 2014; Luker et al. 2017). Hallé and Le Dorze (2014) suggested that prevailing person or patient-centred approaches to stroke services and the strong patient focus limited opportunities to support informal carers and relatives. Luker et al. (2017) supported these claims in recommending a shift towards closer relationships in staff-relative/informal carer relationships and more research into the application of different approaches in clinical practice.

In summary, relatives and informal carers describe being on the periphery of relationships on the stroke unit. Carers consistently ask for more attention to be paid to their needs and not just for the person with stroke (Greenwood and Mackenzie 2010; Stroke Association 2013; Luker et al. 2017). However, this evidence is from therapy and rehabilitation studies and there is a lack of evidence on relatives' experiences in the acute phase. Descriptive qualitative studies have provided evidence on positive relational approaches, for example open, relaxed communication. Some have criticised of an overly person-centred approach that has the potential for relatives' or carers' needs to be overlooked. Apart from goal setting by therapists, there are no studies that specifically research how to develop practices that support the positive relational approaches and closer relationships desired by relatives and informal carers.

2.7.3 *Stroke multidisciplinary team relational experience on stroke units*

For this discussion, the multidisciplinary team (MDT) is defined as, 'a collection of professionals and assistants from different disciplines who share a common area of working practice and committed to meaningful purpose' (Clarke 2013; Harris et al. 2013; Clarke and Forster 2015). Effective MDT working has been considered a

cornerstone to organised stroke unit care since the inception of stroke units (Langhorne and Pollock 2002; Clarke and Forster 2015). From a stroke MDT perspective, good teamwork and relationships are described by staff as very important (Harris et al. 2013).

Most evidence on stroke MDT working is from qualitative studies evaluating MDT performance or mechanisms of MDT working rather than specifically focussing on relational experience (Watkins et al. 2001; Monaghan et al. 2005; Cramm and Nieboer 2011; Harris et al. 2013). Data on staff relational experiences can be drawn from these studies, and there appears to be three main areas that influence staff experience: (i) the quality of relationships with colleagues within the MDT; (ii) having a shared values or sense of purpose and; (iii) the influence of the working environment on opportunities for building relationships.

(i) Quality of colleague relationships within the MDT

Collaboration is described as a key outcome of good MDT relationships (Watkins et al. 2001). Common attributes supporting collaboration include: sharing of knowledge and skills; role understanding, effective communication through regular meetings; common goals and; opportunities for joint education and training (Watkins et al. 2001; Baxter and Brumfitt 2008; Clarke 2010; Cramm and Nieboer 2011; Harris et al. 2013; Clarke and Forster 2015; Royal College of Physicians 2016a). Multiple descriptive methods have been used in studies to measure collaboration through: questionnaires on team performance (Gibbon et al. 2002; Monaghan et al. 2005; Cramm and Nieboer 2011; Harris et al. 2013); ethnographic observations of communication in MDT meetings and staff joint working (Gibbon and Little 1995; Gibbon 1999; Watkins et al. 2001; Seneviratne et al. 2009; Clarke 2010; Kilbride et al. 2011; Harris et al. 2013); and individual staff interviews (Clarke 2010; Kilbride et al. 2011; Harris et al. 2013).

Balanced power relationships are considered to be important for MDT collaboration. Power relationships can vary depending on the SU context, for example, in one case study of three SUs, the medical model view of acute SUs was perceived by professionals to give power to the medical consultant (Baxter and Brumfitt 2008). Non-hierarchical working was associated with balanced power relationships – perceived by staff as mutual collegial relationships; joint decision-making and shared responsibility and; assuming group effort for patient benefit negotiated through opportunistic (rather than formal) dialogue (Baxter and Brumfitt 2008; Seneviratne et al. 2009; Clarke 2010; Kilbride et al. 2011; Harris et al. 2013; Bennett et al. 2015).

Social and emotional well-being has also been described as important for team relationships but has had less attention in studies aiming to develop MDT working. It has been defined as familiarity; rapport; personal concern for colleagues with understanding of the needs and demands of team members; or an individual's perceived value by colleagues and a sense of belonging in the team (Burton et al. 2009; Clarke 2010; Cramm and Nieboer 2011; Kilbride et al. 2011; Harris et al. 2013).

The reality of collaborative MDT working has been difficult to achieve consistently on SUs, and this still remains challenging despite nearly 25 years of MDT research (Gibbon and Little 1995; Pound and Ebrahim 2000; Atwal and Caldwell 2005; Seneviratne et al. 2009). Interventions to improve the quality of MDT relationships have focussed on team leadership, education and training, operational processes (e.g. the structure of MDT meetings or co-location of team members), and joint documentation. Studies have shown that, apart from team leadership, these interventions did not necessarily lead to collaborative MDT relationships (Watkins et al. 2001; Gibbon et al. 2002; Suddick and De Souza 2007; Burton et al. 2009; Cramm and Nieboer 2011). Researchers suggest that positive team relations and collaboration appear to be less about processes and structures, and co-participatory

style intervention studies in which staff can work together to address the key issues in collaborative MDT working are required (Watkins et al. 2001; Gibbon et al. 2002; Burton et al. 2009; Cramm and Nieboer 2011).

Two recent studies have started to build this evidence. The provisional results of a realist evaluation study of in-patient stroke rehabilitation suggested that MDTs who reflect on their practices and working together, and not only reflecting on individual patient care, led to collaboration and partnership working (Fisher et al. 2015). Although how reflection supports MDT working has not yet been explored in detail. A second co-participatory action research study has highlighted different relational experiences to previous studies. The study was focussed on developing the MDT on one SU as a 'community' based on collegial relationships. Developing a MDT 'community' supported a sense of belonging and developed staff connections that fostered good MDT relationships. The intervention also included dedicated time each week for the team to reflect. The researchers found that the way in which the team interpreted themselves, and interpreted their individual value within the stroke team, was inseparable with their clinical practice (Kilbride et al. 2011). These studies provide an interesting new perspective to supporting MDT relationships, and more research is needed to develop the evidence-base in this area.

(ii) Shared values and sense of purpose

Shared values and sense of purpose within MDTs, also part of collaborative working discussed previously, were described as crucial for meaningful and relevant stroke rehabilitation (Lawrence and Kinn 2011; Aadal et al. 2013; Harris et al. 2013; Lawton et al. 2016). Stroke MDTs mostly identified person/patient-centredness or therapeutic approach as their shared values (Harris et al. 2013; Kitson et al. 2013b; Lawton et al. 2016; Rosewilliam et al. 2016). A therapeutic team approach was mainly described in the rehabilitation studies. It has similar attributes to person-centredness, with a stronger focus on interpersonal processes during therapeutic encounters (Lawton et al. 2016).

Patient-centred approaches tended to have a needs-led focus, with staff tailoring rehabilitation and care to the needs and priorities of patients (Lawrence and Kinn 2011; Harris et al. 2013). Whereas therapeutic approaches focussed on interpersonal aspects such as creating trust, being respectful, providing reassurance, fostering hope and using humour (Sundin et al. 2001; Catangui and Roberts 2014; Bennett 2016; Lawton et al. 2016; Ranner et al. 2016). Staff described the need to be seen to be human with patients and relatives, and to create a 'family like' atmosphere on stroke units (Laird et al. 2015; Bennett 2016). Lawton et al.'s (2016) meta-ethnography of therapeutic approaches and Bennett's (2016) qualitative study focussing on nurses' interactions with patients, both described a form of human connectedness and genuine bond as part of a therapeutic relationship that was valued by MDTs and patients.

More recently, authors have described a growing tension from staff who feel their aspirations to deliver practices that align with their shared values have been compromised (Tutton et al. 2012; Taylor 2017). A multi-method qualitative study of staff and patients on one SU described a lack of patient-centredness and dysfunctional therapeutic relationships demonstrated through non- collaboration with patients around goal-setting (Rosewilliam et al. 2016). Staff did not communicate patients' priorities to each other and they lacked a holistic approach, instead focussing on acute medical needs (Rosewilliam et al. 2016). These findings have been confirmed in other studies which described staff privileging certain rehabilitation goals over patient-centred goals in line with organisational needs to discharge patients quickly (O'Connor 2000; Levack et al. 2011; Rosewilliam et al. 2011; Harris et al. 2013). These studies suggest an asymmetry in relationships observed between professionals and patients, and between the stroke MDT and organisational objectives, namely metrics and discharges (Harris et al. 2013; Lawton et al. 2016). Some authors questioned whether a patient-centred or therapeutic approach was even possible in stroke units when they considered the imbalance of

power exacerbated by current health system models and funding (Levack et al. 2011; Lawton et al. 2016).

(iii) The context of working on a stroke unit

The organisational context (acute versus rehabilitation; hospital versus community), and culture in which the stroke MDT worked, influenced their ability to build relationships with patients, relatives and colleagues (Luker et al. 2015; Lawton et al. 2016; Rosewilliam et al. 2016). Since 2011, as a result of increasing medical advancements in the management of acute stroke, there has been a shift in the delivery care away from rehabilitation towards an acute medical model and merging of hyper-acute care leading to larger sizes of MDTs (Rosewilliam et al. 2011; Harris et al. 2013; Lawton et al. 2016; Ryan et al. 2017). Changes in the organisation of stroke services, alongside a squeeze in NHS resources and increased scrutiny through national audit programmes, have led to staff prioritising tasks and patients' physical needs due to a medical model of care, pressures to achieve targets and facilitate discharges, and fewer opportunities for teams to develop good relationships (Levack et al. 2011; Tutton et al. 2012; Harris et al. 2013; Ryan et al. 2017). As one ward sister in Taylor's (2017) study described, "*discharge is king*" (Taylor 2017, p.130).

Several studies described staff control or taking short cuts had crept into MDT practices and that this was influenced by organisational and workload pressures. The reasons cited by staff were the need to manage patients' and relatives' expectations of the service and a requirement for interactions to be completed as quickly as possible (Lloyd et al. 2014; Lawton et al. 2016; Ranner et al. 2016; Ryan et al. 2017; Taylor 2017). Limited time due to staff workloads and high patient turnover negatively impacted on the stroke MDT to develop relationships with colleagues, patients and relatives/informal carers (Bennett 2016; Lawton et al. 2016; Ryan et al. 2017).

The MDT experience of their relationships on SUs appears, therefore, to be highly influenced by the culture and organisation of the SU in which they work. Positive relations with both patients and colleagues in the MDT appear to be less about processes and structures to team working, with evidence that attitudes towards each other as individuals and shared values or sense of purpose are important. Several researchers have concluded from their research that stroke MDT working needs to look beyond team performance (what they do) towards interventions that support team members' well-being, their sense of belonging and how they interpret themselves within the SU MDT (how they are) (Gibbon et al. 2002; Cramm and Nieboer 2011; Kilbride et al. 2011).

In summary, reviewing the literature on the current state of relationships on stroke units, there are wide variations in the quality of experiences for patients, relatives/carers and staff. Patients and relatives/carers describe an emotionally intense time after stroke, with feelings of loss and vulnerability; changes in self compared to before the stroke; and existential questions around the meaning of life after stroke. These experiences are exacerbated when the patient has cognitive and communication difficulties after stroke, and yet this patient group is unrepresented in the evidence of the experience of care and relationships on stroke units. Despite staff aspiring to deliver a person-centred and therapeutic approach, it often falls short of their aspirations. When the focus moves away from the relationship towards physical needs, tasks or targets, all involved experience less meaningful or quality relationships. When relationships are perceived to be more equal, collaborative with opportunities for choice and negotiation, the quality and meaningfulness of experience improves. Researchers call for the stroke discipline to acknowledge the importance and contribution of person/patient-centred, therapeutic relationships in the emotional well-being and recovery of patients with stroke and their relatives, and for MDT working (Burton et al. 2009; Bennett 2016). With relationships being a common important theme for patients, relatives, carers and staff experiences, it is therefore appropriate to look further into relational approaches in stroke care.

2.8 Chapter summary

This chapter has explored the existing discourse into relationships in healthcare and on stroke unit through reviewing current NHS policy, clinical guidelines, theoretical and research literature related to healthcare relationships. In particular, this chapter has explored centredness approaches to care, lifeworld-led/humanising care theories and the operationalisation of relational practice on stroke units. Critical appraisal and synthesis of this literature has led to a number of conclusions which are:

- The literature on healthcare relationships has little conceptual clarity or agreement, with multiple terms originating from different disciplines that appears to reflect the complex, dynamic and co-constructed nature of relationships. In recent years, there has been a paradigm shift in nursing and therapy literature towards relational concepts that engage with the human aspects of healthcare and the wider web of relationships that support a person's health and wellbeing. These emerging concepts on healthcare relationships have not yet been adopted into stroke clinical practice. Further research is needed that explores not only the contribution of these relational concepts to supporting recovery after stroke and increases understanding of how these concepts can be translated in everyday practice.
- In stroke unit practice and NHS healthcare policy, patient or person-centredness is the dominant discourse on healthcare relationships. Policy and guidelines supporting NHS practice do not consider the theoretical or philosophical foundations in which centredness is grounded. Therefore, patient/person centredness has been fragmented into discrete domains or measures which have morphed into more metrics for organisations to achieve, rather than being viewed as a conceptual approach to guide practice.
- There is a significant body of evidence on the implementation of relationship-centredness in UK healthcare. These qualitative studies, grounded in conceptual theory, have developed relationship-centredness

approaches that are conceptually authentic. Whilst these studies provide valuable insights into relationship-centred practice, these studies have been conducted mainly in older persons and dementia care settings. There is more scope to do research within stroke care contexts because of the current challenges specific to stroke services including: the re-organisation of services into acute 'hubs' reinforcing a medical model approach; a heavy focus on national performance monitoring unintentionally influencing the focus of clinical practice and MDT dynamics to meet these targets; and the requirement of effective MDT working to support patient outcomes.

- Specifically in stroke research, policy, and practice, there is increased value placed on physical and medical needs after stroke, with relationships undervalued in comparison. The need to establish therapeutic relationships and promote centredness practices has been well established in the stroke literature. The recent change in the context of care on stroke units is starting to be recognised as a key influence on relational practice. Therefore, there is scope for further research that explores how these relationships can be afforded more status and attention through cultural developments within SUs.
- Research into interventions to develop relationships on stroke units has predominately had an individualistic autonomous focus on individual behaviours or skills, for example, competencies of staff to conduct therapeutic goal-setting, or to deliver effective information-giving for informed consent. Other interventions to support relationships within MDT working have included development of systems and operational processes. These intervention studies have had little impact on developing meaningful relationships. The recent paradigm shift in healthcare relationships towards relational processes of co-constructed human relationships and connectedness requires studies that align with the complex and co-constructed relational processes in everyday stroke unit practice. Two studies have demonstrated the scope for realist evaluation and action-research with its co-participatory approach to provide evidence on

addressing the complex challenges in supporting meaningful healthcare relationships in different contexts (Kilbride et al. 2011; Fisher et al. 2015).

- It is well recognised that relationships with patients who have cognitive and communication problems after stroke are particularly vulnerable when it comes to forming relationships with healthcare staff and yet they are often excluded from studies. This area could benefit from further exploration and description of meaningful relationships and how they are constructed in practice.

This review of the literature has shown that in relationships a focus on human connectedness and the process of co-constructing relationships in clinical practice are important. Power, collaboration, and co-construction are all central to relational theory. Therefore, the theoretical framework and study design required for this thesis should enable the exploration of the nature and processes in relational knowing and how it can be practically realised in clinical practice. In particular, the methodological approach needs to enable the exploration of *different forms of co-constructed knowing*, to include objective and cognitive forms of knowing alongside the experiential, tacit and embodied forms of knowing that align with experience of human relationships described in the literature. Secondly, the research design needs to enable the trialling and refining of complex co-constructed relational practices in real-world clinical practice. Building on the main conclusions from this literature review, the next chapter will discuss the worldviews of relational constructionism, critical theory and pragmatism that framed this thesis, and the rationale for the chosen methodology of action research.

Chapter 3: Methodology - An invitation to a process

“No problem can be solved from the same level of consciousness that created it” (Albert Einstein).

The previous chapter outlined the key concepts on healthcare relationships and considered the need to increase understanding of how to practically support meaningful relationships in everyday practice on stroke units in the UK. This chapter will discuss the theoretical framework and position taken for this thesis to increase understanding of how to co-create these types of relationships; informed by previous research methods used and evidence to date. The theoretical framework of this study draws on constructionism alongside influences from pragmatist and critical paradigms. This framework enables for exploration of co-creating meaningful relationships, in particular the experiential, tacit and embodied experiences of being in relation within everyday practice; and ways in which healthcare staff can practically support these types of relationships on stroke units. The theoretical framework will be discussed and linking key theoretical concepts as rationale for the chosen methodology that combined action research (AR) and appreciative inquiry (AI) into appreciative action research (AAR).

3.1 Aims and objectives of the study

Drawing on the evidence to date and key concepts on healthcare relationships, the overall aim of this study was: to explore with people affected by stroke, their family and stroke unit staff their understandings of meaningful relationships in stroke care and rehabilitation; to articulate the processes that enable these relationships to happen; and to determine how future relationships can be enriched through this knowing. The specific objectives for the study were:

1. To explore with patients, relatives and staff their valued relational care experiences on a stroke unit, in particular noticing those experiences from patients with cognitive and communication difficulties after stroke.
2. To collaboratively identify with patients, relatives and staff what has worked well in their relational experiences on a stroke unit and co-construct 'ideal' RCC practices.
3. Co-develop with patients, relatives and staff ways to enrich meaningful relationship-centred stroke care for all.
4. To facilitate developments to RCC approaches on the stroke unit.
5. Review and reflect with staff co-participants the principles and insights behind meaningful RCC and the specific elements and processes to support consistent RCC in other stroke unit settings.

3.2 Worldviews that framed the approach to this study

I have already introduced in Section 1.2 my personal worldview and, in particular, its relationship to my nursing practice: a pragmatic view that values the clinical application of new knowledge; and the co-creation of knowledge through team working. Both of which shaped how I approached this thesis.

Alongside my personal worldview, a relational constructionist stance was taken alongside key ideas from critical theory, pragmatism and lifeworld perspectives that altogether framed how I engaged with the research. These three worldviews will be discussed in turn, referring to how they relate to this study. Lifeworld-led theory, introduced in Chapter 2, along with relational constructionism, particularly informed how I viewed relationships and their co-construction. Therefore, when discussing relational constructionism, I will also link with key concepts of lifeworld-led theory.

3.2.1 A relational constructionist stance

A constructionist stance views reality as socially constructed by those experiencing it, subjectively based on our unique understandings of the world and shaped by the context in which it occurs (Berger and Luckman 1966). Relational constructionism is one of many themes of social constructionism and has an emphasis on relational processes. Relational constructionism most closely associated with the work of Kenneth Gergen and Dian Marie Hosking (Gergen 2009; McNamee and Hosking 2012)

McNamee summarises the difference of social to relational constructionism as a,

“shift in attention to relational processes that construct identities it requires an entirely different orientation to the world—one where focus on individuals is replaced with relational processes”(McNamee 2012, p.152).

The main features of relational constructionism are summarised in Table 9 below.

Construction	It is centred on construction <i>processes</i> ; it makes people and things social realities.
Dialogue	It focuses on dialogical practices as <i>ways of relating</i> to create and support multiple local realities(Hosking 2011).
Relational	Relational processes occur <i>within interactions</i> , for example speaking, hearing, gestures, signs, symbols, dance etc.
Power	Unlike many constructionisms, it acknowledges power dynamics as a quality of relational processes.

Table 9: Main features of relational constructionism (van der Haar and Hosking 2004; Hosking 2011)

Relational constructionism aligns with the topic and objectives of this study in several ways concerning: (i) subject-object divide; (ii) multiple, simultaneous constructions; (iii) local and contextual constructions.

(i) Subject-object divide

A relational constructionist view considers that there is no subject-object (or self-other) divide; instead it comes from the standpoint of relationships first (McNamee and Hosking 2012). In other words, it views individuals not as separate entities that may or may not form a relationship (supporting isolation) but relatedness, and therefore isolation, comes from the relational process and not the other way round (Gergen 2009; Hosking 2011). This stance on subject-object is different to that of lifeworld-led theory which does not consider a divide between subject and object, instead only world-to-human consciousness (Todres, Galvin & Dahlberg 2007). Lifeworld-led theory has similar concerns around relatedness to relational constructionism, asserting a humanly relational world through the dimensions of the lifeworld (Table 6). In this thesis I used these concepts to inform how I researched relationships, with the lifeworld-led theory shaping how I viewed relational processes described within relational constructionism. In particular, the lifeworld dimensions of embodiment, intersubjectivity and spatiality (Table 6) provided a theoretical framework on how I viewed non-verbal forms of relationship construction.

Gergen (2009), McNamee and Hosking (2012) suggested that previous constructionist studies may have fallen into the trap of individualism and a subject-object divide in pursuit of academic research. Individualism has been shown through language describing a singular self where relationships are secondary to self, for example personal characteristics such as 'personality', 'motives', or phrases such as, "He needs to build a good relationship" (Gergen 2009, p.17). These narratives have the risk of formalising hierarchical position, e.g. validating a claim that one individual knows better (van der Haar and Hosking 2004). Individualist discourse is also seen in the healthcare care literature and policy on relationships. A relational constructionist worldview that perceives the *process* of relationships first may bring new possibilities for developing healthcare practice that has less emphasis on individual responsibility of healthcare workers; and provide an

additional discourse for healthcare relationships that reflects more widely everyday experience.

(ii) Multiple, simultaneous constructions

Secondly, relational constructionism is open to multiple, simultaneous constructions. It does not, therefore, try to eliminate or disparage a certain way of knowing, but instead values multiple, ongoing realities, rather than a singular, fixed way of knowing (van der Haar and Hosking 2004). This enables opportunities to build on previous evidence (but not discounting it), while exploring other ways of relating and knowing that have less attention in previous research that used alternative paradigms. In this study, a position that views multiple simultaneous constructions will enable: (i) the dimensions of a relational lifeworld (Table 6) to be explored; (ii) explore non-language co-constructions of reality and human connections that are particularly relevant for people with stroke who lack verbal communication and; (iii) values different forms of knowing that supports collaboration within a diverse group of people. In this study this includes patients, their family, non-professional and professional staff, and hospital managers. This is particularly interesting as it changes the onus on healthcare staff achieving good relationships towards mutual responsibility between staff, patients and relatives.

(iii) Local and contextual constructions

Finally, relational constructionism views social constructions achieved in relational processes as 'what works here and now' within an interaction (McNamee and Hosking 2012). Processes to support meaningful relationships that are locally and contextually constructed enables opportunities for real-world developments that are relevant to patients, relatives and staff within their local stroke unit contexts. This perspective avoids universal presumptions about knowledge, for example, a general definition of meaningful relationships or general attributes that a member of staff should adopt to be more relational. Instead, it enables a focus for the study on how to supplement the usual ways in which people on stroke units co-ordinate

themselves (i.e. local culture) that increases the value of meaningful relationships and supports pragmatic, sustainable practice developments (van der Haar and Hosking 2004; Crowther and Hosking 2005).

Finally, in keeping with a relational constructionist worldview, I have attempted to use a postmodernist discourse throughout this thesis. The main differences in discourse are outlined in Table 10.

	Modernism	Postmodernism
Scientific interest	Finding out/discovering how things really (probably) are	Co-constructing local-cultural realities
Theory/practice	Development and testing of theories	Practice/performance; theory as practice

Table 10: Differences between modernist and post-modernist assumptions (McNamee and Hosking 2012, p.35)

3.2.2 Critical worldview of knowledge construction

The second worldview that framed this study was a critical one. Critical theory is an umbrella term that challenges and changes the established habits, customs, illusions or coercion of social and political order (Kemmis 2001; Reed 2007; Longo and Dunphy 2012). Using a critical stance enabled this study to attend to common themes in healthcare relationships: the processes of relating and power dynamics; inequalities and hidden voices and; the political and organisational influences on opportunities for relational practice (Baxter and Brumfitt 2008; Luker et al. 2015; Tee and Newman 2015). It is of particular relevance to the objectives in this study for several reasons. Firstly, it enables a critique of local norms around hierarchy of knowledge, for example: theory over practical knowledge; scientific over experiential knowledge; professional over non-professional etc. (Kemmis 2008). Secondly, being informed by critical theory supports a co-participatory nature to the study where power dynamics within the research process are reflected on throughout the study (Kemmis 2008). Finally, it enhances understanding of

particular individual perspectives, social structures, cultures or norms that may impact on co-constructing new local practices (Reed 2007).

A relational constructionist stance views power differently to critical theory. In relational constructionism, power, habitual customs etc. are viewed as unfolding ways of relating linked to assumptions on self and other. *“Power is an ongoing, relational construction, able both to open up and to close down possibilities”* (Hosking 2008, p.671). If there is no self-other divide (as in relational construction), then power is constructed through co-constructing ‘power to’, in different but equal relations that is open and appreciative, in contrast to ‘power over’ (McNamee and Hosking 2012).

I found it helpful to draw on critical theory because power was a significant theme in previous research. Critical theory is often construed as negative, by imposing one’s own standards and critiquing others against them, whereas a critical orientation can also be construed as open and appreciative that aligns with relational constructionism (Hosking 2008). I used a critical orientation within a relational constructionist approach to ensure that the concerns around power inequalities in healthcare relationships were not overlooked; to help deconstruct habitual behaviours or language to facilitate multiple, equal realities and; to reflect on the realities and relations we were co-creating during the study (Hosking and Pluut 2010).

3.2.3 Pragmatism: knowledge guiding action

The relational processes of co-constructing knowing-in-action draw on pragmatism, which is the final worldview that framed my approach to this study. Pragmatism emphasises the need to experiment with knowledge created through real-life issues in a way that is participative and democratic (Gayá Wicks et al. 2008). In research, it is where both participants and researchers co-generate knowledge through a learning action process, summarised by Jan Reed as, *“truth is what works”* (Reed

2007, p.50). In research, it is a process intervening deliberately and actively within exploratory action and highlights experiential and practical forms of knowing (Friedman 2001).

I have engaged with pragmatism to support the exploration and experimentation of the praxis of relationship co-construction within the everyday practices on stroke units. To date, there is little practical contextual application of relational concepts specific to stroke units (McCormack et al. 2011; Dewar and Christley 2013; Papadopoulos et al. 2016). Pragmatism can contribute to this gap in knowledge by the co-construction of new knowing that integrates the application of relational theories in everyday clinical practice (Levin and Greenwood 2001; Gayá Wicks et al. 2008).

In summary, this thesis draws on predominately a relational constructionist stance because of its view of all human participation as a relational process and its synergy with the lifeworld-led approach. A critical and pragmatic influence brings a stronger focus on the praxis of relationship construction and practice change required of the research objectives for this study. Next, I will introduce the chosen methodology of appreciative action research, justifying its choice against the research objectives and within the epistemological worldviews described above.

3.3 Situating appreciative action research within action research methodologies

Appreciative action research (AAR) is part of a family of participatory action research practices and blends together the underlying assumptions of AR and AI (Reason and Bradbury 2008; Holloway and Wheeler 2010). AAR brings together a participatory approach engaging participants as co-inquirers, with a practical orientation to knowledge production and theory development through an explicit affirmative and strengths-based approach to change (Reason and Bradbury 2001; Egan and Lancaster 2005; Dewar 2011). To understand the origins of AAR, the key

concepts within AR and AI will be discussed first before concluding with a discussion on AAR.

3.3.1 Action research (AR)

AR is an eclectic family of approaches committed to generating knowledge and creating change, with the intention of social justice (Casey 2007; Reason and Bradbury 2008; Titchen 2015). AR is defined as,

“A participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes. It seeks to bring together action and reflection, theory and practice, ...in the pursuit of practical problems” (Reason and Bradbury 2001, p.1).

AR originated in the 1940s by social scientists, with the organisational development psychologist and philosopher Kurt Lewin as a key contributor (Reason and Bradbury 2008). There have also been influences from the Tavistock Institute with its origins in psychoanalysis and social psychology. Researchers across a wide range of disciplines including education, organisational development and healthcare have added to the philosophical development of AR, resulting in a variety of epistemological stances (Holter and Schwartz-Barcott 1993). These differences can be placed along a continuum between the interpretive and critical paradigms, with an overarching pragmatism to bring change alongside generating theory grounded in practice (Titchen 2015). The main characteristics of AR are summarised in Table 11.

Characteristic of action research	Description
Meaningful and practical	Actions are value-laden and aim to improve pressing issues in communities and organisations. Concerned with human flourishing (Greenwood and Levin 2006; Reason and Bradbury 2008).
Participation and democracy	Collaborative engagement, opening new communicative spaces. The transformation of power relationships for greater autonomy and democratisation of society (Greenwood and Levin 2006; Kemmis 2008; Herr and Anderson 2014).
Action-orientated	Emergent knowledge generation that links reflection and action or as a consequence of action, and theory and practice. Reflective evaluation and learning about the action (Greenwood and Levin 2006; Reason and Bradbury 2008).

Table 11: Characteristics of action research

AR has been mainly influenced by Jürgen Habermas’ work on critical theory and communicative action which is,

“The kind of reflection and discussion (communicative action) we do when we interrupt what we are doing to explore its nature, dynamics and worth”(Kemmis 2001, p.93).

AR researchers can use qualitative or quantitative methods, although AR sits within the qualitative research paradigm because it seeks to understand phenomena in context, while acknowledging the ‘real-world’ challenges in implementing change (Chenail et al. 2012). AR can encompass various methodologies that reflect different epistemologies, including: Co-operative inquiry; Participatory AR; Feminist AR; Action science; Collaborative inquiry and; AI. Other forms of AR have been developed based on the context in which the research is taking place; for example, workplace AR is heavily influenced by organisational development theory (Bradbury et al. 2008).

In healthcare, AR was first used in the 1970s and has steadily been increasing in popularity among healthcare professions (Waterman et al. 2001; Titchen 2015).

This increase in favour is linked to recognition of how AR can meet the challenge of bridging the gap of theory and research within clinical practice, and its overlap with organisational development, that lend it to supporting practitioner-driven organisational change and practice development (Waterman et al. 2001; Bridges and Meyer 2007; Hughes 2008; Kavanagh et al. 2010).

The process of AR is intuitive and emergent and often framed around a spiral of steps, with each step comprising of concurrent, multiple action cycles of reflecting, planning, action, and evaluating the result-in-action (Lewin 1997; Titchen 2015). These deliberate and explicit cycles are considered central to integrating theory and action (Coghlan and Brannick 2010). Reflection and evaluation in the AR cycles contributes to the rigour of this approach and tends to be a more explicit aspect when compared to AI (Egan and Lancaster 2005). Reflective and reflexive evaluation can occur at many levels:

- the participatory action process (e.g. politics, power);
- the practical aims and outcomes of the inquiry (e.g. will they improve pressing issues for those involved?);
- how much it engages with a wide range of epistemologies (e.g. presentational, experiential) and;
- whether it has achieved transformational change at an individual, group and organisation level (Reason and Bradbury 2001).

Criticisms of AR tend to arise from a positivist view with the claim of a single reality or truth. Some do not regard AR as a legitimate research method due to its lack of objectivity and pragmatic stance that focuses on action-orientated outcomes where the researcher deliberately and actively intervenes at a collective and individual level (Waterman et al. 2001; Kemmis 2008). The knowledge generated is unlike mainstream research studies; it privileges local knowledge that is characterised by practical wisdom, practical reasoning and implicit or tacit knowledge (Carr and

Kemmis 1986; Greenwood and Levin 2006). Drawing on multiple perspectives (in contrast to seeking a universal truth), enables participants to explore new ways of knowing that they may not have been able to previously see. It destabilises habitual ways of thinking, allowing opportunity for creativity and new collaborative learning that can be transformational and impossible to achieve through a positivist worldview (Cook 2009).

Another concern is the tension between theory and action (Gustavsen 2003). The tension appears to have arisen from the perception that if research is focussed on practical action, good quality research is lost, and vice versa (Gustavsen 2003; Herr and Anderson 2014). AR researchers tend to draw on pragmatism and constructionism for their counter-argument. They argue that research acts are conducted, and hence characterised by, those involved and the context in which it is conducted; and that research is not only concerned with outcome but can contribute to theory on design and processes. It is a highly contextual generation of new knowing and actions generated from that new knowing (Reason and Bradbury 2001; Gustavsen 2003).

AR predominantly has a problem-orientated view aimed at co-participation and improvement (Kemmis 2001). Although initial intentions of AR were wellbeing, flourishing of life and human aspiration, the problem-orientated view of AR has been criticised as being counter-productive by diminishing the capacity to create a sense of possibility to change because individuals can become defensive, conversations are stifled and hierarchies re-affirmed due to a deficit-focus (Cooperrider and Srivastva 1987; Ludema et al. 2001; Reason and Bradbury 2001). Appreciative inquiry (AI) was a conceptual reconfiguration of AR aimed at addressing these concerns (Zandee and Cooperrider 2008).

3.3.2 *Appreciative inquiry (AI)*

AI has been described as a theory, a research process and an organisational development method (Ludema et al. 2001; Barrett and Fry 2005; Cooperrider et al. 2005; Gayá Wicks et al. 2008). AI was first conceptualised by Cooperrider and Srivastva in the 1980s as a generative approach to their AR into organisational development. They reconfigured AR into AI as a response to the deficit discourse used in organisations that focussed on problems, human pathology and negative organisational performance (Cooperrider et al. 2005; Zandee and Cooperrider 2008). AI maintains the participatory, democratic, meaningful and practical characteristics of AR (Table 11), but has a fundamental shift in its critical (problem-orientated) perspective throughout the action process. Adopting an explicitly appreciative stance, AI re-aligns back towards the initial intentions of human flourishing in AR by co-creating new knowledge in relation; aiming to illuminate and give life to human systems and; increase the opportunity for creative collaborative change (Zandee and Cooperrider 2008). Cooperrider and Srivastva (1987) describe the contribution of AI to AR,

“(Action research’s) steadfast commitment to a problem-solving view of the world is a primary restraint on its imagination, passion, and positive contribution; that appreciative inquiry represents a viable complement to conventional forms of action research, one uniquely suited for social innovation instead of problem solving; and that through our assumptions and choice of method we largely create the world we later discover” (Cooperrider and Srivastva 1987, p.169).

AI is heavily informed by Gergen and Thatchenkery’s (2004) social constructionist generative theory as a catalyst for social change, alongside the power of metaphor for social transformation (Barrett and Cooperrider 1990). The constructionist stance of AI emphasises that social patterns and structures are co-created in relation with others, with reality considered to be multi-faceted and impermanent. Therefore, AI appears to hold knowledge generated through the process as being more dynamic than some AR approaches (Zandee and Cooperrider 2008; Stringer 2013).

The focus of AI is the *nature of inquiry*, (rather than outcome) about learning, understanding and valuing through appreciative conversations and relationships (Cooperrider et al. 1995; Bushe 2012a). The nature of the inquiry is grounded on five principles summarised in the table below.

Principle	Description
Constructionist Principle	As we talk, so we make. Words are formative in guiding how people construct the world, and in conversations together we create an organisational world that we then experience.
Simultaneity Principle	As we ask questions, so we become transformed. Inquiry and change are not separate moments. Inquiry is intervention.
Poetic Principle	As we choose topics of inquiry, so we open up new horizon of action. Teams and organisations are like an open book that is being constantly co-authored. Pasts, presents and futures are endless sources of learning and interpretation. Any one of these stories can be studied.
Anticipatory Principle	As we anticipate, so we create. The collective imagination and discourse about the future guides the current behaviour of individuals or organisations.
Positive Principle	As we discover positive moments, so we enjoy generative experiences. Momentum for change requires a large amount of positive affect and social bonding such as hope, inspiration, caring and the joy of co-creating.

Table 12: The Core Principles of Appreciative Inquiry (Barrett and Fry 2005; Cooperrider et al. 2005)

The constructionist view of AI advocates that the actual act of inquiry is also the intervention (Simultaneity Principle), it is self-fulfilling in that the questions asked, and the dialogue formed, creates a change (Simultaneity and Poetic Principles). Through learning, understanding and valuing it engages wonderment, creativity, innovation and vision (Anticipatory and Positive Principles) in the change process (Barrett and Fry 2005; Cooperrider and Srivasta 2005). Within AI there is a strong focus on authentic relationships between participants and what gives life to human existence, summarised as,

“AI most likely comes from embracing the polarities of human existence and that it is these tensions of those very forces that most give life and vitality to organisations” (Bushe 2011, p.19)

This focus within AI on authentic human relationships aligns with the research objectives of this study.

Recently, the underlying constructionist principles in AI have developed towards a relational orientation. In particular, the dynamic relational processes at work enabling vitality, collaboration and improvisation creating change (van der Haar and Hosking 2004; Zandee and Cooperrider 2008; Trajkovski et al. 2013a). Relational constructionism opens more opportunities in AI, moving from its reliance on written or spoken narratives in co-constructing realities towards the *relational processes* in co-construction (Bushe and Kassam 2005). This has a specific contribution to my study’s research and non-language ways of relating, for example, tacit and embodied ways of relating. A relational constructionist perspective views the body as integral to construction (action through embodiment) and as a *result* of construction (embodied response) (Hosking and McNamee 2007; Hosking 2011). These developments in AI have led to possibilities of alternative constructions of relational knowing that could apply to the embodied and tacit knowing described in the healthcare relationship literature.

The main process model for AI is the ‘4D’ cycle (Figure 4). The ‘4D’ cycle is based on iterative action cycles and has four phases: Discovery, Dream, Design and Destiny (Bushe and Kassam 2005). The phases are focussed on an affirmative topic, usually, but not always, chosen by the stakeholders in the process. Similar to AR, there can be a wide range of qualitative or quantitative methods used within the process (Watkins et al. 2016). The methods chosen aim to support all voices to be heard, and are therefore usually narrative methods to enable sharing of positive stories.

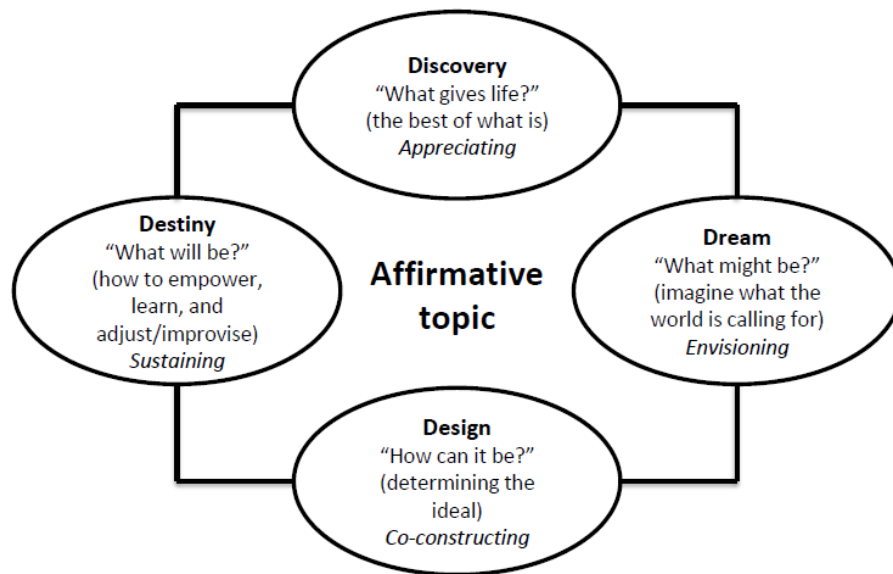


Figure 4: Appreciative Inquiry '4D' Cycle (Cooperrider et al. 2005, p.5)

There are different theoretical aims for each phase of the inquiry that are summarised in Table 13.

Phase of 4D cycle	Theoretical foundations	Application
Discovery	Interpretive	Observing and describing the best of what is. Often through story-telling.
Dream	Experiential	Through a reflexive and questioning approach, explore ideals of what might be. Seeks appreciation of the organisation.
Design	Normative and constructivist	Seeks practical knowledge through collaborative dialogue. Collective agreement on the desired future.
Destiny	Pragmatic	Seeks knowledgeable action, collective innovation and improvisation.

Table 13: Theoretical aims and application of '4D' AI cycle (Cooperrider et al. 2005; Bushe 2011)

Concerns around AI as a research method stem from a lack of understanding of the constructionist worldview and its philosophical intentions by both critics or those using an AI approach (Hosking and McNamee 2007; Titchen 2015). The main

criticisms of AI focus on its: (i) positive stance; (ii) ability to achieve transformational change and; (iii) methodological rigour.

The significance of the positive affect cannot be underestimated – elevating positive emotions is considered to be the vital first step in the change process, it increases relatedness, leads to a strengths based approach and energises to action (Cooperrider et al. 2005). Using an appreciative approach to organisational change has had positive results across different organisational contexts and project sizes, including healthcare (Reed et al. 2002; Smith et al. 2010; Bright et al. 2017). An overly simplified positive focus in some cases of AI have led to criticisms of the positive stance, invalidating negative organisational experiences; repressing conversations about concerns, and inadvertently maintaining power differences through more control to those who have positive voices (Grant and Humphries 2006; Zandee and Cooperrider 2008; Bushe 2011; Sharp et al. 2018). These criticisms stem from a polarised discourse between positive versus negative, or mysteries-to-embrace versus problems-to-be-solved (Fitzgerald et al. 2010). This polarisation can lead to distinguishing: positive as superior to negative and; we can do AI but we can't do AR, which is in contradiction to the constructionist views underpinning AI of valuing multiple realities and mutuality. Polarised discourses may also obscure unintended negative outcomes within AI (Fitzgerald et al. 2010). Bushe (2011) also cautions that transformational change will not occur from AI unless it addresses problems of real concern. In response to this, the 'shadow' in AI has been conceptualised. The shadow is described as censoring where experiences or opinions are judged not to align with the accepted culture or norms (Fitzgerald et al. 2010).

Critical theory may open possibilities to address these concerns. Although critical theory can be construed as negative and in contradiction to AI, a critical view (not being critical in a negative way) shares a similar epistemological foundation to constructionist theories. Critical theory can provide a framework for reflexivity and openness to ensure positive experiences are not valued over more negative ones,

and sensitise the process towards issues of power to be negotiated as the process of AI unfolds (Grant and Humphries 2006; Reed 2007). Being reflexive on the positive stance in AI will more openly acknowledge the shadow, making conscious the previously unknown or unvalued, and affirm multiple rather than polarised views (Sharp et al. 2018). Grant and Humphries (2006) have termed the application of critical theory to AI as 'Critical Appreciative Processes'.

The second critique of AI is regarding the potential of AI to deliver transformational change, with concerns that AI is just an organisational development 'fad' (Bushe and Kassam 2005; Jones 2010). Three reviews of published AI studies have been conducted, two of which were in healthcare (Bushe and Kassam 2005; Trajkovski et al. 2013b; Watkins et al. 2016). Two of the reviews (Bushe and Kassam 2005; Watkins et al. 2016) used qualitative evidence of transformational change to evaluate the success of AI. The third review (Trajkovski et al. 2013a) did not evaluate transformation. Evidence of transformational change was limited in both papers, and in Watkins et al. (2016) review of nursing studies, only one out of the eight AI studies demonstrated transformation. Bushe and Kassam (2005) commented that studies in their review demonstrating transformation tended to display the majority of key characteristics and principles of AI when compared to the studies that did not achieve transformation. This suggests that the nature of the AI process is important. Over-emphasis on the process of AI and the goal-orientated structure of the 4D-cycle reduces the process to co-operative action towards achieving collective goals (Kavanagh et al. 2010). To be transformational, there needs to be a stronger focus on the *nature* of the inquiry, the people involved, their shared human experiences and relationships that generates new knowing (Bushe and Kassam 2005; Fitzgerald et al. 2010; Bushe 2011; Bushe 2013). Further research into aspects that influence AI outcomes and the constructs of transformation are needed (Jones 2010; Bushe 2011; Watkins et al. 2016).

The final critique of AI is concerned with lack of methodological rigour and evaluation, with few papers evaluating the process of AI as a research method (van

der Haar and Hosking 2004; Grant and Humphries 2006; Bushe 2011; Clouder and King 2015). These concerns arise from applying modernist perspectives as a judgement-orientated activity to evaluate AI (van der Haar and Hosking 2004; Egan and Lancaster 2005; McNamee and Hosking 2012; Trajkovski et al. 2013b). For example, authors of a methodological review of AI studies described evaluation challenging due to a lack of reliable methods to measure change and methodological inconsistency (Trajkovski et al. 2013a). However, as previously discussed, rigid application of the AI process in search of methodological rigour limits transformational change (Fitzgerald et al. 2010). Van der Haar and Hosking (2004), within their relational constructionist view of evaluating AI, suggest a responsive evaluation which maintains multiple voices and emerging processes during evaluation. The main aspect of responsive evaluation is the adoption of critical reflexivity at many levels in the AI process (van der Haar and Hosking 2004; Grant and Humphries 2006).

In summary, both AR and AI intend to bring about change that is driven by a commitment to be humanly significant, with these commitments informed by relational, participatory and democratic orientations. Knowing is always gained in and through action with the researcher wholly engaged in the emergent nature of the inquiry (Cooperrider and Srivasta 2005; Reason and Bradbury 2008; Zandee and Cooperrider 2008). Drawing on the discussions around the strengths and criticisms of AR and AI and, in particular: the polarised discourse on deficit versus positive approaches in AR and AI; the relational focus of AI; and processes for feedback and evaluation, I have chosen to combine AR and AI into appreciative action research (AAR) to form the chosen methodology for this study.

3.3.3 Appreciative action research (AAR)

“Appreciative action research offers an integration of the generativity, imagination and attention to language of appreciative inquiry, with the focus on collaborative action, experimentation and practical orientation of action research. It uses the relationships between people to generate on-going dialogue and peer support, feedback and recognition of existing strengths

and assets, what is valued and active achievements from change processes, to both excite and incite further change” (Sharp et al. 2018, p.17).

It is not unusual to draw together different practices from within the diverse family of AR that bring different perspectives and priorities to a study (Cady and Caster 2000; Ghaye et al. 2008; Dewar and Mackay 2010; James et al. 2015; McKeown et al. 2016). AAR combines the principles of AR with those of AI, bringing together the strengths of each approach, whilst attempting to address some of their weaknesses (Egan and Lancaster 2005; Dewar et al. 2017b). Both AR and AI are informed by social constructionism, are collaborative, participatory and aim to create emancipatory change (Waterman et al. 2001; Cooperrider et al. 2005; Dewar and Mackay 2010). Both methodologies recognise the creation of new knowing and social innovation through action (Zandee and Cooperrider 2008).

A combined AAR approach seeks to address the limitations of each individual approach. It attends to concerns about the deficit-focus in AR, and the polarised discourse on positive versus deficit approaches. AAR adopts from AI an intentionally appreciative and positive focus to enable participants to explore and understand what ‘gives life’ to an organisation, what is valued and works well, whilst at the same time considering the ‘shadow’ by exploring concerns, fears or vulnerabilities in an appreciative and generative way (Cady and Caster 2000; Egan and Lancaster 2005; Bushe 2011).

Concerns about AI having less emphasis on evaluation of change, and less emphasis on the constructs leading to transformational change when compared to AR, can be addressed through the systematic practices of reflection and evaluation within iterative cycles in AR (Egan and Lancaster 2005; Ghaye et al. 2008). The way in which evaluation is approached is important, as there is the potential for incongruence around combining the modernist perspective on evaluation in some AR approaches with the contextual and constantly changing constructionist perspective (Egan and Lancaster 2005). Relational constructionism can contribute

to managing this tension. A relational constructionist view enables relational *processes* to be at the centre of (e)valuation through practices that value multiple and diverse voices instead of judgemental, critical, power-over processes of evaluation (Hosking and Pluut 2010; McNamee and Hosking 2012).

The processes of AR and AI have been combined in several ways to produce different models of AAR (Cady and Caster 2000; Egan and Lancaster 2005; Dewar 2011). Some AR studies have been informed by an appreciative approach, but not named the approach as AAR (Ghaye et al. 2008; Ross et al. 2014), so it may be more common than is explicit in the literature. AAR has not yet been used extensively in healthcare. One AAR model, developed by Dewar and colleagues, combined the '4D' cycle of AI with reflexive iterations between reflection and action, and has been successfully used in two large projects in health and social care (Dewar et al. 2011; Sharp et al. 2018). This model had systematic opportunities for feedback, reflection and valuing through appreciative dialogue at each phase of the '4D' cycle

The two projects by Dewar (2011) and Sharp et al. (2018) were both conducted over several years and demonstrated sustainable transformational change, with one study developing into a wider social movement in care homes (Sharp et al. 2018). Dewar (2011) used AAR in a three year study to involve older people, staff and relatives in acute hospital older people settings. The study demonstrated that staff participants could become co-inquirers that sustained practice developments, and the study developed new theory called the Caring Conversations Framework (Dewar and Nolan 2013). Both studies demonstrated co-participation and theory development that are described as key aims and characteristics of quality AR (Hughes 2008).

Dewar (2011) used authenticity criteria for constructivist research as a framework for reflection and evaluation for her study (Nolan 2003). This framework may have been a limitation of the study because evaluation was framed around

constructivism (rather than constructionism). In constructivism, evaluation is framed on *how* interactions (with a focus on language-based interactions) construct knowledge, which has a slightly different emphasis to constructionist evaluation focussing on how relational processes construct knowing, including non-language constructions like tacit knowing (McNamee and Hosking 2012). Since Dewar's (2011) study, there has been further conceptual development of relational constructionist (e)valuation, based on responsive evaluation, that was used to inform my study (Hosking and Pluut 2010; Hosking 2011). A relational constructionist stance considers quality or evaluation criteria as unreflexively passing judgement with universal ways to determine right and wrong (van der Haar and Hosking 2004; McNamee and Hosking 2012). Instead, (e)valuation aims to maintain relationally engaged practices (not hard self-other differentiation), that suspends certainty and maintains multiplicity, is appreciative rather than critical, and is situated in the locally context. This will be discussed further in Section 8.7.

On considering how AAR was to be used in my study, I reflected that the language used in the AAR models were unfamiliar in healthcare discourse and may have been less accessible to healthcare staff. Therefore, to aid engagement with the process, I changed some of the terms used in the AAR cycles. Dream phase was changed to Vision and, later on, the staff participants also referred to this stage as 'Goals' to help engage more staff in the process. The Destiny phase was changed to 'Implementation and Improvisation' to reflect more the processes at work in this phase. Evaluation was changed to (e)valuation to reflect the appreciative and relational constructionist stance taken to this part of the process. The AAR model used for this study is illustrated in Figure 5.

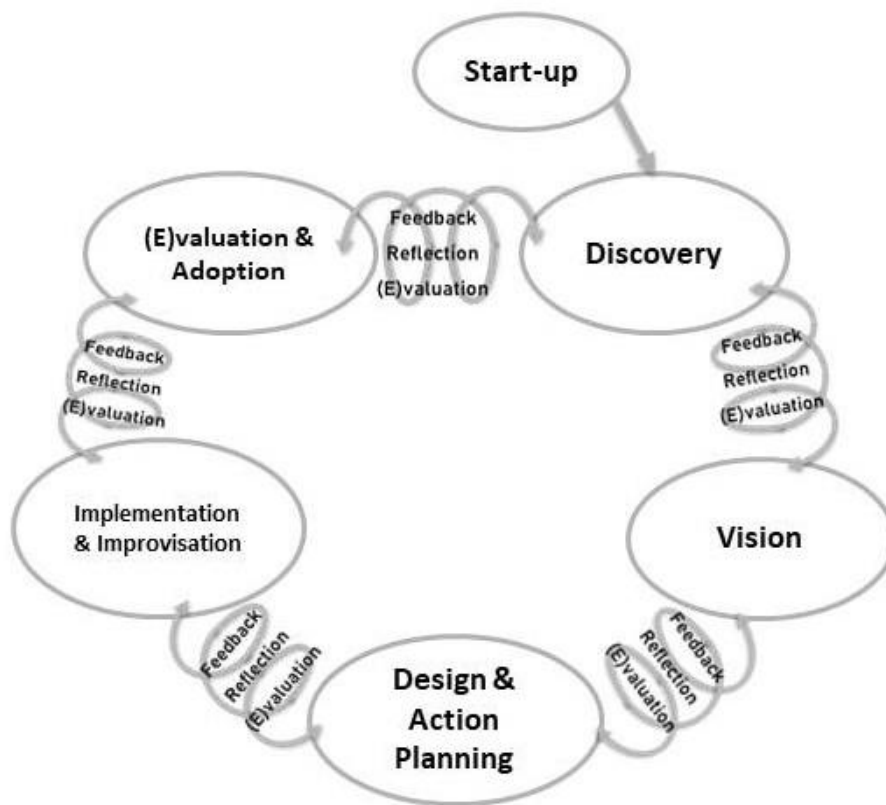


Figure 5: Diagram of the appreciative action research process adapted from Dewar et al. (2017) and Egan and Lancaster (2005)

Application of each phase in the AAR cycle used in this research is summarised in Table 14. Although the phases are described as discrete actions, the actual AAR process is messy, intuitive and emergent (Zandee and Cooperrider 2008). It is important not to lose sight of the AAR processes, while not tightly adhering to a process of phases and cycles that may close down communicative spaces and inhibit action (Cook 2009). As the research progressed, and our familiarity with the process improved, we found holding lightly the phases and cycles was key to nurturing relational practice.

Phase of AAR cycle	Application
Start-up	Introduction of the project to all stakeholders. Developing organisational commitment to the project.
Discovery	Observing and describing the best of what is, what is valued and what helps it to happen. Using feedback, reflection and (e)valuation to make sense of new discoveries, bringing positive practices to consciousness.
Vision	Through new understandings from Discovery, participants explore new opportunities and possibilities, creating a positive image what they want in the future. Using feedback, reflection and (e)valuation cycles to explore new possibilities and multiple perspectives.
Design & Action Planning	Co-creation of practical, real ways to value more often what matters and is most meaningful. Agreeing together how to achieve this.
Implementation & Improvisation	Trying out new practices that support new knowing. Using feedback and reflection to (e)valuate if new practices achieve their vision.
(E)valuation & Adoption	Using feedback, reflection and (e)valuation to embed new practices into habits, routines and cultures, and to consider how to sustain and support continue co-creation and learning.

Table 14: Description of the application of AAR phases

3.1. Appropriateness of the chosen methodology for the research

There are several key concepts within the epistemological and methodological foundations of AAR that align with this study's objectives (Section 3.1). Firstly, AAR aims to create new knowledge to inform practice - in this case knowledge of humanising relational practice on stroke units. Due to its pragmatic nature, and reflexive iterations between action and reflection, it helps to bridge the theory-practice gap by producing knowledge about practice within practice (Herr and Anderson 2014; Sharp et al. 2018). Definitive cycles of feedback, reflection/reflexivity and (e)valuation of the ongoing processes will make change more tangible for co-participants and, therefore, more available for knowledge construction (Waterman et al. 2001; Sharp et al. 2018).

Secondly, an active and deliberative appreciative stance to the inquiry process enables appreciation of current achievements, best practice and what is valued individually, as a team and the hospital organisation (Cady and Caster 2000; Egan and Lancaster 2005). Novelty, surprise and curiosity can emerge as creative disruption with an appreciative stance to the inquiry (Benington and Hartley 2004; Bushe and Storch 2015). There was, at the time of this study being conducted, a culture of problem-focussed organisational development in the NHS, with scepticism on the amount of transformational change realised (Bailey and Burhouse 2019). Additionally, discussing care experiences can be emotive, especially for staff who on the whole strive to ensure patients and their relatives receive the best possible care (Lowes and Gill 2006; Huynh et al. 2008). Using a relatively novel and appreciative approach aimed to reduce defensiveness associated with problem orientated methods, facilitate co-participants to look at their care experiences with 'fresh eyes', and assign new meaning to their care experiences to further develop practice (Ashburner et al. 1996; Scally and Donaldson 1998).

Thirdly, AAR has been described as a form of relational practice itself - an inextricable relationship between process and outcome in relational collaboration leading towards transformational change (Zandee and Cooperrider 2008; Bushe 2012b, 2012a). This aligns closely with the relational focus of the study's objectives, summarised in the following quote,

"An appreciative stance (in AAR) enables a more humanistic, authentic and relational approach to research and practice development that helps people to step out of their formal or ascribed roles and be more fully present with each other" (Dewar et al. 2017, p.121).

Relationship-centred practice is shared and relational; therefore an AAR methodological approach has synergy with the processes of humanising RCC through reflexivity, collaboration and collective action (Ospina et al. 2008; McCormack et al. 2015).

Finally, a relational constructionist stance to AAR enables a research process that engages with the intangible, tacit and embodied constructions of human connectedness alongside verbal and language based constructions, and uses these to inform the practicalities of co-creating relationships in everyday stroke unit practice.

The application of the AAR approach into the design of this study, and the practicalities of organising, conducting and analysing the data from this type of study will be discussed in the next chapter.

Chapter 4: Orientating towards human relationships

The previous chapter described the relational constructionist stance and the methodological approach of appreciative action research (AAR) as a resource for relational engagement to develop transformational change of humanising relational practice on stroke units. This chapter will describe the study design, the participants and recruitment process, how the study was conducted and the approach taken for data analysis. This will include my self-development as an AAR researcher in the skills and approach needed to support a high quality AAR process.

4.1 Overall design

This study had an AAR design and followed an adapted AAR cycle (Figure 5) that comprised of iterative cycles of: initial exploration and understanding of current practice; collaborative design of plans to develop practice and; trying out and evaluating new practices within reflective cycles (Egan and Lancaster 2005; Dewar 2011; Sharp et al. 2018). The iterative cyclical process continued until there was considered to be an understanding of the underlying processes supporting current relational practice. It was a collaborative, reflexive and emergent design that focussed on pragmatic outcomes to develop and describe valued humanising relational practices within the context of stroke units.

The study was conducted over two sites; both sites being in-patient stroke units in district general hospitals and caring for adults with acute stroke. The sites were selected for pragmatic reasons from the South West and Wessex regions. Stroke units in these regions were invited to show expressions of interest through presentations at regional Stroke Research Network meetings. I then visited the interested stroke units to discuss further with the clinical team the study aims, and to gain an idea of their enthusiasm and commitment to the project. Five sites expressed an interest. The reasons for exclusion were: one site was outside the

Wessex/South West region; another was already participating in a similar study on humanising care; and the third had an unusual organisation of their MDT due to a combination of elderly care and stroke beds on one ward. Both stroke units selected were 'combined stroke units' that are defined as,

"No separation between acute and rehabilitation beds.... (they) accept patients acutely but also provide rehabilitation for at least several weeks if necessary" (Hoffman 2007).

On the first site, the inquiry and data generation was carried out between April 2016 and August 2017 (16 months). The inquiry and data generation on the second site occurred over five months from August 2017 to December 2017. Data from the first site provided tentative principles and insights into processes that supported humanising relational practice that were explored further and evaluated in the second site. The flow chart below provides a summary of the process.

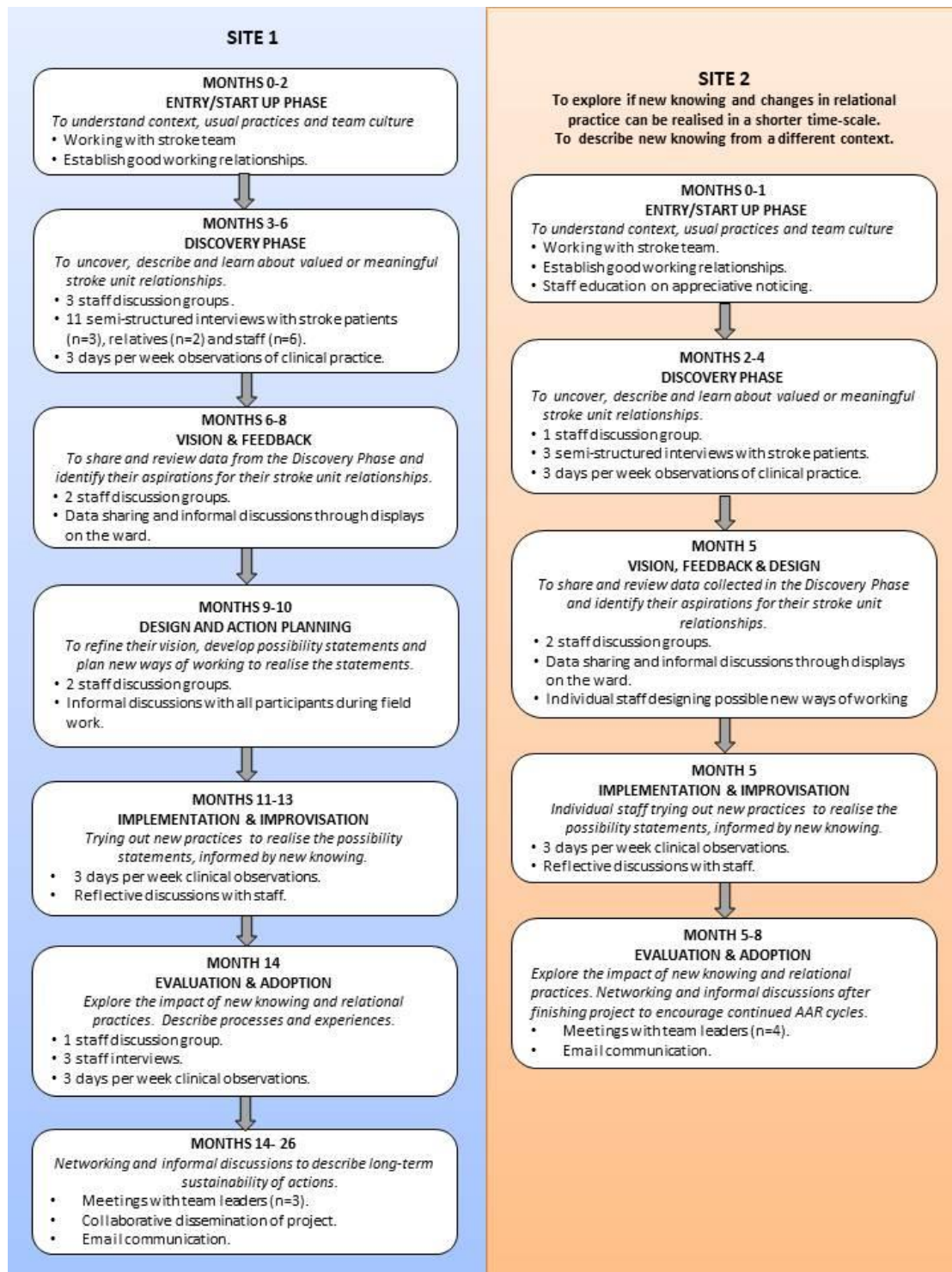


Figure 6: Flow-chart summary of the research process

4.2 Starting the conversation: developing aims and objectives for the study

Initial aims and objectives were written as part of the research protocol to secure funding and ethical approval. These were broadly developed in conjunction with stroke survivors from a local stroke survivor support group alongside conversations with clinical and academic colleagues. The participatory epistemology in AR study aspires to valuing the ‘researched’ community as part of the whole research process; including collaboratively working together to develop meaningful research questions (Brydon-Miller 2008). There was therefore a degree of discord between being true to a participatory research approach, while being unable to deviate too far from the original research protocol’s aims and objectives approved by the local Research and Development (R&D) departments and NHS Research Ethics Committee (REC).

There is a significance placed on ‘starting the conversation’ that sets the scene, or the principles on which the inquiry is based. There is a need to form an open communicative space that emphasises inclusivity and collectivism (the participatory nature) alongside the broadly constructionist view (that includes relational constructionism) where the inquiry is the intervention, starting with the first question asked (Kemmis 2008; Gayá Wicks and Reason 2009; Bushe 2012b). To support this open communicative space that enabled participants to identify their own research topics that were meaningful to them, I made a conscious effort not to present the detail of the aims and objectives already developed. Therefore, during introductory site meetings, I described my rationale for choosing a research topic on exploring relationships, regularly checking that this had resonance with the staff participant group. For example, these are comments from some staff participants at the start-up meetings,

“I can see how this study will establish partnerships in care in patients, I like the appreciative aspect” (S36 Doctor, Start-up meeting, Site 1).

“I like how the project will also look after staff, this is important for us” (S16 Nurse, Start-up meeting, Site 1).

“Patients are moving through too fast, you can’t develop a relationship with them” (S10, Therapy assistant, Start-up meeting, Site 2).

I then facilitated co-development of the specific study objectives with the research participants in the hope that the objectives were meaningful and relevant to their context. I was open for the research objectives to change and emerge as the study progressed, but also needed to maintain focus on the original research aim, which was:

To use appreciative action research with people after stroke, their family and the multidisciplinary team (MDT) to mutually discover their own understandings of valued relationships in stroke unit care and rehabilitation, and how their relationships can be enriched through this knowing.

The initial research questions developed were sufficiently broad to encompass any new directions of collaborative inquiry under the umbrella of relational practice, and were as follows:

- How do patients, their relatives or carers and staff on stroke units describe their valued relational experiences?
- How does the MDT describe positive inter-colleague relations that enable them to create and maintain relationships in clinical practice?
- What are the processes that enrich humanising relationships for all, and in particular focussing on patients with limited verbal communication ability?
- What needs to be in place for change to happen on other stroke units?

4.3 The community of inquirers

Three main stakeholder groups were invited to be part of a community of inquirers:

- (i) In-patients on the stroke unit (at the time of recruitment);
- (ii) Their family or informal carers, and;
- (iii) Stroke unit staff and managers.

All stakeholders had their individual experiences and knowledge of giving or receiving care on the stroke unit, and taking a relational constructionist stance, it was important to include and enable as many of these in different but equal relation (Hosking and McNamee 2007). Hence the criteria for inclusion into the study was broad, with exclusions based on ethical considerations of including people, for example patients who had communication difficulties or low levels of consciousness.

I was aware of the significance of the terms 'patient', 'relative', 'carer' and 'staff' within a co-participatory approach, in particular, the implied roles and hidden power differences within these terms. Yet all the stakeholders used these terms within their usual discourse, and when 'starting the conversation' I felt it was important to use a familiar discourse that all stakeholders could access and identify with. Therefore, I continued to use these terms throughout my fieldwork.

It was not possible to invite all stakeholders over the duration of the project, because the number of participants would have become too big for the time and resources of a PhD study. During recruitment of staff, patients and relatives on the stroke units, I made a judgement to also seek out those seldom held voices in stroke research – namely patients with impaired cognition and communication and nonprofessional stroke MDT team members (Brady et al. 2013; Clarke 2013). Therefore, the process of inviting stakeholders could be defined as judgment or purposive (Bourgeault et al. 2010).

As a researcher, I aimed to hold a participatory and relational constructionist stance, and learn together through inquiry with the stakeholders. I was a co-participant in the study, and so could be classed as the fourth stakeholder group in the community of researchers. My researcher position will be discussed later in this chapter.

4.3.1 *In-patients with a diagnosis of stroke*

The patient's role was to co-create knowing through interviews, conversations and observations of their care. 32 in-patients with stroke were invited and 17 patients agreed to participate. Different patients were recruited at different stages during the study as all decided not to continue in the study once they had been discharged from the stroke unit. The majority of patients were considered for recruitment as long as they were well enough to participate in one, or a combination of: observations on the ward; an interview; or discussion groups. Patients with communication or cognitive problems, or low levels of consciousness, were actively recruited as this was a particular research objective. The criteria for recruitment were as follows:

Inclusion criteria:

- a current inpatient, or discharged within the last 4 weeks;
- on the stroke unit at the point of recruitment;
- with a principle diagnosis of acute or recent (within the last 2 months) stroke;
- 18 years of age or over.

Exclusion criteria:

- Patients determined as too unwell by the consultant or stroke MDT responsible for their care.

Table 15 summarises the demographics of the patient participants. Participants from Site 1 had a more diverse range of ages, and included more with cognitive or communication difficulty.

Participant demographic	Site 1	Site 2	Total
Total numbers	10	7	17
Age (years)			
46-55	1	0	1
56-65	2	0	2
66-75	1	4	5
76-85	3	3	6
86-95	3	0	3
Sex			
Male	2	2	5
Female	8	5	12
Cognitive or Communication difficulty			
Yes	7	2	9
No	3	5	8

Table 15: Patient participant demographics

4.3.2 Relatives or informal carers

Relatives or informal carers of patients on the ward were invited to participate if they had been directly involved in the care or support of the person with stroke (i.e. not a distant relative) and visited regularly on the ward. Their role was to co-create knowing through interviews, conversations and observations of their care, and to review and comment on the core themes developed during field work. Other relatives or informal carers were not invited because those participating required a direct experience of the care that was provided by the stroke unit MDT, either for themselves or for their family member with stroke.

Fourteen relatives or informal carers were approached, with seven relatives and no informal carers agreeing to participate in the study. Similar to the patient participants, new relatives or carers were invited along the duration of the project as and when new relatives came onto the stroke units. The number of potential patient and relative participants was dependent on the patient turnover on the stroke units. It was, therefore, not possible to have a fixed recruitment number for

each phase due to the time restrictions of the study. The recruitment criteria were as follows:

Inclusion criteria:

- a family member or carer of a person with stroke receiving, or having recently received (within the last 4 weeks) care from the stroke unit;
- who has been directly involved in the care or support of the person with stroke and;
- is determined by the stroke MDT as a regular visitor and;
- is 18 years of age or over.

Exclusion criteria:

- considered by the stroke MDT as unable to contribute due to limited cognitive or physical capacity.

Table 16 shows the demographics of the relatives recruited to the study.

Participant demographic	Site 1	Site 2	Total
Total numbers	3	4	7
Age (years)			
56-65	0	1	1
66-75	2	0	2
76-85	1	3	4
Sex			
Male	2	1	3
Female	1	3	4
Relationship to patient			
Husband	2	1	3
Wife	1	2	3
Daughter	0	1	1

Table 16: Relative participant demographic

4.3.3 Staff

The entire stroke MDT and a small number of managers and hospital executives were invited to participate. The staff members' role was to explore, learn together and develop practice through interviews, observations of their usual practice, discussion groups and reflective/reflexive conversations in the field. The intention

was to include all staff members that were considered by their colleagues to be a part of the stroke MDT.

There was no fixed point to end staff recruitment, so if other staff fitting the recruitment criteria became interested in participating later on in the study they could be included. The recruitment criteria are listed below.

Inclusion criteria:

- leaders and managers who had an influence on the culture and operational processes on the stroke unit, or;
- hospital volunteers, or;
- members of staff that included: doctors, nurses, healthcare assistants, physiotherapists, occupational therapists, speech and language therapists, rehabilitation assistants, dieticians, ward clerks, housekeepers, hospital security, and;
- identified by the stroke unit MDT to be a principle member of the team.

Exclusion criteria:

- It was anticipated that visiting staff members to the stroke unit, for example, porters, phlebotomists, diabetes specialist nurses etc. would not be included in the study because they tend not to be considered part of the core stroke multidisciplinary team.

74 staff and volunteers were invited to participate, with 65 agreeing to be involved.

Participant demographic	Site 1	Site 2	Total
Total numbers	40	25	65
Age (years)			
18-25	10	5	15
26-35	10	7	17
36-45	4	5	9
46-55	13	3	16
56-65	3	4	7
>65	0	1	1
Occupation			
Nurse	16	6	22
Healthcare assistant	10	3	13
Doctor	3	5	8
Occupational Therapist	3	3	6
Physiotherapist	3	1	4
Therapy assistant	2	3	5
Manager	2	1	3
Ancillary staff	1	1	2
Speech Therapist	0	2	2
Healthcare experience (years)			
0-5	17	8	25
6-10	4	3	7
11-15	5	4	9
16-20	6	3	9
21-25	3	2	5
>25	5	5	10

Table 17: Staff participant demographics

4.3.4 Co-participant researcher and researcher positionality

A participatory and relational constructionist stance guided my researcher position but it took time to understand and integrate these concepts into my approach to the study. I was aware that practicing co-participation created tensions over the control of the research process, the action orientation of the research and whose voice is represented in the data. These tensions have been cited as common in AR studies (Hughes 2008; Ospina et al. 2008).

A participatory stance, with the aim of mutual development of knowledge, brought me into the study as a co-inquirer and provided a focus for my reflection and reflexivity (Hope and Waterman 2003). Being a co-inquirer enabled me to draw on my own lifeworld to co-construct the AAR with others (McNamee and Hosking 2012). I therefore engaged in cycles of reflection on my personal and professional experiences, values and perspectives to help me become more conscious of what I brought to the relationships, how I facilitated co-participation, and what impact this had on the research (Bodiford and Camargo-Borges 2014). These cycles of reflection were conducted with other staff participants in the study and with academic supervisors with expertise in AAR and co-participatory research. These reflective and reflexive processes were captured within my personal research diary, my academic supervision notes and within observational notes conversations with staff participants.

Relational constructionism further developed my participatory stance. It shifted the focus of my researcher position with participants towards the research process itself which, according to Hosking and Pluut (2010), enables a relational conception of ethics and responsibility. My relationally constructed researcher position and the position of the co-participants was, *"complex and evolving"* (Waterman et al. 2001, p.34) along a continuum of insider to outsider positions depending on: the particular phase and direction of the inquiry; the context in which, and how, relationships were co-constructed (Herr and Anderson 2014). During my reflection I regularly reflected, 'How do we begin / how are we making new knowing together?' and, 'What personal and team transformations are happening while making new knowing together?' This was in order to pay particular attention to the relationships and knowing that would be co-created through the project (Gayá Wicks and Reason 2009; Hosking and Pluut 2010).

In the beginning, I considered myself an outsider because I was not part of their team and lacked local knowledge of cultures and routines. My first experience

being with the team was a feeling similar to it being my first day in a new job. Being a newcomer enabled me to ask sometimes naive relational questions about the team, how they worked together and with service users, which I may not have noticed if I was already integrated into the team.

I also considered myself to be, to a certain degree, an insider because I was part of the same cultural group – a nurse who works in a stroke unit with knowledge of stroke care and the NHS system. Within the hierarchical culture of nursing, I was highly conscious that my clinical role as a consultant nurse could lead to the team considering me as an expert or assume me the role as a leader that could have a negative impact on the co-participatory nature of the study. I therefore introduced myself as a stroke nurse and emphasising I was a novice researcher who was there to learn with them about relationships on stroke units, alongside learning how to do AAR and complete my doctoral studies.

I invested a significant amount in developing initial relationships through spending time with staff, patients, relatives and carers, shadowing staff, and having social conversations on the wards (patients and relatives), in the staff room or at the nurses' station. I felt it was important to establish staff relationships through helping with the workload and, for example, I offered to help supervise patients or assist with giving out meals. One nurse said,

“Thank you for your help earlier” [Helping by supervising patients take their medication on her drugs round] when it is like this it is really appreciated.” (S121 Nurse, Observation notes, Site 2).

The relationships, and hence the subsequent participatory nature of the inquiry, were different on the second site. I did not have as much time to invest in relationships with participants before starting the AAR process. It was noticeable that staff and relatives were less relaxed and open in discussing their experiences compared to the first site. It highlighted the importance of investing time in

building relationships, and that this could be difficult to achieve in a short space of time, something that is also cited in the AR literature (Coghlan and Brannick 2014). This is explored further when discussing the data in Chapter 7:.

A key aspect of AAR is fostering open and appreciative communicative spaces to move beyond the personal self-interest towards its inclusive, collective and transformative aims (Kemmis 2008; Gayá Wicks and Reason 2009). This required being a facilitator (easing a process) and an animateur (enlivening and affirming) to hold a space for reflection, learning, creativity and action (Dewar 2011; McKeown et al. 2016). These aspects of the inquiry process are also explored in Chapter 7:.

With regard to researcher position, it is worth noting that initially I took on the role as facilitator and animateur, with four other staff participants adopting this role as the inquiry developed.

Fostering open communicative spaces required me to have a continual reflective and reflexive focus towards the how the study was being conducted, for example, when to listen, when to be more challenging, and to consider the language I used to ensure it supported the values of co-participation and AI. This is important for quality and trustworthiness of the research process (Hope and Waterman 2003). My focus on how the research process was managed was supported through personal reflective diaries, weekly discussion with supervisors and reflective discussions with staff participants. I regularly referred, and re-referred, to the humanising values framework and principles of AAR to frame my reflexivity and reflection. An example of this was how I responded to times of high workload on the ward,

Case example: The atmosphere on the ward was busy and felt strained. I noticed that there was hardly any social talk among the staff, patients or relatives. It appeared to me that the team was very focussed on their tasks to complete, and the patients did not want to trouble the busy staff.

I reflected on how the atmosphere of the ward (humanising dimensions of spatiality and mood) appeared to obscure opportunities to interact and develop relationships with others (staff, patients and relatives). I wondered if this solely because of their task focus. I reflected on what I thought I could do co-create opportunities to continue to value what is humanly meaningful at these times of high workload. I considered with my supervisor other perspectives, for example is it 'wrong' to have times like this? I reflected that I need to explore further others' experience of this when I next on the ward (Reflective diary, May 2016).

I tried to proceed with the research as a collective endeavour rather than an individualistic achievement for my doctoral study (Ospina et al. 2008; Bodiford and Camargo-Borges 2014). In reality there were some tensions between the 'action' and 'research' aspects of the study and sharing control of the AAR process. This has been discussed extensively in the AR literature (Israel et al. 1998; Karnieli-Miller et al. 2009). It was a challenge to marry my aspirations towards authentic participatory research, the pragmatic practice developments, the research expectations to make a contribution to new knowledge and evidence this through completion of my doctoral thesis. For example, this is an excerpt from my reflective diary,

'My position in the project will change through the study and at times I may need to be more directive to meet my PhD deadline. However I need to be open and flexible to what is important for the participants, for example the sister invited me be involved with responding to a complaint that led the inquiry in a different direction that was particularly relevant for the clinical leaders' (Reflective diary, March 2016).

Ultimately this led to me viewing the study as two parallel and connected activities – one being the action inquiry, and secondly my academic endeavours for my doctoral thesis. I tried to maintain my ethical responsibility to be participative throughout the entire research process, including conceptual developments and publications, by asking different staff participants to sense-check the work to ensure relevance with their stroke unit communities.

In summary, my research position reflected the relational constructionist, critical and pragmatic methodological groundings. Being reflective and reflexive was pivotal to maintain a participatory and humanly relational stance for several reasons: enhancing the ethical approach and awareness of control of the research process; ensuring human relational processes were attended to throughout the inquiry; contributing towards quality and trustworthiness; and diminishing the tensions over the action-orientations of the research (Ospina et al. 2008; Bodiford and Camargo-Borges 2014).

4.3.5 *Gaining access to the community of co-participants*

To gain access to the community of co-participants, I required site permission from the hospital NHS Research and Development (R&D) departments and NHS Research Ethics Committee (REC). Site access was facilitated through achieving adoption of the study to the NIHR Clinical Research Network Portfolio. The ethical aspects of this study were considered in detail as part of the NHS and University ethical applications. A summary of the key ethical considerations are:

- A favourable opinion from NHS Ethics and R&D approval was obtained prior to starting data collection (Appendices 2 and 3).
- Being a registered nurse, in addition to the principles of research ethics, I was bound by the Code of Conduct of the Nursing and Midwifery Council (2015).
- Data were stored and protected under the Data Protection Act (1998), the University of Bournemouth's Research Ethics Code of Practice (2014) and the sponsor, Royal Bournemouth Hospitals NHS Foundation Trust's protocols for data management.
- There was a possibility of observing or disclosing unsafe practices. The Nursing and Midwifery Council Code (2015) which required me to raise concerns immediately if patients or public are at risk. The study information sheets informed participants of my obligation to report any unsafe practices.

- There was a risk that discussions may be upsetting for some individuals, and plans were put in place for supporting participants (including myself) if this occurred.

The consent process had tensions between the informed consent process required for NHS ethics approval, and the reality of the consent within the evolutionary and improvisational processes of AAR research design (Barrett 1998b; Reason and Bradbury 2008). It was impossible to predict and specify the direction of inquiry and what practice changes will occur (Webb et al. 1998; Goodwin 2006). Therefore, I took an ethical stance to informed consent, described by Goodwin (2006) and Ospina et al. (2008) as involving openness, disclosure and continuous re-negotiation of the participants' involvement. In this study that meant checking for agreement to continue with the study when the direction of inquiry, or if the participant's involvement, changed (O'Reilly et al. 2011). All participants were regularly reminded that they were able to withdraw consent at any time for no reason and that this would not have any repercussions on their ongoing care or work. As part of the ongoing consent process, participants also had their consent verbally checked immediately prior to starting data collection.

4.3.6 *Patients with capacity to consent*

Using the study participant information sheet (Appendix 4), I shared all the relevant information about the study and any new knowing or new practice developments arising from previous AAR cycles that the patient had not been involved in. Although accurate and clear information-giving was ethically important for the consent process, I saw it not as a task that needed to be done, but rather another process of being in relation with the participants. When discussing the study, patients often shared experiences of meaningful encounters that enabled me to use them as examples of how they could potentially contribute to the study.

I was aware that many of the stages of informed consent have complex linguistic and cognitive demands and are not always easy to convey, even in the situation of a

non-vulnerable, healthy, well educated, and linguistically competent individual (Penn et al. 2009). I relied significantly on my previous clinical experience of communicating with people with stroke to inform my approach to information-giving. Patients were given at least 24 hours to consider taking part and, if they subsequently decided to take part, they were asked to complete a written consent form (Appendix 5).

4.3.7 *Patients with capacity alongside communication or cognitive problems*

Jayes and Palmer (2014a) warn that people with aphasia after stroke are particularly vulnerable when giving consent. The authors warn that researchers with limited understanding of aphasia may erroneously conclude that a person lacks capacity to give informed consent, or paradoxically, make an inaccurate judgement on a person's understanding of a study. These challenges in consent, described by Jayes and Palmer (2014b), can be reasonably applied to any person with communication or cognitive problems after stroke. For this patient group I relied heavily on my own past clinical experience, and the clinicians (predominately speech and occupational therapists) on the stroke units to support the information giving and consent process. I checked with ward staff if the patient required any communication support and asked for specific advice for each individual according to their communication ability. Often a staff member re-checked comprehension and consent to protect the patient from inaccurate judgements of understanding. Involving a second independent person during information giving and consent in those with severe communication or cognitive problems reassured me that ethically and legally (Mental Capacity Act 2005) every measure possible had been tried to support informed consent.

A supported communication information sheet (Appendix 6) and consent form (Appendix 7) had reduced simplified text with images to reinforce salient information, and were used when appropriate. I was aware of the limited evidence on effective strategies for supporting informed consent in those with aphasia that

suggested periodic pausing and checking for understanding was more effective than over-reliance on aphasia friendly materials (Kagan and Kimelman 1995; Penn et al. 2009).

4.3.8 *Patients lacking capacity*

For patients who did not have the capacity to consent due to low levels of consciousness, severe cognitive or communication problems, the patient's immediate next of kin was invited to offer their opinion as to whether the patient would object to being in this study in accordance with the Mental Capacity Act (2005). This particular group of participants were invited to contribute by having their interactions with others on the ward observed. The stroke team asked for the next of kin's permission to pass on their contact details to me, and I then followed a similar consent process to above, providing information on the study using the consultee study information sheet (Appendix 8), asking the next of kin to sign a consultee declaration form (Appendix 9) if they felt that the patient would not object. As part of the NHS ethical approval, processes were in place to gain post-enrolment consent if the patient re-gained capacity to consent during data collection (Appendix 10); however, this was never required.

4.3.9 *Relative consent*

Relatives were approached by the nursing or therapy team while they were visiting their relative on the stroke unit. If the relative expressed an interest in the study, the same consent process as for patients with capacity to consent was followed, using specific information sheets for relatives (Appendix 11).

4.3.10 *Staff consent*

The consent process for staff was similar to patients with capacity. All who showed an interest in taking part were given an information sheet (Appendix 12) detailing

the three data collection methods of observation, interviews and discussion groups. The information sheet emphasised that their choice to participate would not have any impact on their working environment.

Before starting data collection, and in particular observational data, I tried to check with all staff to be involved that they had signed a written consent form. Unfortunately, the very nature of observing clinical care on the ward resulted in me having little or no control over who entered the setting that I was observing. In those cases, I weighed up the risk to being unable to achieve full disclosure of information to all participants before they were included in the study versus the disruption to the setting and data collection if observations were stopped to obtain consent on each and every occasion. For those staff that joined an observation and had not consented, I ensured that I spoke to them immediately afterwards, gave them the study information sheet and asked for their consent to use the observational data. I did not process the data for at least 24 hours to give them due time to consider joining the study that enabled me to destroy data if they declined taking part. Fortunately this situation did not occur.

4.4 Attending to the ways in which relationships within the research process were created

This section will describe the forms of practice within the AAR methodology that aimed to facilitate co-creation of knowledge and practices that created possibilities for transformational change (McNamee and Hosking 2012; Bodiford and Camargo-Borges 2014). For ease and clarity of presentation, these forms of practice will be discussed using the framework of the AAR cycle (Figure 5) that was used to develop the research protocol required for funding, ethical and site approval. In reality the process was emergent, reflexive and responded to what was happening in the moment. Therefore, some action cycles were completed in a conversation, others took the entire duration of the project, and even cycles within cycles.

Because of its emergent and reflexive nature, it was important for the study to remain grounded in the worldviews of relational constructionism and lifeworld-led approach (Galvin and Todres 2013; Gergen 2009). I aimed for choices about the research process to be: a relationally responsive act; sensitive to the human experience (lifeworld); and constructing and negotiating knowing through the core AI principles summarised in Table 12 (Gergen 2009; Bodiford and Camargo-Borges 2014).

4.4.1 Data generation

There were several approaches used in data generation that were the same for both sites. Firstly, a narrative approach or storytelling through interviews, group discussions and informal discussions; and secondly, an ethnographic approach through observation of stroke unit practices captured within field notes. Table 18 summarises the amount of data generated.

Data generation method	Site 1	Site 2	Total
Semi-structured interviews	14	3	n=17
Staff discussion groups	8	2	n=10
Field notes of informal discussions & observations (hours)	290.5	110	400.5

Table 18: Total quantities of data generated by each approach

Multiple approaches enabled the exploration of different perspectives, engaged different participants, and allowed for flexibility of data generation that was responsive to the clinical context. An advantage of using multiple approaches was the minimisation of the limitations and partial perspective of one approach (Reed 2007). Combinations of all these approaches were used in every phase of the study, apart from the interviews that were only conducted in the discovery Phase. There were subtle changes in the focus of the approaches depending on the phase of the inquiry that are outlined in Table 19. The majority of data comprised of field notes of observations and informal discussions.

Phases		Approach to data generation
1 / 2	Entry and Start-up	Informal observations and discussions focussing on norms, routines, rituals, power relations and establishing relationships with participants. Discussion groups with service leads to introduce the study. Informal interviews with service leads to explore their views and values on relationships.
3	Discovery	Semi-structured interviews. Informal staff discussion groups. Informal observations and discussions. Focus on noticing and affirming positive and meaningful relationships.
4 / 5	Vision and Feedback	Story-telling of data from discovery phase in informal discussions and group discussions to explore relational values and what are meaningful relationships. Informal observations and discussions to explore further themes arising from discovery phase.
6 / 7	Design and Action Planning	Staff participant and researcher collection of informal observations. Discussion groups to agree on generate provocative statements or generative metaphors. Focus is on framing relational practice in new ways.
8	Implementation and Improvisation	Informal discussion and observations of trying out new practices to support meaningful relationships. Focus on creativity and improvisation.
9/ 10	Evaluation and Adoption	Discussion groups and informal discussion with staff participants. Focus on what has worked well, how to value and sustain new practices. Informal discussion with some staff participants continued for at least 18 months after study completion.

Table 19: Data generation in each phase of AAR cycle

The inquiry's focus on meaningful relationships within stroke units required a focus for data generation on how participants related and interconnected through subjective, tacit, affective and humanising dimensions in clinical relationships (Tresolini and The Pew-Fetzer Task Force 1994; Bridges et al. 2013; Waters and Buchanan 2017). It has been shown that healthcare workers, potentially reinforced through the medicalisation of UK healthcare, can have difficulty in articulating their caring knowledge, skills and experiences that tend to be embodied in nature (Nolan et al. 2004; Dahlberg et al. 2009; Dewar and Mackay 2010). My aim through using

multiple approaches was to create a range of opportunities to capture tacit and embodied knowing described as,

“when it cannot be explicitly articulated and when the body knows what to do without deliberation or forethought” (Kontos and Naglie 2009, p.689).

The same approach for the AAR cycles and data generations was used for both sites. The next section will describe in detail the processes undertaken in the first site, following by a brief description of the process on the second site that will focus on the differences in the inquiry process. The different timescales of the AAR phases are summarised in Figure 6.

4.4.2 Site 1: Contextual information

The first site was a stroke unit in a district general hospital in the south west of England. The hospital had around 470 beds. The stroke unit was a 31 bedded combined acute and rehabilitation ward, based within the elderly care division of the Medical Directorate. The bays had on average 7 beds per bay and were single-sex. There were four side rooms and separate doctors, sisters and therapy offices on the ward. There was a therapy kitchen and day room that doubled up as a therapy area that led out into a garden.

The team comprised of a core leadership team of two stroke consultants, a ward sister and therapy lead (physiotherapist). Junior doctors, nursing, and therapy teams were based on the ward along with a ward clerk and housekeeper. There were at least daily visits from speech therapy, pharmacy and discharge co-ordinators. All teams had staff vacancies and relied on temporary staff. A core team of a therapist, nurse, discharge co-ordinator and occasionally junior doctor met for a board round each morning to discuss patient flow. There was a once a week MDT meeting for formal goal setting.

4.4.3 *Phases 1 and 2: Entry and Start-up*

Access to the site and my changing researcher position has already been discussed above, therefore in this section I will focus on when field work started. For the initial two months of the project I worked alongside staff on the stroke unit for three days a week with the main intention to build relationships with all participants. I did this by purposefully remembering and calling all staff by name; by showing a genuine interest in them and their roles on the ward and; by sitting in the staff room with them at break-times to get to know them and share conversations about our lives outside of work. Building relationships was highly important for the success of the study, and I was therefore cautious not to form assumptions based on my prior clinical experience of working in a stroke MDT. I checked understanding with participants and during regular reflection with supervisors (Dewar and Mackay 2010).

A second intention was to become orientated to the team members, norms, culture and customs of the ward and the wider hospital organisation through informal observations, discussion and informal interviews with service leads. This was mainly achieved by shadowing several different members of the MDT, attending team meetings, handovers and ward rounds. I also read notices and circulars that were placed in the staff room. I regarded the orientation time as a key opportunity – it was the only time that I saw this service through ‘fresh eyes’, therefore I was conscious of the ‘surprise and sense making’ phenomenon which newcomers experience in unfamiliar settings (Louis 1980). These surprises were useful observations to help me ask curious questions during the later discovery phase of the study. I purposefully shadowed a diverse range of staff members in a range of activities on the ward, therapy areas and meeting rooms or offices. I focussed on how relationship dynamics, interactions and language changed in differing contexts within the ward and/or team.

A third aspect of this orientation time was for me to get to know the local research nurse and R&D Department. I felt that this was important as I would be a researcher in the hospital for over a year and, with my study being adopted by the Clinical Research Network portfolio, I had additional reporting obligations on recruitment. It was important for me that they saw me as a colleague, so that I felt more confident to ask for the help with recruitment or operational tasks (for example, booking a room for focus groups) in the future.

I was mindful that the initial questions asked would set the scene for the inquiry (referred to as the Simultaneity Principle in AI). This importance is described by Joy Peterson;

“Appreciative Inquiry teaches that language creates reality, and that change begins with the questions you ask. First, acknowledge that the act of inquiring is never neutral, it is in itself an intervention, and exerts some kind of influence. Secondly, the demeanour of the inquirer, as well as the wording of the question largely determines the answer; therefore, the responsibility for the outcome lies with the asker. In other words, you find what you look for. If you go looking for what's broken, you will find lots of broken stuff. If you look for what's working, you will find that most things are. What you focus on grows and expands. It confirms the wisdom of the old adage, ‘Be careful what you ask for, you'll probably get it!’” (Peterson 2003, p.1).

The main areas of focus to begin collaborative discussions on the inquiry included:

- What are your hopes and concerns about this study?
- Who do you think will be directly impacted by this study?
- What changes on the stroke unit does the team/you hope for?
- Who do you think needs to be involved? Who needs to be involved to add creativity to the process? Who needs to be involved for it to succeed?

4.4.4 Phase 3: Discovery

The purpose for the discovery phase was to uncover, describe, learn about and appreciate the most valued experiences on the stroke unit, the ‘highpoints’ when

staff, patients and relatives share stories of what was valued or meaningful in their daily practice (Cooperrider et al. 2005). In this phase, my intention was to facilitate and include many different, and equally valued, perspectives of experiences within the stroke unit context, with a particular emphasis on the Positive Principle in AI (Table 12) appreciation of the best of what is already happening (Hosking and McNamee 2007). The discovery phase generated the most amounts of data through observations, informal discussions, discussion groups and semi-structured interviews.

(i) Observation

Observations were recorded in the form of field notes during, or immediately after, an observation. Each observation lasted between one and two hours, with up to four observations for each day that I attended the stroke unit. They involved different times of the day, including weekends, evenings and part of night shifts. I observed interactions between the MDT and between staff with patients and/or relatives. MDT meetings, board rounds, team meetings, handovers, ward rounds, relative meetings, case conferences, therapy sessions along with usual ward care were observed. The observations were often conducted in collaboration with a staff member in order to alleviate anxiety or unease of being observed and to enable reflective discussions after the observation. As the study progressed and all participants became more familiar with my presence, formal arrangements prior to observations were required less, with staff often inviting me into interactions on the ward.

Observations were conducted as a participant observer; although I was not able to perform direct clinical care due to my local research contract, I engaged with those being observed (Reed 2007). While observing, I paid attention to the behaviour, language (verbal and non-verbal) and actions used to develop relationships. A powerful consequence of observing practice was the subsequent reflective and reflexive discussions with the participants that gave insights into the participants'

lifeworld and understandings of the experience and judgement of clinicians that informed their practice. I attempted to provide immediate feedback on any positive aspects of encounters that I observed to check my understanding and so that participants had a sense of the type of data I was noticing. Immediate feedback and reflection-in-the-moment (i.e. facilitating reflection during, or immediately after, an encounter) maintained an aliveness and direct application of clinical reflection that was a novel approach for staff. Sometimes this led to a more in-depth conversation of mutual sense-making, where interpretation went beyond our individual perspectives to bring together new learning or understanding. Engagement with various forms of knowing and sense-checking are cited as signs of quality and collaboration in AR studies (Friedman 2001; Cook 2009).

Observing was through both an appreciative lens and a lifeworld-led/humanising lens. It required skills of active noticing of what is working well (that I termed appreciative noticing); being generous and affirmative (not problem focussed); creating a sense of community with both commonality and uniqueness; and being attuned to my own embodied knowing of what is humanly meaningful (Barrett 1995; Newhard 2010; Galvin and Todres 2013). These took practice and a considerable amount of reflection to develop. When it was achieved, there was a sense of vitality or energy in the process as we started to understand and co-create new insights together.

(ii) Interviews

For ward-based participants, with the exception of two patients who preferred to be interviewed at their bed space, one-to-one interviews were conducted in a private room on the stroke unit. This protected against interruptions and provided confidentiality that was not able to be achieved with the other approaches to data generation. Interviews were at a pre-arranged time with most lasting around an hour. In total 11 interviews were conducted in this phase.

Three managers were interviewed – the Director of Nursing, Matron and Medical Director who also happened to be a Consultant on the Stroke Unit. This was a purposeful sample identified by the stroke unit team leaders and the Director of Nursing, who was responsible for care quality in the organisation. These interviews aimed to explore meaningful relationships and additionally to describe the organisational culture that may impact on the inquiry. It was also an opportunity to engage the wider hospital organisation in the inquiry which was beneficial for the support of future practice developments. The interviews were conducted in each manager's own office.

Interviews with all staff participants broadly followed the interview schedule (Appendix 13). It was based on appreciative interview questions developed by Cooperrider et al. (2005) to focus the interviewee on their positive experiences of human relationships on the stroke unit. Areas covered were: descriptions of meaningful experiences while on the stroke unit and exploring why they were meaningful; descriptions of how they felt during their meaningful experiences; and exploration of what enabled the meaningful experiences to happen; and what aspects of care on the stroke unit would you like to see happening in 10 years' time. Over time these questions were refined and changed to reflect the emerging data and evolving direction of the inquiry. The interviews were a space to allow for richer descriptions of individual participants' experiences of meaningful relationships. Within the interviews both photo-elicitation and emotional touchpoints were used to facilitate articulation and elaboration of the more nuanced and tacit aspects of relationships. These data generation methods are discussed in more detail below.

Photo-elicitation

Photo-elicitation involved using a range of images provided by me to support the research interview (Appendix 14.3). Three interviewees chose not to use photo-elicitation, preferring to have a conventional interview. Using images is a creative

research method used to encourage participants to contribute a richer data than if solely using traditional interview techniques (Olliffe and Bottorff 2007; Dewar 2012; Justesen et al. 2014). Images seem to facilitate the communication of abstract concepts and enable participants to access emotions and feelings beyond the usual verbal or written discourse (Justesen et al. 2014). Photo-elicitation has been used successfully in AAR and NHS practice development to understand experiences of patients, relatives and staff (Dewar and Nolan 2013; Smith et al. 2017). In this study, photo-elicitation not only facilitated participants conveyance of stories, emotions and meanings of their experiences; its' unconventional approach also created a sense of surprise that contributed to generating a positive energy for the AAR process (Cooperrider et al. 2005). Each participant was asked to choose an image from a range of 35 images taken from an online resource from NHS Education for Scotland (2012) developed to facilitate feedback using a relationship-centred approach (Smith et al. 2017). Some examples of the questions asked with the images are:

- Choose an image that reflects a memorable or meaningful experience on the stroke unit;
- Choose an image that reflects how you feel about being cared for on the stroke unit;
- Choose an image that reflects how you feel working here.

An example of an image that was chosen by a patient participant to describe their meaningful relationships is shown below.



"It's very difficult if you are having what they think are hallucinations. And you don't know what that means even. So it is very, very difficult. Holding hands, when it happens, is extremely important. It really is enormously reassuring and it makes you feel that you, you're OK. That life is alright and goes on, and you're not really going out of your brain. If people can tolerate it, it is terrifically important." (P02 Patient interview, Site 1).

Figure 7: Photo-elicitation image used to for data generation

Emotional touchpoints

Emotional touchpoints were also used in interviews for understanding of emotions experienced (Appendix 14.2) (Dewar et al. 2010; Odell 2014; Smith et al. 2017). Interviewees were asked to think about a key point in the patient journey or a key aspect of care or work, for example goal setting or talking to the doctors. They were then asked to select from a range of positive and negative emotional words that best described how they felt about the experience (see Appendix 14.2, Table A - 2). Two patient participants with communication disability who participated in discovery interviews did not have the vocabulary to use photo-elicitation. After discussion with the patients' speech and language therapist on effective strategies to support their communication, I chose to use emotional touchpoints in the interview. The emotional touchpoints were taken from the same online resource as the photo-elicitation cards (NHS Education for Scotland 2012). This method enabled the patient to have greater control over the direction of the interview by pointing to different topic or emotion cards without needing to rely on their verbal ability.

Including negative emotions in the emotional touchpoints enabled exploration beyond what is positive to what is valued and meaningful. Sometimes this was expressed negatively and then explored further by questioning with an appreciative lens, for example, helping interviewees to consider how they would *like* to feel. Emotional touchpoints have been described by Dewar et al. (Dewar et al. 2010) to be an effective approach in their AAR study to explore and articulate emotions of experiences in hospital settings that can then be used to directly influence practice developments.

All interviews were recorded and transcribed verbatim, including filler utterances (e.g. um or ahh) and pauses (see Appendix 15 for an example). A written summary of key understandings from the interview was shared and discussed with the participant within 72 hours of the interview. This was to clarify intended meanings and allow further exploration and discussion. The participant was asked verbally for permission for anonymised key themes or stories arising from their interview to be shared with other participants within the ongoing inquiry. Table 20 summaries the demographics of participants interviewed in the discovery phase in Site 1.

Patient	Sex	Age range	Communication ability	
P01	M	56-65	Severe expressive, mild receptive aphasia	
P02	F	86-95	Severe cognitive problems and hallucinations	
P10	M	46-55	Severe expressive, moderate receptive aphasia	
Relative	Sex	Age range	Relationship to patient	
R01	F	75-86	Wife of husband with recent stroke and dementia.	
R03	M	65-76	Husband of wife with reduced level of consciousness and cognitive communication problems	
Staff	Sex	Age range	Role	Years' experience
S36	M	36-45	Physician	21
S35	F	46-55	Nurse Manager	26
S34	F	46-55	Nurse Manager	23
S32	M	46-55	Staff Nurse	26
S18	F	36-45	Ward Sister	17
S14	F	46-55	Therapy Assistant	34

Table 20: Site 1 Discovery Phase Interviewees

(iii) Discussion Groups

The discussion groups were arranged by the clinical leaders in the MDT. They occurred either on the ward in the staff room and the therapy office, or in a meeting room elsewhere in the hospital. Three discussion groups of between six to eight staff from different disciplines in the stroke MDT were held in the discovery phase. The purpose of these groups was for the team to share their values, experiences and history of positive caring experiences and relationships on the stroke unit, and comprised of similar questions to those in the interview schedule (Cooperrider et al. 2005). Discussion groups complemented the observations, informal discussions and interviews as it was a space to share stories already generated (Appendix 14), to reflect and learn from these as a group that created openness to valuing different perspectives. Photo-elicitation and emotional touchpoints (Appendix 14.2 and 14.3) were used for part of the time to encourage attention towards their tacit knowing (Wilkinson 1998; Kontos and Naglie 2009).

At the start of the discussion group, all participants agreed ways of working for the meeting that included confidentiality and respect for others' opinions and values. I facilitated the discussion. Notes on the key points of the discussion were made on a flip chart or post-it notes and displayed during the discussion for participants to agree, change and refer back to. These notes became the field notes generated from the discussion group. The data generated in the discovery phase were used for reflective discussions and as a basis for the next phases in the inquiry.

4.4.5 Phases 4 and 5: Vision and Feedback

This next phase is usually termed the 'Dream Phase' (Cooperrider et al. 2005; Egan and Lancaster 2005).

"The dream phase is about generating new possibilities for the future that capture the heightened aspirations and positive affect generated during the discovery... they paint a compelling picture of what the human system could or should become" (Coghlan and Brydon-Miller 2014, pp.45-46).

From the outset I felt uncomfortable using the term 'dream' within a clinical context where a positivist discourse appeared to be more familiar and accepted, and I considered that it may even deter some clinicians from getting involved. In the AI literature the terms assigned to each phase of the cycle are not static and, therefore, I chose to use the term 'vision' that had been used previously in clinical settings by Dewar and Nolan (2013) and was a term I had heard more often used by staff participants.

During this phase, two main activities were occurring: firstly, to feedback the data generated in the discovery phase and collaboratively explore its meanings and; secondly, to surface participants' values and aspirations, to enable them to say what they really feel and want for their relationships on the stroke unit (Bushe and Storch 2015). These two activities enabled many participant voices to be heard, sharing what they cared about, and enabled a move towards a sense of community and collaboration through allowing each other to share their deeply held values.

The aim for these activities was to identify aspirations (visions) at a person and team-level for their stroke unit relationships (Cooperrider et al. 2005; Bushe 2011).

(i) Feedback

All participants had been involved in feedback through reflective and reflexive discussions in the discovery phase, however, this was an opportunity to feedback multiple perspectives from the emerging data to as many of the participants as possible. I tried to create opportunities for feedback that would fit into busy ward life. These included: displaying key quotes or themes with related examples in communal areas that could be accessed by all participants; five minute discussions at the beginning of staff meetings or handovers; longer discussions during coffee and lunch breaks in the ward staff room; and formal discussion groups (see Appendix 14 for examples). Field notes were used to record feedback discussions. I knew through some discussions with participants that displaying information resulted in staff, patients and relatives discussing the data while I was not on the ward. Although this resulted in me not capturing their discussions, I felt that it was important for the inquiry to generate these discussions and enable as many people as possible to engage with the data.

Patients and relatives had less involvement in this phase of the inquiry. Although they identified what was most valued in their stroke unit relationships through sharing stories, the changes were more long-term and it was difficult to gain feedback about change because of the high turnover of patient and relatives.

I arranged two discussion groups and invited staff participants to join if they would like to explore and discuss the data more deeply. I felt that it was important to have dedicated time to explore the data together as a team. Telling and hearing positive experiences of relationships provided deeper understanding, and new perspectives, to everyday interactions that everyone could hear and contribute to. For example, after sharing a relative's story about their experience of being in a therapy session, a physiotherapist said,

“Involving relatives in therapy sessions – we know that it is a good idea, but it is not always comfortable as I feel that the relative is watching you. But if you don’t involve them, it may feel to the relative that we take them away and do things to the patient, then hand them back at the end, with no idea of what we have done” (S25 Physiotherapist, Discussion group, Site 1).

Similar to previous discussion groups in this study, I summarised key themes from the meeting on a flip chart during the discussion to confirm my understandings from the group. With the permission of the group, I audio-recorded the discussion to check data.

(ii) Meaningfulness, values and beliefs

As discussions on the feedback of data progressed, staff participants started to think about what it was that made certain encounters and relationships meaningful to them, and as illustrated in the quote above, also to explore others’ lifeworlds. This was a key reflexive aspect of the inquiry, and was often observed as a ‘lightbulb moment’ when staff connected their values with how they felt about their practice. For example, a therapy assistant reflected on a meaningful experience,

“It was a unique experience, and I remember it even after all this time, it sits with me a lot..... We were all laughing, and the patients were laughing and engaging in the conversation too. We were talking openly, talking to everyone; it gave them the opportunity to join in if they wanted, to make them feel that they were not just patients. We were being human” (S14 Therapy assistant, Discussion group, Site 1).

Through feedback and exploring their values and aspirations, staff participants started to co-develop what was important to nurture and develop within their relational practice, which was their vision.

4.4.6 Phase 6: Design

This phase was a time for staff, patients and relatives to refine their vision. It was a time for staff to connect with current and past practices so that they could recognise a sense of identity, pride and identify culture and habitual practices associated with their values and beliefs. For patients and relatives, it was a time to reflect on their stroke unit experiences, what were the high points that they would

like to remain, and their wishes for other patients in the future. The overall aim of this phase was to look forward to, and design, a more positive and hopeful image of how stroke unit relationships could be in future (Cooperrider et al. 2005). This included valuing current good practice to maintain and nurture.

Design was not a discrete phase; instead, it developed from the feedback discussions with staff, or with patients and relatives within interviews and conversations on the ward. The focus of the conversation was to facilitate how participants *could* be, or what needs to be in place, to support what they have identified as most meaningful to their relationships or practice. One activity used to make explicit these aspirations for was staff participants developing aspiration or possibility statements, also termed provocative propositions (Barrett and Fry 2005; Bushe 2011) about their relational practice. Staff then planned new ways of working, or affirmed current practice, to realise these statements.

(i) Developing possibility statements

In the AI literature possibility statements have several aims:

- To be affirmative;
- To challenge the status quo, common assumptions and routines, i.e. they are provocative;
- To bridge past successes with future possibilities – the best of what is with the best of what might be and;
- A set of principles or commitments about how people want to work together
- Be grounded in reality and written in the present (Ludema et al. 2001; Cooperrider et al. 2005; Reed 2007).

Limited time with the staff participants in discussion groups resulted in this part of the process being curtailed by staff needing to get back to clinical commitments. I

therefore worked with the data and generated 19 statements drawn from data on participant (staff/patient/relative) discussions around stories of meaningful relationships. I wanted to ensure opportunity for staff to engage with this process if they wanted to and, therefore, developed the draft statements sitting in the staff room, at the nurses' station or ward day room so that I could check the wording of statements with staff as they were being developed and they could join me if desired. Most staff engaged by being curious about what I was doing. I also felt that developing the statements on the ward helped me to remain grounded in their context.

The 19 draft statements were discussed and refined further into seven statements (Appendix 17) during two discussion groups and several informal discussions with staff during coffee breaks in the staff room.

4.4.7 Phase 7: Action planning

This phase occurred at the same time as developing the possibility statements. It was a collaborative process in either formal or informal discussion groups. Staff participants were encouraged to draw on their new understandings and to be playful and creative about ways to develop their practice. Using stories from the data we explored the barriers and facilitators to achieving their desired relational practice. For example, after a participant sharing a recent experience, or reading a story that I had captured during my observations, we framed our action discussions around: 'What enabled this (relational experience) to happen in that particular moment?' and; 'How could we create more opportunities for this to happen again?' Exploring the barriers and facilitators helped staff participants to translate their aspirations into possibilities for their practice. Sometimes it led to generating more creative and novel suggestions to change practice. For example, we had one discussion about how they could continue to share memorable experiences that surfaced human relationships, and how not everyone had the opportunity to engage with stories. Ideas ranged from: organising regular team reflection;

incorporating stories into teaching or; drawing on the one team's love of cake, putting stories into fortune cookies that could be given to colleagues as gifts.

4.4.8 Phase 8: Implementation or Improvisation

The focus of this phase was to try out new ways of working through implementation and improvisation, grounded in new ways of knowing. There are important distinctions between implementation and improvisation. The AI literature associates the latter with successful transformational change (van der Haar and Hosking 2004; Bushe and Kassam 2005; Bushe and Storch 2015; Watkins et al. 2016). Implementation correlates with traditional change management and is described as focussing on an end result, a specific tangible change. It is suggested that this has the potential to 'close down' possibilities or impose one particular construction (van der Haar and Hosking 2004; Bushe and Kassam 2005); whereas improvisation can have many continuous and sometimes disparate changes that are linked to a bigger intangible change. Improvisation is described as self-organising, relationally responsive, change as a way of being rather than an end result or outcome. It is described to open up new possibilities in the present moment (van der Haar and Hosking 2004; Bushe and Kassam 2005; Bushe 2011). Improvisation has similar attributes to humanising values in terms of being present-centred, relational-process focussed, and without a clear sense of what is unfolding (Todres et al. 2007). The main attributes of improvisation are summarised in the table below.

Characteristic of improvisation	Description
Expansive competence	Interrupting habitual patterns and conventional practices through self-reflexiveness; being able to experiment.
Retrospective sense-making	Acting without a clear sense of how things will unfold, and based on what has already happened. A reflexive monitoring of action.
Minimal structures for maximal flexibility	Allowing for freedom to express considerable diversity and creativity. Attends to the process rather than the outcome.
Interdependence	An ongoing social accomplishment, emergent and elusive, brings together multiple perspectives towards a mutual orientation. Includes supportive behaviours like mentoring, listening, encouraging.
Values errors as a source of learning	Embracing 'being on the edge of unknown', and the errors that can come from this, rather than relying on over-planned strategies.

Table 21: Attributes of improvisation in AI (Barrett 1998)

This phase was an ongoing, emergent process that was, at times, difficult for me to see because, as a co-participant, I was also immersed in the process. Data for this phase were developed through reviewing my reflective diaries on how I perceived our practice was developing, and when decisions were taken try different approaches; reflective discussions with my academic supervisors and; reflections with staff participants after they had tried out new ways of working, recorded as field notes.

Activities of implementation and improvisation both aimed to be faithful to the agreed values and vision of relational practice. In reality, the staff participants tended to adopt an implementation approach to their actions. This was unsurprising, as this was the usual way in which they developed practice in their team. Our experiences aligned with the authors cited above. Our action planning appeared to focus on tangible practice changes which did not nurture the intangible, nuanced and constantly changing relational aspects of their practice. Therefore, there were many mini action cycles of reflexive iterations between experimenting with new ways of working and evaluation through observations,

informal reflective and reflexive discussions that generated new learning and tinkering with new ways of working. This phase also required facilitation to maintain curiosity and openness alongside encouragement to take risks and try out new ideas more indicative of improvisation.

4.4.9 Phases 9 and 10: Evaluation and Adoption

Data generation comprised of one discussion group, three interviews (Table 22) and informal observations alongside reflective discussions. Approximately 15% of the staff participants were involved in these final phases. The discussion group and interviews were audio-recorded and transcribed verbatim, with a written summary of key understandings shared and discussed with the participant within to clarify intended meanings and allow for further exploration and discussion.

Staff	Sex	Age range	Role	Experience (years)
S21	F	26-35	Healthcare assistant	12
S25	F	26-35	Physiotherapist	10
S03	F	36-45	Physiotherapist	13

Table 22: Site 1 Evaluation Phase interviewees

The focus of this phase was to review changes to relational practice up to that point, explore with staff the impact of developing their relational knowing and relational ways of working, and understand how they could be sustained and nurtured. Moore (2008, p.219) summaries the purpose of this phase as, *“learning, empowering and improvising to sustain that future”*. It was important that any evaluation adopted the same appreciative, constructionist and participatory stance used throughout the inquiry so far. Therefore, I sought to facilitate ‘appreciative evaluation’ and ‘responsive evaluation’ that tried to describe and understand different constructions rather than explain and resolve them into global conclusions (Reed 2007; McNamee 2012). The types of questions asked were questions of value and appreciation, and the ways in which others responded to the staff participants’ locally-constructed relational knowing (Appendix 18). For example, one staff member described how, through developing her relational knowing, she viewed a

colleague's practice differently, valuing her colleague's different approach with similar intentions and values to her own.

At first, the staff participants found it difficult to describe the largely intangible changes that had occurred. It was helpful to frame the question of evaluating the project on how they would communicate the project to new members of their team, or as a presentation to colleagues in other departments.

4.5 Moving towards relational practices across stroke unit settings: Site 2

The aim of conducting a similar inquiry on a second site was to explore whether transformational changes described in the first site could be realised in another stroke unit, and in a timescale that would be realistic for services to implement in a non-research context. It was anticipated that the learning from the first site could inform and focus the direction of inquiry with the potential to reduce the amount of time to achieve change.

The approach to the inquiry was the same as for the first site, following the same phases of the AAR cycle, but over a smaller timeframe of five months, compared with 16 months in the first site. After providing a contextual description of Site 2, I will briefly describe the phases and the main differences to those previously described for the first site.

4.5.1 Site 2: Contextual information

The second stroke unit was in district general hospital in the south west of England. The hospital was slightly smaller to site one with around 400 beds. The stroke unit was a 22 bedded combined acute and rehabilitation ward based within the Elderly Care Directorate of the Medical Directorate. The bays had on average five beds per bay and were single-sex. There were three side rooms and separate doctors',

sister's and therapy offices on the ward. There was a day room with a large table for MDT meetings, a patient kitchen, and a separate quiet room for meetings with relatives. The speech therapists' office and therapy gym were on a neighbouring ward.

The team comprised of a core leadership team of three stroke consultants (one long-term locum), a ward sister and therapy lead (occupational therapist). Junior doctors, nursing, and therapy teams were based on the ward along with a ward clerk and housekeeper. There were at least daily visits from pharmacy and a specialist palliative care nurse. There were no staff vacancies during the project. The team met together each morning for a handover and once a week for a MDT meeting where formal rehabilitation goals were set.

4.5.2 *Phases 1 and 2: Entry and Start-up Phase*

In this phase, the introduction of the study and participant recruitment was the same as Site 1. The exception was staff participants were invited to be involved in data generation from the outset to gather positive stories in the discovery phase. This was to explore if it was practical and feasible alongside their daily work and whether sooner engagement and more participants noticing positive practice, would facilitate the 'Simultaneity Principle' (Table 12).

Staff participants who were willing to be involved were given their own notebook to record observations and reflections. I provided group and individual guidance on appreciative noticing and using their emotional and embodied response to attend to what was humanly meaningful. Staff members were asked to record what they felt was important, meaningful or touched them. There were guiding questions written in the notebooks to support their recording (Appendix 19). We agreed that the notebooks would remain confidential, but to serve as their own aide memoir when sharing stories in focus groups or reflective conversations.

4.5.3 Phase 3: Discovery Phase

The aims of the discovery phase were the same as for Site 1, the difference being that from the beginning staff participants were jointly involved with me in gathering observations and stories from their own practice (in the first site this occurred several months into the inquiry). One participant commented on the discovery process that indicates a reflexive and reflective element and some of her challenges,

“It feels like we’re all warming up to the study and starting to notice things in ourselves and others, but we recognise it takes time to get used to appreciating and sharing these” (S104 Manager, Observation notes, Site 2).

For data generation, I had a slightly different focus to the staff participants during the discovery phase. I was more focussed on the processes: how the project was formed by the team, and any different perspectives to what had been described on the first site. One discussion group and three patient interviews (Table 23) were conducted by me. I attended the ward three days per week to support the staff in their discoveries, and conduct my own observations and informal discussions.

Patient	Sex	Age range	Communication ability
P104	F	75-86	Normal
P105	F	76-86	Variable receptive comprehension with slow processing of verbal information, limited verbal ability.
P106	M	66-75	Normal

Table 23: Site 2 Discovery Phase interviewees

4.5.4 Phases 4 to 6: Vision, Feedback and Design

During feedback, it became evident that the staff, although willing, had collected very few stories to share with others. We recognised that their appreciative noticing was obscured, and they all cited very different reasons for this, both personal and work-related. For example, these are comments from the staff participants about appreciative noticing,

“Some of the nurses are very objective and say that they don’t do this warm and fuzzy stuff” (S122 Junior Sister, Discussion Group, Site 2).

“I’m not sure I observed anything from the ward round. I was thinking about the process. I liked how the consultant checks in with us all about his decisions. It is very collaborative” (S104 Manager, Observation Notes, Site 2).

Therefore, data predominately generated by me, were fed back to the participants using the same activities as in Site 1 to generate conversations to explore their relational knowing.

4.5.5 Phases 7 to 8: Action planning, implementation and improvisation

Within the limited timescale of the project, there was less opportunity for action planning, improvisation and evaluation compared with the first site. Most staff participants focussed on discovering activities, and remained needing facilitation for their appreciative noticing. Four staff participants appeared to develop their appreciative noticing more easily, and took individual mini reflexive action cycles, captured in my field notes during discussions with them. However, these did not have the opportunity to ripple out into team-based action and improvisation.

A significant impact on these latter phases was: firstly, reduced time to form relationships with most of the team that may have resulted less trust in me as a facilitator and; secondly, some of the MDT were in the process of internal organisational changes that were having a significant negative impact on the team dynamics and morale, for example this therapist told me,

“I feel undervalued, I feel vulnerable.... Normally I’m quite confident, but not this week [because of the changes]” (S106 Speech therapist, Observation notes, Site 2).

“We are being watched more, we have more stats to complete, even when we are not with patients. Then there is open visiting. Relatives sometimes watch us, and tell us we are doing something wrong (if they have a caring background), I find that hard.” (S102 Therapy assistant, Discussion Group, Site 2).

This dominated discussions within the team and diminished the staff participants' energy and creativity to develop practice through improvisation.

4.5.6 *Phases 9 and 10: Evaluation and Adoption*

On evaluation, in comparison to the first site, staff changes in their way of thinking or being were in the early stages. Therefore, any transformational change could be tentatively described at an individual rather than group level.

The second site contributed new learning on the processes and timescales to conducting an AAR approach in a short space of time. The discovery phase provided valuable insights into relational practices with a different stroke MDT, confirming similarities and providing new perspectives. The next section will describe how the data from both sites were analysed to generate new knowing.

4.6 Sense-making and generating knowing

To emphasise the unstable and contextual character of generating knowledge in AR (Greenwood and Levin 2006), I have chosen to use the term 'knowing' instead of 'knowledge'. A constructionist stance in AAR views practical wisdom, practical reasoning and tacit knowledge as central characteristics to co-generating knowing (Carr and Kemmis 1986; Greenwood and Levin 2006). Hence in AAR, the processes by which participants make sense of their data are equally valued as academic activities of data analysis. In this study, data analysis was not a single point in the research process, instead it was a fluid and continuous process. Analysis occurred in every action cycle in collaboration with the participants through sense-making, which generated new data that led to further analysis. Analysis used a relational constructionist and lifeworld-led lens, with the key orientations outlined in Table 24.

Relational constructionist lens	Humanising lifeworld-led lens
<p>Analysis occurs with participants and is conducted to give space to multiple different, but equal realities by holding uncertainty and using minimal structures to support improvisation.</p> <p>Relational constructionism makes explicit the <i>processes at work</i> that participants use to construct relational realities. It is less concerned with what is co-created, but how relational realities are co-created.</p> <p>The focus of analysis is the communication used to construct relational realities. Relational constructionism tends to emphasise language-based communication, but can include any act or artefact used to construct a communication.</p>	<p>Analysis has an existential focus (what it means to be human, guided by the Humanising Value Framework (Table 7))</p> <p>Analysis focusses on the lived experience, and is open and flexible, moving back and forth between the sense of the whole and its parts.</p> <p>Analysis occurs through giving space to <i>embodied relational understanding</i> – the lived body’s role in understanding and creating meaning.</p> <p>A humanising lifeworld-led lens makes explicit <i>aesthetic dimensions</i> of being in relation with one another. Aesthetic dimensions can be described as one’s felt sense, tacit or embodied knowing.</p>

Table 24: Relational constructionist/Humanising lifeworld-led lens to data analysis (Dahlberg et al. 2009; Hosking and Pluut 2010; McNamee and Hosking 2012; Todres 2007)

To maintain transparency in the analysis process, I carefully documented processes and changes to analysis (including rationale), and who collaborated with which parts of the analysis.

There were two main stages of the analysis:

1. Organising data so that they could be easily communicated, experienced and discussed with others (Reed 2007) and;
2. Interpretation so that elements of meaning, rather than simply content, are described (Savin-Baden 2004).

The stages within these processes had both collaborative and researcher-led elements that are summarised in the table below.

	Collaborative (including researcher)	Researcher-led (with regular member-checking)
Organising data	1. Ongoing identification of meanings, values and aspirations from continual data generation.	1. Ongoing feedback leading to reflexive discussions to explore participant perspectives on what is valued.
	2. Sense-making of themes and patterns through dialogue with participants.	2. Collating and summarising narratives to ease accessibility for participants.
	3. Agreement on possibility statements and themes to inform actions.	3. Generating themes and possibility statements for review by participants
		4. Chronological organisation to identify any logical connection between events across sites.
		5. Coding of main themes of data generated from both sites that aligned with the research questions.
Interpretation of data	4. Collaborative interpretation to frame the data as elements of meanings rather than solely descriptions.	6. Analysis across sites to summarise processes across settings and those specific to each setting.

Table 25: Procedure of analysis

4.6.1 Sense-making

The primary aim of sense-making in AAR is to reduce and interpret the meanings and, through dialogue with the participants, make sense of the themes and patterns discovered in the interviews and discussion group (Cooperrider et al. 2005). Collaborative sense-making aimed to maintain relevance to current practice on the stroke unit and allow ongoing opportunities for checking interpretation of the data. Therefore, sense-making also contributed to the rigour of the study (Titchen 2015).

Transcribed data from all data generation activities were summarised into vignettes or stories (Appendix 14, Figure A- 4) These were shared either through conversations or displayed on the ward which allowed for further reflection and discussion among participants and helped to organise the participants' experiences into collaborative sense-making. These stories,

“had inherent integrity or coherence in that they could be isolated as discrete units that address some kind of individual or social action, and they reflected the context in which the action took place”(Kikooma 2010, p.43)

The sense-making process was iterative, leading to more understandings, more perspectives on the same story in which others then would become part of the same story. I recorded this sense-making process in my reflective diary, further organised the data into themes and took new themes back to the participants to check interpretation.

(i) Aesthetic sense-making and embodied relational understanding

Both lifeworld-led care and AI refer to tacit, aesthetic and embodied form of knowing, with this more explicit within lifeworld-led theory. To attend to the tacit, embodied aspects of human relationships during analysis, I drew on Todres’ (2007; 2008) aesthetic dimension of sense-making. Todres described aesthetic sense-making as a responsive felt-sense of the heart *and* the head, that is,

“not just a personal cognitive process but requires the participation of the ‘lived body’ as an authenticating or validating procedure. Such lived body participation is always ‘more than words can say’, and the experience of ‘sense-making’ involves an engagement with a kind of language that is bodily and sensorily involved” (Todres 2007, p.31).

Within lifeworld-led theory, Todres (2008) and Galvin and Todres (2013) developed the concept of aesthetic sense-making when considering the type of knowing that can guide humanly sensitive practice in complex and unique situations that they termed ‘embodied relational understanding’. This form of analysis is especially relevant to this study’s research objectives (Section 3.1).

Therefore, analysis focussed on data that were emotionally impactful or elicited an embodied response (felt-sense) for either myself or the staff participants. This informed what to focus on that was humanly meaningful. For example, this nurse

was talking to me about a second group of stories that were displayed on the ward notice board,

*“I don’t think that these stories are as strong as the first ones (the first stories displayed), some of the stories on the first posters meant more to me”
We then explored together why the first set of stories meant more to her.
(S121 Nurse, Observation notes, Site 2).*

4.6.2 Immersion/Crystallisation

After the initial, predominately collaborative, sense-making and theming processes (stages 1 to 3 in Table 25), I then conducted independently a secondary analysis using a process of Immersion/Crystallisation to further summarise and group themes across the data from both sites (stages 4 to 6 in Table 25) to answer the research questions (Borkan 1999). Immersion/Crystallisation is intuitive and engaged, described as requiring, *“to hear, see and feel the data”* (Borkan 1999, p.180) and aligns with the aesthetic sense-making and embodied relational understanding in lifeworld-led theory (Todres et al. 2007).

Immersion/Crystallisation involved a systematic, iterative process in which I immersed myself in a portion of the data; reflected on the analysis to articulate insights or themes noticed in the immersion process (crystallisation); next these were considered within the context of the original data; and finally discussed with the participants to ensure that meaning and relevance to the participants was maintained (Reason and Bradbury 2008). Regular discussions with my research supervisors on my analysis supported the crystallisation process, highlighting possible alternative interpretations. Table 26 shows an example of this process.

Pass	Purpose	Questions asked	Processes recorded in NVivo
First Pass	Read while 'holding' any preconceptions. Notice key insights, themes, patterns, emotions or surprises.	What is this section of data about? Who is involved? What are they trying to say? What is the overall story/ the big picture? Where was my responsive felt-sense while reading this?	Annotating data Memos linked to data
Second Pass	To notice specifically themes from the first pass.	Where is the evidence to support / against the themes? Why am I reacting to the text the way I am?	Memos linked to data
Third pass	To re-check the text. Using photo-elicitation to create metaphors of the inferences developed from previous passes.	Have I missed anything not referred to in the themes? Are there any alternative interpretations? Do the metaphors provide alternative insights?	Key words and concepts were added to the possible themes. Metaphors and images added to the linked memos.
Fourth pass	To notice specifically themes relating to processes to support relational practice.	What ways of knowing are being uncovered? How are these ways of knowing explored and developed? Who is involved and how?	Annotating data Memos linked to data
Fifth pass	To reflect with participants the developed themes from previous passes.	Do these themes resonate with you? Are they relevant to your context? How do you feel about what you read? Do you have any alternative interpretations?	Re-wording and re-grouping of themes.

Table 26: Passes of Immersion/Crystallisation completed during analysis (Borkan 1999)

The NVivo 11 qualitative software tool aided managing such large quantities of data and facilitated the re-organising of the data-sets for different sequences of analysis, while preserving the linked annotations, memos and images from each pass. My

reflective research diary was also transcribed into NVivo so I could code my diary and link it to other data-sets that supported transparency of my influence and contribution to the analysis.

The sequence for analysis was: (i) individual data-sets (individual interviews, discussion groups, an interaction or encounter); (ii) participant level data-sets (data grouped according to individual staff, patient or relative participant) and finally; (iii) chronologically that was concerned with the effects of interventions over time. Each data-set involved the same process outlined in Table 26. An example of how the analysis developed is shown below (Table 27).

Original data	Researcher's initial insights, patterns or themes	New knowing from discussion with participants
<p>"For me, my face always tells what's happening, so when I've got so much to do I've had to really re-train my face to look like - I am really listening to you, because I'm not fully. I probably should be listening more effectively, but I've got so much going on in my head, I'm processing what I'm doing next, and they teach you not to do that don't they, but I'm still finding that quite hard."</p> <p>(S18 Nurse, site 1)</p>	<p><i>Pausing from usual tasks to really listen, immersing in the moment.</i></p> <p><i>Quietenning the list is really hard to do. Maybe it is about learning to live with the list and not let it become all consuming?</i></p> <p><i>What does this mean when tasks take over? It depends on the situation, it is necessary sometimes. But if done all the times, it feels like an opportunity is lost.</i></p> <p><i>I'm not sure I am able to always quieten the list.</i></p> <p><i>How can you get support to quieten the list and support for the way you feel if you are not always able to listen how you want to?</i></p>	<p>Many describe times when they are 'lost in the moment', that lead to a sense of a strong connection.</p> <p>Experience helps to manage the list. I feel responsible for those with less experience. How can we help them?</p> <p>What is important to me may not be as important to others, they may not see it as a priority. Sometimes I understand that. If it is really important I will find someone with similar values to me, who will understand how it feels. How do you know who these people are?</p> <p>Actions from this project can't be 'another task'; they feel different and need to be done differently.</p>

Table 27: Example of individual data-set analysis and participant discussion

During the analysis above, several insights and themes were grouped together when there was similar meaning. An example of the grouping of themes is shown in Table 28.

First analysis themes	Secondary analysis grouping of themes
<p>Focussing on the patient first and not the task.</p> <p>Momentarily pausing from tasks can mean so much to others.</p> <p>Making a personal promise not to rush with patients.</p> <p>Treat people as people, despite the targets.</p> <p>Noticing patient's cues can help them feel more comfortable.</p>	<p>Creating moments to be with a person, not only what I need to do or what we are here for.</p>

Table 28: Grouping of themes

During a secondary analysis, the themes were grouped together to reflect the knowledge and processes to support humanising relational practice. Analysis continued to use a relational constructionist and lifeworld-led lens. In addition, I also used an extended epistemology of ways of knowing in AR (Heron 1996; Heron and Reason 2008), and the principles of AI (Cooperrider et al. 2005). This was to help focus on and articulate the processes at work, and to maintain being open to the many different ways in which relating can take place. The key principles are summarised in Table 29.

Extended Epistemology of ways of Knowing in Action Research	Principles of Appreciative Inquiry
Experiential knowing The experience of one's presence in relation to presence of others. This knowing is tacit, and pre-verbal as well as sound, solid and vibrant at the moment of the experience.	Constructionist Principle 'Words create worlds'- Co-creation of realities through words, our conversation, symbols, metaphors and stories.
Presentational knowing Emerges from, and articulates, experiential knowing. Shapes experiential knowing into a communicable form (e.g. through the arts, storytelling etc.). Can be constrained by language and propositional knowing.	Simultaneity Principle Inquiry and change are not separate undertakings. The questions asked shape what is discovered and what people pursue.
Propositional knowing Knowing 'about' in cognitive, intellectual terms e.g. ideas and theories. Essential for naming what it is like to be in the world, in order to achieve action. Need to be careful not to create monopoly of knowledge, or power-over.	Poetic Principle Teams and organisations are human inventions that are made and re-made, we can choose any topic to learn from. The topic chosen is itself a decisive act about how we want to grow and expand.
Practical knowing Knowing in its fullness is consummated in and through agency and action. New skills and knowing that lead to transformative change.	Narrative Principle The act of sharing and co-constructing stories about positive experiences initiates powerful interactions and relationships from which grows co-operation and desire to change.
	Positive Principle As we discover positive moments, the more opportunities there are to create and sustain a generative discourse that is essential for capacity to change.

Table 29: Analysis of Processes - Extended Epistemology of Knowing in AR and Principles of AI (Barrett and Fry 2005; Cooperrider et al. 2005; Heron and Reason 2008)

Using multiple theories and concepts, with similar intentions and some overlap, served, *“as fluid and flexible resources for action”* (McNamee and Hosking 2012, p.77) that is synonymous with a relational constructionist approach.

Details of themes generated from secondary analysis are shown in Table 30. These final themes were shared initially with two of the staff participants and later within a discussion group of eight staff participants to confirm meaning and relevance within their context (Reason and Bradbury 2008).

Key knowing or process	Themes
Human connectedness supporting well-being	It felt like a different relationship. Helping us to feel better while on the stroke unit.
Sensitising to experiences	Noticing what matters to us both. Being with a person, not only what I need to do or why we are here.
Sharing and reflecting	Connecting through stories. Connecting through sharing experiences. Reflecting on what is meaningful. Being open and curious to other perspectives.
Trying out new practices	Keeping it informal. Having the freedom to act in a relational way.

Table 30: Secondary analysis of processes that support relational practice

4.7 Trustworthiness of the inquiry

A broader discussion on this study’s trustworthiness and rigour can be found in Section 8.7. In this section, I will focus on the processes relevant to this chapter on data generation and analysis. Trustworthiness in AAR is explored in the interrelating of research, action and reflection (Altrichter et al. 1993; Webb et al. 1998). Consistent with my chosen methodology, I took a constructionist lens to assess the trustworthiness, in which the data are always partial and contextual (i.e. not fixed nor universally valid), and the active construction of new realities is itself an interpretation, and in need of interpretation (Gergen 1999; Aguinaldo 2004; McNamee 2010). Therefore, fixed criteria by which to examine the quality of AAR is avoided, instead there is a focus on its moral and ethical concerns. Within AR and

Al there are five areas to consider: (i) relational processes, (ii) reflexivity, (iii) multiplicity of knowing, (iv) real-world relevance and (v) transformational change. These are summarised in Table 38. Each point will be considered in turn, referring to the study design, except for transformational change which is an outcome of the research process and will be discussed in section 8.7.

4.7.1 Relational processes

With regards to study design, relational processes focus on upholding the participatory nature of the research, in particular whether the study is explicit in developing a praxis of relational participation (Herr and Anderson 2014). The co-participatory and relational approach to the study has been discussed in section 4.3 on how I co-created a community of inquirers.

Another aspect of the quality of the relational processes was transparency as part of the collaborative and researcher-led interpretation of the data (Fossey et al. 2002; Herr and Anderson 2014). With a constructionist stance, it was important that the research process and data analysis were clearly explained to and engaged the participants who were collaborating in the interpretation of the data to inform their actions. Within this study there were clear processes of feedback and collaborative sense-making in the analysis that described in Table 25.

4.7.2 Reflexivity

Reflexivity is the cornerstone of quality in AAR (van der Haar and Hosking 2004; Roddy and Dewar 2016). It is described by Finlay (2002, p.532) as a, *“thoughtful, conscious, self-awareness”* that encompasses, *“continual evaluation of subjective responses, intersubjective dynamics, and the research process itself”*. In AAR it is not just the researcher reflecting on their values, perceptions, and influence on the process, but also the participants as part of the action cycles in relation with each other (Roddy and Dewar 2016).

Within this study, reflexivity was integrated into many aspects of the process. In the inquiry itself, reflexivity was encouraged through being curious and open to explore different perspectives that were evident in the style of questioning during the inquiry. The action cycles facilitated reflective and reflexive discussions with the staff participants at regular points during the inquiry. In particular, at the point of feedback of data by reading stories, reflecting on them and how we saw ourselves in relation to the stories.

Personally, my reflective diary and reflective discussions with my supervisors (recorded in supervisory notes) were a record of the direction that the inquiry took, that detailed a rationale for changes in direction, my attempts at a participatory stance to the inquiry, and my changes in self as the inquiry progressed. This was important when considering my role and behaviours as facilitator, and the process requiring me to have an explicit appreciative stance. For example, below is an extract from my research diary early on in the inquiry that reflected on my previous experience as a nurse that I brought to the inquiry alongside learning a new appreciative perspective to clinical practice.

"I am trying to change my thinking towards an appreciative stance. Sometimes I find it really hard to find positive interactions on the ward. There is also a tension with my experience as a stroke nurse, my professional responsibility as a registered nurse and my new roles as a researcher and facilitator – I find it really hard not to intervene if I see poor practice or a staff member struggling due to lack of experience. I've also noticed that I find problems exciting and intriguing, there something in me that is energised by trying to fix problems. How am I going to let go of this?" (Researcher reflective diary, April 2016).

In addition to my supervisors, when I developed closer relationships with staff participants we engaged in mutual reflective discussions to inform our collaborative interpretation. These discussions were important in highlighting our felt (embodied) response to a situation or story and the co-construction of

relationships. This had two benefits. Firstly, they supported one of the research outcomes as a process that enhanced sensitivity to embodied relational knowing. Secondly, it was an opportunity to share our feelings and different embodied responses that supported the reflexive process.

4.7.3 *Multiplicity of knowing*

Transparency allowed for multiplicity of knowing in non-hierarchical ways by making the development of new theory as a collaborative activity (Hosking and McNamee 2007). By developing relational knowing as a collaborative activity through sense-making, and attempting to keep the data and analysis as open and available as possible, it enabled participants to access and understand how their knowing contributed to overall theory development. This aligns with the participatory values of AR that are considered be significant for the trustworthiness of AR studies (Herr and Anderson 2004). On reflection, this collaboration was achieved further with staff participants than patients or relatives who were not involved for the whole project, and therefore having awareness of their contribution to overall theory development was limited.

4.7.4 *Real-world relevance*

Real-world relevance is concerned with whether the research is grounded in the everyday concerns of the co-participants (Hope and Waterman 2003). For this research, spending time in the start-up phase exploring what was important for all stakeholders, and not imposing a set of research questions on them, was important to ensure what we were researching was relevant to their stroke unit context. Cycles of reflection alongside action enabled us all to keep checking its relevance. For the researcher-led part of the analysis that used Immersion/Crystallisation (Table 25), the staff participants were involved in regular sense-checking of the analysis. Transparency of the Immersion/Crystallisation stages and how themes were developed enabled the staff to have a critical and reflective dialogue with me

on each stage of the analysis, which supported relevance and credibility to their context (Savin-Baden 2004; Morse 2015). Therefore, transparency enabled the new knowing and theory to have relevance and credibility with the participants (Hughes 2008).

4.8 Chapter summary

This chapter has described how the worldviews of relational constructionism and lifeworld-led theory have underpinned the AAR process used in this study. The data generation activities that led to participants attending to the ways in which meaningful relationships were co-created were described through the different phases of AAR. The AAR phases were collaborative, reflexive and emergent, and focussed on pragmatic outcomes to develop valued humanising relational practices within the context of two stroke units. Throughout these phases and data analysis, lifeworld-led theory informed the inquiry into the tacit aspects of relationships. Finally, the quality of data generation and analysis was explored through examining the trustworthiness of the study, provided through examples of reflexivity and transparency. The next three chapters will discuss the themes developed that described valued relationships on the stroke units, and the processes that supported humanising relational practice.

Chapter 5: Co-constructing meaningful relational experiences on stroke units

5.1 Introduction

5.1.1 *Overview of analysis and discussion of data*

For ease and clarity of presentation, the data are presented in three chapters to respond in turn to the research questions (Section 4.2). The first two chapters relate to: a) the knowing co-constructed by patients, relatives and staff of what are meaningful relationships within the context of their stroke units; and b) how they co-created opportunities for meaningful relationships in day-to-day encounters. The first chapter presents data on the relationships between patients, relatives and staff, with a particular focus on patients who have difficulty communicating verbally. The second chapter focusses on staff working relationships within a MDT. The third chapter relates to the processes and orientating themes that supported transformational change, described as a freedom to respond relationally.

It is important to emphasise that the data and thematic categories are all inter-related and inter-dependent, reflecting the co-created and co-dependent nature of being-in-relation with others. The data and themes on meaningful stroke unit relationships co-developed during this study are relevant to patients, relatives and staff alike. A relational constructionist stance is taken in these chapters to explore the knowing and process between patients, relatives and staff.

5.1.2 *Chapter introduction*

This chapter presents the data predominately generated in the discovery phases Figure 5 over both sites, and focusses on the first research question:

How do patients, their relatives and staff¹ on the stroke units describe meaningful relational experiences?

Participants described moments of human connectedness within their relationships on the stroke units. Human connectedness was particularly meaningful for participants as it led to feelings of well-being. This is described as the overarching theme of *moments of human connectedness supporting well-being*. Using the data presented here, I aim to capture the variety of meaningful relational experiences described and observed in relationships, communication, individual preferences, and cultural norms within the stroke units. The data are organised by the thematic categories of: (i) Knowing who I am; (ii) They're our extended family, and; (iii) Opening up possibilities (Table 31).

There were equally as many negative, as well as positive, experiences described or observed. Although the more negative data were not disregarded, within the appreciative principles of the study, they were reframed into affirmative conversations, and hence most of the data presented here will be interpretations with an appreciative lens.

Overarching Theme	Main themes	Sub-themes
Moments of human connectedness leading to well-being	1. 'Knowing who I am, not only why I'm here'	1.1 Noticing and mentioning uniquenesses 1.2 Life beyond the stroke unit 1.3 Attending towards others
	2. 'They're our extended family'	2.1 'No them and us' (mutuality) 2.2 Open and informal 2.3 Responding relationally
	3. Opening up possibilities	3.1 Being present-focussed 3.2 Sharing experiences 3.3 Co-creating stories

Table 31: Thematic categories for meaningful relational experiences

¹ Patients, relatives and staff are collectively called participants in this chapter.

5.1.3 Introduction to data concerning patients with verbal communication difficulties

During this chapter, I am going to focus at times on relational experiences when verbal communication difficulties are present. This is because little is known of the impact of patients' verbal communication difficulties on the relationship dynamic within the context of stroke units, and to date, most recommendations for developing therapeutic relationships in practice have focussed on verbal communication (see Section 2.5).

All participants reported that communication difficulties, a low level of consciousness, confusion or hallucinations as a result of stroke, impacted on forming relationships. For example, all participants (with relatives to a lesser degree) described feeling worried about misunderstandings in their interactions. One patient described his previous communication impairment as, *"devastating, especially when trying to communicate with my family."* (P01 Patient, Observation notes, Site 1). Nurses and doctors particularly described a lack of time available to spend with those who had difficulty communicating verbally,

"If I just could have 15 minutes to sit and talk to them (patients with communication difficulties), if I could get them to smile if they have had a bad day, that would be amazing" (S20 Nurse, Discussion group, Site 1).

"It's really hard on my ward round when they (the patient) can't communicate. It's hard to recognise them (the patient) when I only see them for 10 minutes" (S36 Doctor, Observation notes, Site 1).

These data are consistent with descriptions in other qualitative studies into acquired brain injury and stroke (Nordehn et al. 2006; Gordon et al. 2009; Lloyd et al. 2014).

The vast majority of the sub-themes for *human connectedness supporting well-being* were the same, regardless of patients' communication abilities. There were some notable differences in the data between patients with or without

communication difficulties, and when this occurred, the differences will be presented separately at the end of each sub-theme.

5.2 Theme 1: Knowing who I am, not only why I'm here

Most participants described changes in the dynamics, or energy of an interaction, towards a more meaningful connection when those involved moved beyond their roles within the hospital organisation as patient, staff member or relative. While reviewing the data, one staff participant summarised this connection as, *"getting to know who I am, not only why I'm here"* (S25 Physiotherapist, Discussion group, Site 1). This theme and sub-themes were also important for staff relationships with colleagues, which will be discussed in the next chapter.

Insights into a person's uniqueness usually came from talking openly about family life, hobbies, personal preferences or values. A nurse described this as, *"giving something of your essential self"* (S32 Nurse, Interview, Site 1) that was more than their professional role. For example Joanna, a Therapy assistant, shared a memorable moment when she and some nurses were showing to the patients yoga positions from a class the night before and she recalled the change towards something more meaningful that appeared to be through a commonality of being human,

"I think that it was like a gelling moment, it was like a bonding, you know, it was like oh these nurses and the rest of the staff they are human beings, you know, they are not just these coloured uniforms that go round checking charts all the time and drawing curtains" (S14 Therapy assistant, Interview, Site 1).

The change towards a human connectedness through getting to know others resulted in a sense of well-being that was often described by all participants as feeling comfortable, reassured, included and valued; often shown through sharing banter on the ward, which was illustrated by the following quotes,

“It is a basic human trait – you know their idiosyncrasies if you know the patient better. For example Mr Stevens (a patient) can’t communicate at all, but we communicate with him. I feel comfortable with him because I know him” (S37 Nurse, Discussion Group, Site 1).

“I’ve talked about Nurse Mark, he’s very caring. I felt that I could go to Mark because I’ve got a bad leg, which I’ve got to talk to the doctor about. So we’ve had, a bit of joshing around my leg. That was, that was quite fun. But he was very good about that” (R03 Relative, Interview, Site 1).

5.2.1 Sub-theme: Noticing and mentioning uniquenesses

Most participants described the need to work collaboratively in sharing information that supported a person’s uniquenesses and enabled others the opportunity to get to know the person. One staff member described this as, *“noticing and pointing out uniqueness, the personal aspects of a patient” (S03 Physiotherapist, Discussion Group, Site 1)*. This was not usually done through their conventional discourse; predominately an institutional discourse around clinical or operational needs. Instead, participants tended to share uniqueness in an informal, conversational manner and often in the form of vignettes, allowing for subtle nuances to be shared. Family meetings and opportunistic conversations with staff were where sharing uniquenesses were observed most often. For example, one relative mentioned briefly after listening to her father having a joke with staff,

“You need to laugh in a place like this. He loves his banter. His grandsons always give him a really hard time, so he will love this” (R02 Relative, Observation notes, Site 1).

This brief opportunistic conversation with a relative brought many insights about the patient. How he enjoys a laugh with others, that he has grandsons, and about his relationship with them. The following field-notes of a family meeting with the MDT exemplify sharing uniquenesses of the patient and how the patient was uniquely affected by stroke,

Sometimes staff used specific examples of the patient’s recovery, “We are practicing standing up out of her chair but she tires easily so we can only manage about two stands before she tires”. Other times staff used abstract

descriptions including, “Her cognitive function is not good”. The family shared stories of the patient before the stroke, they gave a picture of how she was, she loved her garden, driving and how she was stubborn and reluctant to ask for help. For me, observing this conversation felt like a jigsaw being co-created by everyone of what they felt was best for the patient (Observational notes, Site 2).

However, this sharing occurred much less often than clinical or operational discourse, which was reflected in my field notes,

I have observed several MDT meetings now; I find it really hard to get any relational data from them. I wonder why this is? Is it because they are task-driven interactions? (August 2016, Reflective diary, Site 1).

Often staff reported that written information that could support relationships with service-users was inaccurate, out of date or tended to be too generalised. It suggests that knowing and sharing about uniquenesses are contextual and fluid, and maybe difficult to capture through the methods and discourse of clinical record-keeping. For example,

“When I do social histories I’ve tended to just ask, do they have any occupations or interests just because it is on the form, isn’t it? I would tell the team, ‘oh they like to read’ – what’s good about that? But now when they say, ‘they like to read’, I ask what exactly does that mean, or take that back to the patient to find out more” (S14 Therapy assistant, Discussion Group, Site 1).

Sharing about service users’ uniquenesses between team members seemed to be facilitated through the team being physically co-located on the stroke unit. For example,

“Even if you don’t treat a patient, you walk past them every day, or a patient calls you over. You know how long they have been in hospital, you hear things about them. They’re not just names on a list.” (S03 Physiotherapist, Observation data, Site 1).

On the wards, working collaboratively with the patient, relatives and staff to share uniquenesses was particularly important when patients had difficulty communicating for themselves, for example, one Healthcare assistant said,

"I don't know where, or who, she lives with. This is important as I couldn't rely on the patient to tell me. It works well when the staff nurse checks that we've all got the information" (S26 Healthcare assistant, Observation Notes, Site 1).

Some patients with communication difficulty described how they relied heavily on staff, relatives or friends to tell others of their uniquenesses. In the next example, Simon was a patient who had aphasia. He could reliably answer yes/no. His communication during the interview was supported by using emotional touchpoint cards (Section 4.4.4). Simon had chosen the topic card titled 'sharing information',

Interviewer: So, when staff talk to each other about you,

Simon: Yes.

Interviewer: And they are talking between themselves and with you, you feel respected, (patient had pointed to the 'respected' card)

Simon: Yes. (intonation suggests this is not definitive and patient points to the 'included' card))

Interviewer: Included?

Simon: Yes. (Definitive intonation)

(Patient points to 'fortunate' and 'trusted' cards)

Interviewer: Fortunate. And trusted.

Simon: Yes.

Interviewer: They talk to each other and share information with each other about you?

Simon: Yes, yes.

Interviewer: And you hear that do you?

Simon: Yes

Interviewer: And you like that do you - when they share information about you?

Simon: Yes, yes, yes

Interviewer: So when one person finds out a little bit of information about you through talking with you, then-

Simon: Yes

Interviewer: -they go and share it with everybody else?

Simon: Yes.

Interviewer: Do you think that they are good at doing that, sharing that information?

Simon: Yes, yes, yes. (P01 Patient, Interview, Site 1).

This patient described that listening to staff talk about him and his recovery, fostered his relationships with staff through feelings of being included and respected as a person. When patients were unable to share information about themselves, staff and relatives often co-constructed conversations about the patient that supported the patient's uniqueness and self-hood. These co-constructed conversations enabled the development of relationships that are discussed in more detail in the third theme - 'Opening up possibilities for meaningful relationships'.

5.2.2 Sub-theme: Life beyond the stroke unit

Often connecting with others was observed or described as happening when sharing about their lives *beyond the stroke unit* (Table 31). For example, a Healthcare assistant regularly shared with a relative about playing in an amateur football team, and the relative described looking forward to talking to her after a match. In this example Maria, a patient, had previously worked in a London department store,

"They find out little things about me, and then they will come up with something else like the thing about the Selfridge situation because, they

discovered that I actually worked there for quite a long time. And they were interested in that because they had seen the Mr Selfridge programmes on television” (P02 Patient, Interview, Site 1).

Stories about their lives *beyond the stroke unit* were often triggered through artefacts (for example photographs, gifts, books or magazines), and visiting relatives, pets or musicians. Having triggers to get to know a person were especially significant for patients with limited communication. These are two examples,

“You find ways to find out about them, for example, her washbag was very organised when she first came in, and she has a lot of purple things in her cupboard” (S25 Physiotherapist, Observation notes, Site 1).

“I liked her family being by her bedside overnight, talking to her and telling her stories about her life”. (S22 Healthcare assistant, Observation notes, Site 1).

As mentioned in the last quote, many staff valued and relied upon relatives telling them about the patients’ lives beyond the stroke unit , especially when patients were unable to do this themselves,

“I like talking to relatives – like this patient here, I found out that he lives in Spain for half of the year and he likes to sing in bars. After the stroke you see none of that now. I like to hear the relatives tell me things about the patients” (S115 Nurse, Observation notes, Site 2).

All participants described two different realities while on the stroke unit – home life and ward life. Through talking about and understanding each other’s lives outside of the context of the stroke unit, there was a greater understanding of each other’s personal journey and a sense of how things were for the person. This understanding of a person’s life beyond the stroke unit could nurture relationships,

“I think because I went to the (patient’s) home and saw how they were going to have to cope once they had left hospital. Actually the thing that I remember is he (the patient) was aphasic so it was very it was very much her (patient’s wife) telling us about what his life was like. And there was a boat outside and they had had to put it up for sale, because he wouldn’t have been able to sail anymore, so I suppose it was just much more personal, I really got to know them a lot more” (S14 Therapy assistant, Interview, Site 1).

“You feel they've (the nurses) got a list to work through, and we elongate it as we go along..... I mean, they have private lives too, and they obviously have families to cope with and things like that and it must be difficult” (P02 Patient, Interview, Site 1).

Most relatives and some patients talked about the struggle to balance home commitments with needing to be on the stroke unit. When relationships with staff were more distant, and lacked a bringing together of their home lives with what was happening on the stroke unit, some patients and relatives described feelings of anxiety and concern for their inability to fulfil their responsibilities.

*“Because there, there's no point in people saying, ‘You don't need to go up (to the ward) every day’, I do need to go up every day. Because if I do stay at home I can't settle. I don't want to be an interfering old biddy, but I get a little bit angry that no-one seems to care, oh not no-one, **some** people don't care” (R01 Relative, Interview, Site 1).*

Concerns about life beyond the stroke unit appeared to be heightened when the patient had communication difficulties and they relied on others to help them connect with life beyond the stroke unit. Molly who was recovering from aphasia said her family visited, “umpteenth times” (P105 Patient, Interview, Site 2) and this helped her stay connected with her life beyond the stroke unit. This next example is from interview notes from a conversation with a patient who had expressive communication difficulties,

*We talked about his partner. He has been in hospital for over 6 months now. He is not sure how his relationship is with her. He wants to get home so that he can focus on his relationship. He has been with her for 2 years. He was previously married for 5 years and his mother told me that he has 2 children (aged 12 and 14) that he has joint custody for.... He cannot talk to them on the phone when he is here because his communication disability does not allow him to talk on the phone. He held his phone up to his ear and said “F**k.” None of the staff on the ward knew he had children (P10 Patient, Interview, Site 1).*

Occasionally nurses were observed trying to support connections with friends or family through asking pets to visit, lending their smart phones, calling relatives on the ward phone or locating a hospital lap-top so that they could access video-calls that made communication easier. These were observed as joyful and memorable events for both staff and patients. One patient with communication difficulty, after seeing his partner who lived overseas on a Skype call, said to his consultant immediately afterwards, *"Hello Boss! It's good today. I'm happy"* (P03 Patient, Observation notes, Site 1).

Some were observed either coming to the stroke unit on their days off (staff) or after they had been discharged (relatives and patients). It seemed to reflect the importance of the relationship for those involved. For example, a hospital security guard, who regularly supervised a patient, visited the ward on his day off with the patients observed smiling and enjoying the interaction. After he left, patients and nurses told me how much they valued him. The link between home and work can be seen in this example when a nurse described what happens when patients or relatives see him out of work,

"If I am ever in town on a day off or if I'm on a late shift going into work, it's unusual for me not to run into three people, two or three people that I've nursed or relatives. And they all obviously make a point of coming up to me, and some of them I don't remember or I don't always recognise people, if they are at the other side of the street or whatever. Suddenly there will be people waving or shouting hello, that sort of thing. You know, so I think that I've done pretty well over time" (S32 Nurse, Interview, Site 1).

The value placed on the stroke unit as being part of the wider community outside of the hospital, and how this supports the quality of care was reinforced by a manager,

"Here there is a real link between these professionals, particularly the nurses, and the local community. It is family, really, they use this hospital, their loved ones use this hospital. And I think, actually, that goes a long way in terms of thinking about compassion and care" (S34 Manager, Interview, Site 1).

The manager in the quote above also describes how the relationship is like a family, and this will be discussed more in the second theme: 'They're our extended family'.

5.2.3 Sub-theme: Attending towards others

'Attending towards' refers to the practice of attending to the other person, opening up a space for possibilities of human connectedness. I did not name this theme 'being attentive', or 'paying attention to' because the process appeared to be broader. Attending towards included listening to, focussing on, and gaining more of an understanding of the person from their perspective; and/or the *process* of moving towards forming a human connection, regardless of whether understanding was achieved. The latter was relevant for all participants, including those patients with verbal communication difficulties.

All participants valued experiencing others attending towards them. They described how the process enabled human connections to happen. This quote came from a doctor describing a conversation with a patient about the patient's symptoms,

"Allowing people to express, what happened in their own words. And then to not lead that but then help them develop thatit's really important to know what they mean by that. Otherwise you are making an assumption"
(S36 Doctor, Interview, Site 1).

It illustrates the significance of listening which supported the doctor and patient to co-create relationship. Listening was transactional, that is, to gain understanding of an individual personally. Additionally, it was a creative act in itself; through this type listening, a relationship was co-created in which the doctor did not impose his assumptions of what the patient was experiencing. This is further illustrated in the following reflection by a healthcare assistant in which the patient felt listened and which built trust towards the healthcare assistant,

I and two colleagues were asked to hoist a patient out of bed. No one usually has much luck with encouraging to get this patient up as they often

are in a lot of pain and anxious. With much persuasion we managed to change the patient's mind.

One nurse held the patient's legs for support. We all manoeuvred the patient slowly and steady, all with their own role for making sure the patient was supported, safe and stable.

When the patient had safely landed into his chair, he smiled. He hugged me and gave me a high five.

The communication was fantastic and I felt that gave that patient the confidence to know he was going to be ok. We had won his trust – which was so important. He smiled the whole time. He even allowed us all to put him back into bed once he had time with his family, and afterwards he hugged me again and said, "You're one in a million". It meant so much to this patient that we all took time to notice him and his well-being (S21 Healthcare assistant, Reflective story, Site 1).

There were also many times when patients felt that they were not being listened to. This often led to anger, frustration and an erosion of relationships with staff. One patient said,

"If people and staff aren't listening to me or are restrictive, then it feels frustrating and makes me angry. It is as if they are taking pleasure out of it" (P102 Patient, Observation notes, Site 2).

Relatives' perspectives were similar to those described by patients – they valued staff who not only gave information but listened and understood how they *felt* about their and their loved one's situation. When staff understood how the relatives themselves were feeling, staff communicated what the relative needed to hear, rather than what the member of staff thought needed to be said. One husband described how staff did not fully understand his perspective and therefore he had repeated conversations with doctors,

"Jenny was a fairly extreme case, in that she was definitely dying when she first arrived. So we went through the most extreme parts of saying what you do about resuscitation, and what you do about things like, if she has pneumonia, what are we going to do? And we were completely clear about

*that, so I was ... happy to have that conversation.... one slight negative was that we went through that (conversation) **three** times. I know perfectly well that the supposition is that relatives don't take it in the first time. But I do and I was completely clear about it. It was alright because Jenny's a believer, I'm a believer, so,... [sigh] I mean it was an emotional time a difficult time, but it is quite important that whoever is having that conversation is listening to the person and if the person has got it on board" (R03 Relative, Interview, Site 1).*

Similarly, staff described the importance of really listening and trying to see others from their perspective. This was not always listening to verbal communication, but often was listening or understanding in a non-verbal (body language) and felt (embodied) sense, when they responded to a 'feeling inside'. This staff nurse shared her story of how she used her intuition or felt-sense in supporting the relatives of a dying patient,

"One day I was looking after an end of life patient for only four hours. The two daughters had stayed here for the last 48 hours without leaving his bedside. I introduced myself and told them that I was here to care for them. I freshened him up and went and got the daughters from the restaurant when finished. Once he passed away, they did not want to stay at all, so I explained what would happen. But I felt worried about them, so I asked them to ring me later. When she did, she was ok, and she thanked me for all that I'd done and that she'd never forget me and how I'd cared for her father on his final journey.

A few weeks later she came to the ward, she saw me and immediately gave me a big hug and a lovely card. I was tearful. It meant a lot to me. I am a good nurse. It made me feel good" (S33 Nurse, Reflective story, Site 1).

Attending towards the relatives in this way co-created an opportunity for the relatives to leave immediately after the death of their father, while opening opportunities for the nurse to continue to support them when they were no longer on the ward.

The busy atmosphere and high workload of the stroke units increased the significance of attending towards others, as it was often difficult to do. Patients and

relatives both valued staff giving them time and attention. Many staff described that listening was difficult and at times effortful to achieve in the busy ward environment. For example,

“I probably should be listening more effectively, but I've got so much going on in my head I'm processing what I'm doing next, and they teach you not to do that don't they, but I'm still finding that quite hard” (S18 Staff Nurse, Interview, Site 1).

For most participants, attending towards others were opportunities to get to know more of the person through conversation. For those with verbal communication impairment, the transactional element of listening was less significant. The intention, or act of attending towards, the patient with communication impairment appeared to be as valued (if not more) when co-creating meaningful relationships. In the data there were many examples of attending towards patients with limited or no communication which created human connectedness without relying on verbal language or knowing personal information. Attending towards was described, or observed, as mirroring facial expressions, using touch, responding to an emotional response towards a patient's non-verbal communication, or a felt (embodied) sense of connection. The following are two examples of this,

“I have only heard Pat speak once since her stroke. But there is one nurse, she is so devoted, it is not what she says, she just knows when Pat has had enough” (R104 Relative, Observation notes, Site 2).

Jane (Healthcare assistant) was sitting beside the patient, Simon, on his bed. Both were sitting looking at the wall with his photographs pinned to it. They were having a conversation about his partner and daughter, sharing some new photos that have just been brought in today by his sister. Simon started to talk about his stroke, indicating this by picking up and dropping his paralysed arm.

Jane recalled, “I remember when you first came in, you were in that bed there (pointing) and you couldn't speak, and you were scared. I sat with you for about half an hour. First we tried pen and paper, that didn't work. Then I

tried pictures. That didn't work. I still couldn't understand you. But at the end you gave me a big hug!"

Simon gave Jane a hug; both had tears in their eyes.

"And now we've just had our first conversation when I've understood everything that you've said. It's been two months tomorrow that you've been here. You've changed so much, you're a different person. You are so much better" (S19 Health care assistant, Observation notes, Site 1).

In both examples the staff seemed to attend to the patients non-verbally through an intuitive, felt-sense. In the second example, Jane described that she had a sense that Simon may be scared. Although she did could not confirm this with Simon, she responded to her felt-sense, despite the vulnerability of misunderstanding, by attempting to reach out towards him with all the resources and communication skills she had to hand. Even with not being able to understand him, Simon responded to her attempts to reach out towards him with a hug. It was evident from this observation that Simon and Jane had co-created some form of connectedness between them without words, and without fully understanding.

5.2.4 Summary and discussion of Theme 1: Knowing who I am

The data presented for this first theme 'Knowing who I am, not only why I'm here' demonstrated that knowledge of a person's uniqueness supported co-creating relationships. In particular, understanding about a person's life experiences and social context beyond the stroke unit, not their defined role on the stroke unit e.g. nurse or patient, helped with this knowing. This confirms other studies into stroke rehabilitation, and the wider context of centredness practices, that have consistently described treating others as individuals (rather than focussing on their role), and knowing what is important to them, as foundations to positive experiences of care and rehabilitation (Jones et al. 1997; Williams and Irurita 2004; Mangset et al. 2008; Bridges et al. 2010; Dewar and Mackay 2010; Lawrence and Kinn 2011; Dewar and Nolan 2013; Brown et al. 2014). Data presented in this chapter supports Rosewilliam et al.'s (2016) findings into patient-centred goal-setting on a stroke unit. The researchers found that a lack of sharing information

about what was important to the patient led to breakdown in therapeutic relationships between staff and patients. Through analysing the data with both a lifeworld-led and relational constructionist lens (Table 24), the data presented suggests an alternative perspective where the foundations for meaningful connections appear to be a commonality of being human. This has previously been described by Galvin & Todres within their framework for humanising care as, *“an ongoing dialogue or ‘play’ between what we have in common, and how we make sense of this in very personal ways”* (Galvin and Todres 2013, p.14).

Analysis of the data concerning patients with limited or no verbal communication ability offers more insights into their relationships while on a stroke unit. Firstly, the act of attending (reaching out) towards another person has been shown to be immensely meaningful for some in the co-creation of human connectedness instead of, or alongside, getting to know the person. The data presented here supports several phenomenological studies (Jones et al. 1997; Sundin and Jansson 2003; Nyström 2009) with patients with communication impairment that described how non-verbal cues of reaching out to understand can engender feelings comfort and security, alleviating feelings of isolation or loneliness.

Secondly, the analysis revealed that patients with verbal communication difficulties relied on others (staff, relatives, and friends) to support their uniqueness in the network of social relations on the stroke unit through sharing stories about them. The data confirms what has been conceptualised by Hydén and Antelius (2011) as ‘vicarious storytelling’, part of a jigsaw puzzle strategy of communication supporting those with communication disability. This aspect will be discussed further in Theme 3 (Section 5.4.3).

Finally, the data concerning patients with verbal communication difficulties was more explicit on both body language and focussing on the felt-sense to meaningfully connect with others. Although this was also present in data from

patients without communication difficulties, it was not always as explicit, as if verbal communication took precedence. The data shows that attending towards others involves not only verbal communication and body language but also openness to one's felt-sense and emotional response when in relation with others. Sundin et al. (2000) and Sundin and Jansson's (2003) studies into nurses' communication with patients with aphasia after stroke confirm the data presented here. The authors describe openness as particularly relevant for embodied connections and sharing patients' experiences through silent dialogue, allowing feelings to guide them – which I describe as embodied listening. The importance of listening for getting to know patients, and the effective transaction of information, has been referred to many times in the literature (McGilton et al. 2012; Aadal et al. 2013; Constand et al. 2014; Rosewilliam et al. 2016). This data described embodied listening beyond transaction of information has similarities with the literature on people with limited consciousness, dementia, confusion and aphasia. All of these conditions have the potential to obscure personhood and how things are for the person, for example Thompson & McKeever (2014, p.412) say,

“Without language, the ability to narrate lived experiences is lost. The individual cannot inform the world who he/she is, or understand who others are”.

The literature on dementia, brain injury and aphasia all draw on Merleau-Ponty's (1945/2013) notion of 'body-subject', in which there are aspects of selfhood within the body that may persist despite severe cognitive or communication difficulties. Therefore, through being sensitive or attentive to these movements, groans, sounds and 'felt-sense', staff and relatives can begin to connect with the patient's insiderness and self-hood without necessarily understanding, also described in this data (Hyden 2013; Kontos and Martin 2013; Watson 2016; Gjermestad 2017).

It therefore appears, that the intention of attending towards others, and being guided by listening (in its broadest sense), opens up opportunities to understand the other's human experiences of being in the world, leading to human connectedness.

5.3 Theme 2: ‘They’re our extended family’

When participants were asked to describe their positive relational experiences, they described them as a bond similar to their own family relationships, exemplified in the following quote,

“Everyone had grown an attachment to Barrie (patient), and he had become part of the family of Ward 3 (pseudonym)” (S21 Healthcare assistant, Reflective story, Site 1).

Family-type relationships were mainly, although not always, built on participants knowing each other personally that overlaps with Theme 1. Family-type relationships were described as, *“including everyone” (S03 Physiotherapist, Site 1)* and, *“no them and us” (P104 Patient, Interview, Site 2)*. Staff were described as letting their guard down, being *“less closed” (S14 Therapy assistant, Discussion group, Site 2)* and *“friendly” (R102 Relative, Observation notes, Site 2)*. These relationships contributed to well-being, described by participants as feeling supported, relaxed and comfortable with each other.

Three sub-themes were developed that captured the main characteristics of the participants’ family-type relationships in the data: (i) ‘No them and us’ (mutuality); (ii) Open and informal and; (iii) A freedom to respond in relation. The first two sub-themes (mutuality, openness and informality) supported feeling of being part of a family, which appeared to be reinforced by the third sub-theme, when a person was free to respond relationally.

5.3.1 Sub-theme: ‘No them and us’ (mutuality)

Most participants described their meaningful relationships on the stroke unit when they felt that they had co-created trust and mutual worth. Many times this was observed as a simple non-verbal connection, for example one relative described how the nurses were with her husband,

“They would be cheerful, sort of treat him like a human being....they kind of look at him and smile, and uh, just treat him normally” (R01 Relative, Interview, Site 1).

Patients more often described occasions when mutuality was not present and they felt that they had less power in their relationships with staff. For example, in this next quote a patient called me over while I was observing a doctor’s ward round,

She (the patient) said that she has a desperate desire to go home as she feels that she is at the end of her life and time is running out. She mentioned that the doctors are in a huddle talking and asked, “Why aren’t they more open? I think that they are keeping me here because I’m nasty. I don’t trust them” (Observation notes, Site 1).

Other patients, in particular those with communication difficulties, were observed refusing or not co-operating with particular staff, for example refusing to be hoisted into a chair or only agreeing to therapy from a certain staff member, which could be seen as one way for them to gain some control over their relationships with staff.

Many staff described that when they perceived a balanced relationship with patients or relatives, rather than power-over, the encounter was more meaningful. For example,

“It was less of a therapist-patient relationship, and more of ‘let’s just give it a go!’ It felt like a different relationship. The patient was directing the session, I enjoyed that. Because I had warned her that it wouldn’t work, and we all knew that, it wasn’t serious. She (the patient) wasn’t pushing any pressure on us, there was no agenda, she just wanted to give it a go. We aligned our expectations as I was wondering what would happen without the cricket (a transfer aid) and she was the same” (S03 Physiotherapist, Discussion Group, Site 1).

In this interaction, the therapist had felt that she had created ‘power-with’ each other. They collaboratively negotiated a way forward for the treatment session that opened possibilities for a different, more meaningful encounter for them both. The physiotherapist continued her reflection of the encounter,

"We all giggled all the way through as we knew that we had tried something that would be difficult but we were all in it together. Although we didn't successfully help the lady into the chair, she was happy that she had tried something that she was aiming to be able to do" (S03 Physiotherapist, Discussion Group, Site 1).

In this encounter, it was not the outcome or therapy goals that were significant, in fact these were not achieved here, but the human connectedness co-created through mutuality.

For relatives there was a slightly different emphasis in the data. Feelings of when there was 'no them and us' with staff were similarly valued. Because most relatives already had close relationships with the patient, they described that knowing the rules and routines of the stroke unit were particularly important. It supported a sense of belonging to the stroke unit 'family' and, therefore, reduced feelings of 'them and us'. Examples of when relatives got to know the rules and routines of the ward included: purposefully being present at ward rounds or handovers to listen to staff discussions; gaining permissions to access to the ward kitchen or; how to find out which nurse or doctor was responsible for their relative each day. This is exemplified in the next quote from a husband who shared his experience of navigating the stroke unit rules to support his wife,

"A huge positive for the whole way this ward is run, is allowing us to feed Jenny (the patient). I mean we've had amazing access to the ward. 24 hours, 24/7. I hope it's because we're reasonably useful as well. I'm completely aware it is a female ward, and I'm a bloke, but I think that it's marvellous, stretching of the regulations. I think she needed us because she was, well she was dying, so she needed us, and she had her care from her family, and so, even if even if she had died she would have felt cared for and you know that she was surrounded by, the love of her family. And not dying alone. So I think that's very, I think that is fantastic and very important and wonderful of the whole system" (R03 Relative, Interview, Site 1).

Knowing rules and routines were also described by patients with communication difficulties as helping them feel more at ease on the stroke unit. In the quote

below, a patient who was recovering from aphasia that had left her unable to communicate when she was first admitted to the stroke unit described her experience,

"It's strange when you come in first. You don't know anything and you would like to know how to do things and there's nobody to ask. I thought I could have asked somebody, but it's not quite like that, is it? When you come in you see those lights and you don't know what they're for. If I knew, I could do it" (P105 Patient, Interview, Site 2).

For patients with verbal communication difficulties, knowing the rules and routines may not necessarily contribute to a 'family-type' relationship. However, it could enable them to have more meaning and understanding of their situation and, therefore, contributed towards 'power-to' the patient, exemplified in the previous quote, *"If I knew, I could do it" (P105 Patient, Interview, Site 2).*

When patients were very drowsy or unconscious, many staff participants were observed using touch or chatting away to the patient. Some staff would create a sense of mutuality and 'power-to' the patient by asking their permission, or explaining what they were doing, for example,

'A healthcare assistant went to take a patient's blood pressure. She talked to the patient all the way through. For each type of observation she asked permission from the patient, explaining that the blood pressure cuff was about to go tight, saying thank you when she had finished. The patient responded only by briefly opening her eyes. The healthcare assistant continued chatting. When discussing this with her afterwards, she said, "I talk to patients who are too drowsy to talk to me. I feel silly doing it sometimes, but it is respectful".' (S113 Healthcare assistant, Observation notes, Site 2).

In another observation, a doctor demonstrated this through touch,

'The doctor put his hand on the barely conscious patient's shoulder before starting to talk to the stroke team about plans for the patient.' (S36 Doctor, Observation notes, Site 1).

In discussion groups most staff, including non-clinical staff, described it was important for them to do this to show respect to the patient. They placed a significant amount of value in including in their conversations patients who were unable to communicate verbally. This is similar to what has been discussed previously in Theme 1 about the importance of attending towards a person who has communication impairments, and in this analysis staff appeared to be trying to reach out to prevent a feeling of excessive control or 'power-over' the patient.

Most of the examples from the data above could also refer to the informality or openness of the relationship, which was also found in the analysis of family-type relations.

5.3.2 Sub-Theme: Open and Informal

"I think talking openly, talking in the ward as if you are talking to everyone, it gives them the opportunity to join in if they want to..... there's always been that ability to have that bit of banter with the patients with get them to join in more, and make them feel like they're not just patients" (S14 Therapy assistant, Discussion group, Site 1).

Many participants felt that positive relationships within the stroke unit were family-like in that they were familiar, comfortable and light-hearted, with participants often observed having social conversations and easy banter with each other. It appeared to be a reflection of co-creating relationships beyond the roles of patient/relative/staff towards the individual described in Theme 1 (Section 5.2). Often openness was described as being friendly and approachable,

"We are friendly; a member of staff usually approaches a relative if they are standing by the desk looking a little lost" (S05 Therapy assistant, Discussion group, Site 1).

'One relative described to me what he liked about the stroke unit, "They are all so friendly – they call you by your first name. That makes it more friendly" (Observation notes, Site 1).

Informality was often observed as humour and banter that appeared to affirm being comfortable and familiar in their relationships,

I observed a healthcare assistant helping a patient choose her clothes. The interaction was full of banter and the healthcare assistant used the patient's family first names, referring to them throughout their conversation. Afterwards the healthcare assistant said, "It's easy because I know her, I've been here all week" (S39 Healthcare assistant, Observation notes, Site 1).

"Banter's good, we often have banter with the patients and even the relatives when they have been here for a while. One relative we had a little dance together in the corridor!" (S121 Nurse, Observation notes, Site 2).

The analysis described the last two sub-themes of mutuality, being informal and open, as characteristics of family-type relationships that were part of a sense of belonging on the stroke units. Feeling that one belongs to the stroke unit 'family' was entwined with being able to respond relationally to one another, which will be explored in the next sub-theme.

5.3.3 Sub-theme: Responding relationally

"We kind of know each other. And we know when to stop, when to support" (S05 Therapy assistant, Discussion group, Site 1).

This final sub-theme on family-type relationships concerns participants' freedom to respond to being-in-relation with others on the stroke unit. Responding relationally was mainly observed or described by relative and staff participants towards patients, and occasionally between relatives and staff. For relatives, the freedom to respond relationally towards the patient was related to knowing the rules and routines of the ward which has been discussed previously.

In the following example, a nurse recalls how she was caring for a patient who was very drowsy,

"I started to sing an Irish song with Ingrid (the patient), I didn't know that she knew any Irish songs, it was just one I liked. Ingrid joined in and carried

on the words. I made me feel lovely (smiling)” (S20 Nurse, Observation notes, Site 1).

While caring for Ingrid, the nurse felt comfortable enough with the patient to start singing. When Ingrid started singing it revealed a small part of her self to the nurse and created being-in-relation by singing together. This could be seen as Ingrid responding relationally within her limited, or situated, freedom caused by her drowsiness.

The initial relational response to Ingrid by the nurse led to the experience widening to include more of the MDT later the same morning,

‘A musician was on the ward playing Irish songs on her ukulele to Ingrid (the patient), and again Ingrid joined in with the singing. Nurses, therapists and the housekeeper who were nearby came and stood around her bed listening to Ingrid singing. All were smiling.’ (Observation notes, Site 1).

The music had opened up possibilities for Ingrid to connect with the wider team and consequently gave the staff a small sense of Ingrid’s uniqueness that had previously been obscured by being drowsy after her stroke (Theme 1). The analysis of sharing of joint experiences on the stroke unit, like in this example, will be explored further in the next theme.

Notably, non-clinical staff such as porters, housekeepers and security guards were seen pausing from their tasks to respond relationally to patients. For example, a housekeeper was observed walking past a patient who was crying, and she sat next to the patient and comforted her; or a security guard was observed wiping food off the face of the patient he was supervising. On some occasions staff may not know the person (as described in Theme 1), but they still had the freedom or felt able to respond relationally to another as part of belonging to the stroke unit ‘family’. This may suggest wider cultural influences enabling staff to respond relationally to others.

5.3.4 Summary and discussion of Theme 2: *'They're our extended family'*

The analysis presented in this second theme described that family-type relationships appeared to affirm and support a sense of belonging or togetherness. Other qualitative studies have similarly described family-type relationships, in both in-patient and stroke unit settings, that foster a sense of belonging (Laird et al. 2015; Bennett 2016). A sense of belonging, or togetherness, is reflected in both the work of Nolan et al. (2006; 2008) within the Senses Framework (Table 4) and Todres et al.'s (2007; 2009) Humanisation Values Framework (Table 7), both of which affirms their importance within the experience of human relationships. Previous evidence on family-type relationships has predominately focussed on nursing relationships, whereas data presented here broadens the evidence to the wider stroke MDT and non-clinical staff, and suggests that family-type relationships are important for all.

The analysis confirms previous studies in which meaningful relationships on stroke units have mutuality, congruence and trust (Jones et al. 1997; Gallagher 2011; Lawrence and Kinn 2011; Lawton et al. 2016). The analysis showed that mutuality was co-created through being informal, friendly or approachable, using banter and knowing the rules and routines of the stroke unit. Banter has also been described in other research studies as important for building meaningful connections, that not only enshrined a person's uniqueness, but also created cohesiveness and a sense of belonging for staff, patients and relatives (Beck 1997; Dean and Major 2008; Pryor 2010; McCreaddie and Payne 2014; Bennett 2016). Previous research also supports the analysis that unwritten hospital rules and rituals can impact negatively on service-users' feelings of mutuality in relationships and their sense of belonging on wards (McCormack et al. 2010; Smith et al. 2010; Rosewilliam et al. 2016; Ryan et al. 2017).

The sub-theme of mutuality provided insights into the co-creation of ‘power-with’ one another within the participants’ experience of family-type relationships. The impact of healthcare workers’ power over service-users is described extensively in the literature, and has already been discussed in literature review (Section 2.7.1). The literature on person or patient-centredness advocates balancing power within service-user and staff relationships through shared decision-making and professionals sharing their power with service-users (Bridges et al. 2010; Rosewilliam et al. 2011; Rosewilliam et al. 2016). Analysing the data through a relational constructionist and a lifeworld-led lens (Table 24) has viewed power dynamics differently; that power is situated and contextual, with power relationships being co-created as part of the relationship construction process (Tresolini and The Pew-Fetzer Task Force 1994; McNamee and Hosking 2012; Galvin and Todres 2013). The analysis showed that within staff and service-user relationships, based on mutuality and openness, individuals together co-created power relations. This analysis re-aligns the perception of unequal power as negative if power is mutually co-created, dynamic and under constant change within the relationship.

The final sub-theme, responding relationally to reach out to others at a deeply human level, was supported through mutuality, openness and informality in relationships within a wider sense of belonging through experiencing family-like relationships on the stroke unit. Brown Wilson’s (2009) study within care homes also described ‘responsive relationships’ in which carers were able to respond to what was significant to that person, supported through getting to know the person first. Analysis of data on ‘responding relationally’ further develops Brown Wilson’s (2009) results by describing a relational response towards those that are not yet known, or if their self is obscured through the effects of the stroke on their conscious level or communication. Staff and relatives responded at a deeply human, even pre-cognitive level, for example, the nurse who started singing to the patient who was drowsy. Data on patients with limited verbal communication, in

which their self is obscured, described a situated freedom to respond relationally within the limitations of their current physical impairments, for example, when the patient who was drowsy responded to the nurse singing by joining in. A situated relational response was often co-created through others. Situated freedom within human relationships has been conceptualised by Todres (2007), with similar concepts described within studies on patients with communication difficulties after stroke through embodied communication and silent dialogue (Sundin et al. 2000, 2002; Nyström 2006; Hyden 2013).

5.4 Theme 3: Opening up possibilities for meaningful relationships

“I have a real connection with Daniel (a patient), we just clicked” (S21 Healthcare assistant, Observation notes, Site 1).

There were many experiences from the data in which moments of human connection strengthened healthcare relationships. Opportunities for moments of human connection were often co-created as part of usual daily stroke unit activities, for example, sitting with a patient who was confused, completing a kitchen assessment, or a meeting with relatives. Opening up possibilities for human connections comprised of a way of being focussed on the present moment and what is unfolding, along with a discourse that has a relational focus. Three sub-themes were developed from the data analysis to describe how possibilities for human connection were co-created: (i) being focussed on the present-moment and their connectedness; (ii) sharing experiences within the lived space of the stroke unit and; (iii) co-creating stories. These three themes enabled participants to respond in the moment, foster a sense of belonging through commonality of shared experiences or narratives, and develop a local discourse that valued relationality.

5.4.1 Sub-theme: Pausing in-the-moment

Staff described *“being zoned out”* (S33 Nurse, Site 1), or immersed within their encounter with a patient. For example,

“Sometimes I am so focussed on the person I forget what I need to do, I am so engrossed in-the-moment” (S17 Health care assistant, Discussion group, Site 1).

Within my research notes I often described these observations as ‘pauses’. There appeared to be a slowing down of time for those involved, with less attention or awareness of the tasks and workload, instead being immersed in what is unfolding. There was a notable change in priority, moving away from practical and physical aspects of stroke unit life towards being fully present in-the moment. The intensity of focus appeared to be on the person or the relationship being co-constructed together. In the data, pausing in-the-moment was observed between all participants, and observed the least between patients.

Pausing to be present in-the-moment sometimes led to unexpected reciprocal positive outcomes for those involved. Two notable examples are,

“We never made it to the chair, but that didn’t matter. Probably mood wise we accomplished a lot, she did – we all did” (S03 Physiotherapist, Discussion group, Site 1).

‘An occupational therapist talked with me about her conversation with a patient who had aphasia who could only respond with ‘yes’. She said, “I sometimes forget that she can only say yes or no because we are having such a good conversation together” (S06 Occupational Therapist, Observational notes, Site 1).

Both staff members above described that through focussing less on the task that they were there to do (a therapy session), and being present in-the-moment, brought different opportunities to be in relation. For example, in the first quote above, the physiotherapy described pausing from her planned physiotherapy session opened up new opportunities for the patient negotiate what she would to work on with the physiotherapist, supporting a more balanced relationship and building trust. The physiotherapist described how it was light-hearted and enjoyable to try something unplanned, and the positive experience changed her approach with the rest of her patients that day. Both participants reflected afterwards that these were unexpected, more meaningful outcomes.

This next example involves the husband of a patient with severe cognitive and communication problems. Although this was the only example in the data, it is notable as it illustrates the impact of not pausing from the physical and practical tasks to be present in-the-moment. In this example, the relative described practical tasks as, “getting things done”. His focus on the practicalities of his wife’s care appeared to diminish his felt sense (or embodied listening) of what his wife is thinking,

“To start with I could feel exactly what she thinks. But I think now, I’m almost an, obstacle because I’ve been so involved in pushing and getting things done, and usually perhaps jumping in a little earlier before she has communicated.” (R03 Relative, Interview, Site 1).

5.4.2 Sub-theme: Sharing experiences

The second sub-theme of opening possibilities for meaningful relationships is ‘sharing experiences’. Examples of shared experiences observed included making a cake during a therapy session; a patient’s dog brought on the ward to visit; or looking through family photographs together. Shared experiences within the stroke unit could lead to strong feelings of connection, or a bond, that reinforced the family-type relationship described in Theme 2 (Section 5.3). These shared experiences happened within usual stroke unit activities, in both clinical and non-clinically focussed encounters, for example,

It was Moira’s (a patient) birthday in bay 3. Moira had no relatives or local friends to visit her as she lived out-of-area. The night staff had blown up gloves as balloons and tied them to her bed. Another nurse hung up her cards on the wall so that she could see them from her bed, and the ward sister bought a cake. The team sang happy birthday to Moira. Later a relative of another patient brought Moira a card and gift. One staff member smiled when she saw what the team had team done. She said to the ward sister, “I know that you’re not the type, but give me a hug, you’re a real softy!” (Observation notes, Site 2).

The significance of the shared experiences was how the process of co-creating experiences together opened possibilities to develop a strong embodied or emotional connection, often described by participants as “*sharing a feeling*” (S08 Reflective story, Site 1), or, “*feeling it in here (pointing to their chest)*” (S31 Observation notes, Site 1). These experiences were the same for patients with verbal communication difficulties, because the feeling of being connected through the joint experience did not rely on verbal communication. For example,

‘I observed a joint kitchen assessment with an occupational therapist and a speech therapist. The patient had severe aphasia and cognitive problems after her stroke. The task of making a cup of tea required a lot of support from both therapists. It was obvious that the patient had made a connection with the speech therapist, the patient was smiling with her and gave her lots of eye contact. Once finished making a cup of tea, the speech therapist said, “Oh you’re enjoying that cup of tea! It would be nice with a biscuit – would you like a biscuit?”

I felt a sense of excitement whenever the patient did something more than what was expected. It was joyful to will her on to do more and more. Through the experience of the kitchen assessment, I felt an emotional attachment to the patient as I was willing her on to do better.

Afterwards I asked both therapists if they had a similar feeling. Had they formed a bond with the patient by doing that assessment even though the patient was unable to converse with them? The therapists both confirmed that they felt that they had formed a relationship with her. The speech therapist explained that was why she became a therapist - to get to know them through spending time with them, regardless of what the conversation is, and regardless of what the task is, she felt that she was able to connect with the patient.’ (P107 Patient, S106 Speech Therapist & S107 Occupational Therapist, Observation notes, Site 2).

The act of making a cup of tea enabled both therapists to form a connection with the patient through being present together in the experience, and sharing in the success of when the patient did or understood something. Through the shared experience, the therapists developed more understanding of how the patient is experiencing her lifeworld now, and a sense of hope for her recovery. I also had a similar experience to the therapists through observing the interaction.

Experiences that enabled all involved to be present in-the-moment were less about the activity, and more about how the activity provided opportunity to develop relationships and human connectedness. Shared experiences often occurred in communal spaces that drew in others, illustrated in the examples above where other relatives joined in the birthday celebrations, or more staff gathering around to listen to the music (see example in Section 5.3.3).

5.4.3 Sub-theme: Co-creating stories

Participants often used story-telling as a means of relating through story construction. One healthcare assistant described her experience of co-creating stories with patients or colleagues as,

“You understand how they feel, how important you are to them” (S21 Healthcare assistant interview, site 1).

Stories often started with something in common, for example living on the same street, or having relatives abroad in the same country, that opened possibilities to co-create a sense of togetherness, and continued to provide openings over the patient’s hospital stay. In the following example, the conversation was between a housekeeper and a patient (Ruby) in the stroke unit day room. The patient was baking with a ward volunteer. The housekeeper was passing the day room and briefly spoke to the patient,

“Are there apples in that Ruby?” Ruby laughed and explained the joke to the rest of the room. Ruby had on her bedside table a large pile of apples that she never ate and the pile was growing bigger each day. After Ruby had finished her story, the housekeeper laughed and replied, “You’ll be apple bobbing later!” (S123 Housekeeper, Observation notes, Site 2).

Over the weeks that Ruby had been in hospital, the housekeeper and Ruby had an evolving story about the apples on her table. The story was light-hearted, and fostered friendliness between the housekeeper and Ruby, often used to open up further social conversation. Through small moments of sharing a joke over many days, they created a sense togetherness and belonging.

Often brief stories that characterised the patient's uniqueness, or relationship with a staff member, were informally dropped into conversations. For example this Occupational Therapist was talking to a patient's relative,

"She likes to give me a hug each time I see her, she is very tactile isn't she? Yes! She is getting used to holding the doctor's hand when he comes to talk to her, she likes the doctor!" (S124 Occupational Therapist, Observational notes, Site 2).

Vicarious storytelling was regularly observed by relatives and staff when the patient had limited verbal communication. This next example illustrates vicarious storytelling that included narratives of the patient's uniqueness alongside co-constructing relationships between staff and relatives. In the example, five family members (two daughters, her husband, sister and granddaughter) of a patient, called Chloe, were having a family meeting with a doctor, speech therapist, occupational therapist and social worker. The example starts halfway through the meeting, when the doctor had finished speaking to the family about Chloe's medical care,

'Next the occupational therapist started to feedback her assessments. "We have noticed that the stroke has affected Chloe's cognition as well as her language, she lacks initiation and she can only perform one step tasks." The speech therapist then started talking about Chloe's communication problems and described when she, Chloe and the occupational therapist made a cup of tea together. She continued, "We put everything in front of her, and she picked up each item, looked at it and put it down again. It wasn't until we put the milk bottle into her hand that she started pouring from it." After the speech therapist had finished her example, the daughters shared how she always loved doing the Daily Mail crossword, and she was trying to do it yesterday. The daughter opened up her note book and showed Chloe's writing and how they had been helping her practise her handwriting. While the family were sharing their experiences with Chloe, the whole room felt relaxed and animated. The speech therapist continued, "I can tell she has a good sense of humour, she has a good laugh and giggle with me".' (S106 Speech Therapist, S107 Occupational Therapist & R102 Relative, Observation notes, Site 2).

In this conversation, there was initially information-giving using medical terminology, for example 'cognition' and 'initiation'. Once the speech therapist

moved the conversation towards Chloe's actual experiences on the ward using less medical discourse to describe making a cup of tea, the relatives started to respond with their own experiences of how Chloe had been since her stroke. This led to an open discussion and sharing of information where staff and relatives discussed their experiences of how Chloe was before and since her stroke. The process of sharing stories about Chloe was a relational activity. Firstly, the staff got to know more about Chloe as a person (Theme 1, Section 5.2). Secondly, the staff and relatives developed an understanding of how both the family and staff were helping Chloe to recover, fostering a sense of 'being in this together' (Theme 2, Section 5.3). Thirdly, the staff and relatives felt more comfortable with each other through collaborating on the story construction (Sub-theme 5.3.2), evident by the increased social interaction and humour observed between staff and the relatives in the following days.

5.4.4 Summary and discussion of Theme 3: Opening up possibilities for meaningful relationships.

This third theme described three common ways in which patients, relatives and staff opened up possibilities to develop relationships. These were: (i) pausing to be more present in-the-moment and attentive to the relational process being co-created; (ii) sharing experiences and; (iii) co-creating stories that both brought a sense of belonging or togetherness.

Being present in-the-moment has been referred to extensively in the literature on healthcare relationships as: being attentive, fully engaged, committed, being 'in the zone', or being 'tuned in' that describes a giving-of-self within a dynamic, co-constructed encounter (Beach et al. 2006; Bright et al. 2015; Bennett 2016). From a lifeworld perspective, the analysis reflects Todres' (2008) description of embodied relational understanding, in which present-centred is described as 'being with' and where the 'self' is fully responsive and active when we are present-centred. It is 'being with' that opens possibilities of a bond or connection with another.

Furthermore, the analysis suggests that 'pausing' from usual practicalities and busyness of stroke unit life, and focussing more on experiential knowing within the relational encounter, is a result of, and may enhance, being present in-the-moment for all participants.

The analysis then turned to how sharing experiences while on the stroke unit can support meaningful relationships and human connectedness. For all participants, and possibly more so for those with communication difficulties, the analysis described a complex mix of verbal and body language, emotional responses and felt-sense guiding shared experiences and informing their experiences of human connectedness. Although each person may hold, or take meaning from, their shared experience differently, there was a commonality and sense of togetherness through co-creating the experience. For staff participants, there appeared to be developing new knowing on 'what it must be like' for the patient and their altered meaning of their lifeworld after stroke.

Focussing analysis on relational experiences of those with communication difficulties made explicit the embodied, felt-sense of connection through sharing experiences that were not always able to be described in words. A similar connection through silent dialogue has been described by Sundin and Jansson (2003) between nurses and patients with aphasia during routine care, where a feeling of connection encompasses the nurse and guides the interaction with the patient.

Another insight through focusing on patients with communication difficulties highlighted the role of vicarious story telling in co-creating a sense of the patient's uniqueness. The value of vicarious storytelling to co-construct meaning, and understand more of the patient with communication difficulties, has been shown in

previous studies to support greater sensitivity towards the patient (Hydén and Antelius 2011; Gjermestad 2017). Vicarious storytelling has the potential to reduce feelings of loss of identity and sense of self that has been described in patients with communication difficulty and stroke (Ellis-Hill et al. 2008; Nyström 2009). This analysis has also shown a further benefit to staff-relative relationships through cooperation between staff and relatives during storytelling, which has not been previously described.

5.5 Chapter Summary

This first chapter addresses the research question,

‘How do patients, their carers and staff on stroke units describe their positive relational care experiences?’

The analysis suggested that all participants (patients, relatives and staff) valued similar relational care experiences. These experiences were described as connecting with each other at a human level. The participants described mutuality and reciprocity in relationships with each other, with the need to feel comfortable or at ease, equally valued and respected. Meaningful relational experiences happened when participants connected with each other at a deeply human level that led to feelings of well-being, being comfortable and relaxed with each other. They appeared to support a sense of togetherness, a sense of community that was held in their shared journey within the lived space of the stroke unit. Possibilities to co-create human connections were opened up through being fully present with one another; sharing experiences and collaborating together to co-create stories around the patient.

Developing meaningful and valued relationships with those with limited or no communication ability has been described as more complex and nuanced. Relational experiences are similar for all participants regardless of verbal communication ability. Tacit, embodied and co-constructive forms of knowing

appeared to be more explicit when developing relationships with those who have difficulty communicating verbally.

Adopting a relational constructionist and lifeworld-led lens to analysis provided insights into how participants sharing experiences, and co-creating stories, led to moments of connectedness during the patient's admission that created openings, within shared experiences and narratives, for a shared journey through the lived space of the stroke unit. This enhances the significance of the stroke unit place to co-create new narratives and experiences that aligns with a sense of place and continuity (Table 4: The Senses Framework supporting relationship-centred care (Nolan et al. 2006) or personal journey (Table 7: Humanising Value Framework of the dimensions of humanisation of care (Todres et al. 2009; Galvin and Todres 2013)). The analysis confirms the importance of continuity of connections over time but also illustrates that this can be achieved in brief interactions, and with patients who have shorter lengths of stay, if staff view their work as a relational activity full of possibilities for human connections. Through participating in the study, staff participants increasingly recognised the importance of their own relationships with their colleagues in order to support their insights into their clinical practice as a relational activity. This will be explored further in the next chapter.

Chapter 6: Co-constructing staff colleague relationships that create meaningful relational experiences

6.1 Introduction

“It’s a tough job to care for people’s well-being, not just for the patients, but for those working alongside them. It’s so important for team work to work” (S21 Healthcare assistant, Reflective story, Site 1).

The previous chapter explored valued relational experiences between a triad of patients, relatives and staff. This chapter will specifically focus on the staff participants and their relational experiences with their colleagues. Stroke unit staff identified for themselves who they considered to be part of their team. They identified both healthcare staff traditionally considered to be core members of any stroke multidisciplinary team (MDT); doctors, nurses, physiotherapists, occupational therapists, speech and language therapists, healthcare assistants, therapy assistants; and they identified additional staff including audit data collectors, ward clerks, housekeepers, ward volunteers and hospital security. The main data sources for this chapter were staff interviews and reflective discussions with staff, generated through discussion groups and informal conversations conducted during clinical observations throughout all phases of the AAR process (Figure 5). Data presented in this chapter will address the second research question:

How does the stroke unit MDT describe positive inter-colleague relations that enable them to create and maintain relationships in clinical practice?

Selections of data that exemplify the overarching theme of *valuing our human experience at work* will be presented, with the aim of capturing the array of staff experiences within the stroke units. As a result of valuing each other’s human experience at work, staff described positive impacts on their relationships with service-users. This was described by one nurse as being, *“more relaxed and more patient” (S115 Nurse, Observation notes, Site 2)*. Through data analysis three main themes were developed: (i) ‘Knowing individuals a bit more’; (ii) I’ve got your back and; (iii) An atmosphere of possibility despite adversity.

Overarching Theme	Main Themes	Sub-themes
Valuing our human experience at work	1. 'Knowing individuals a bit more'	1.1 'The private person and the professional person'
		1.2 'Someone who understands that's how I feel'
	2. 'I've got your back'	2.1 Mutual respect
		2.2 The voice of experience
	3. Atmosphere of possibility despite adversity	3.1 'Despite great adversity'
		3.2 'Despite targets and management'
		3.3 'You need to quieten that list'

Table 32: Thematic categories of staff colleague relational experiences

Within the data on staff experiences at work, there were more negative descriptions compared to data on their experiences with patients and relatives. In the same way as with discussions with service-users, these negative experiences were not disregarded. Instead, within the appreciative focus of the study, they were reframed into affirmative conversations with staff in order to focus on positive aspects that supported relational practice. Hence the data presented here will again be with an appreciative lens.

6.2 Theme 1: Knowing individuals a bit more

This theme aligns with the first theme in the previous chapter 'Knowing who I am'. Staff described positive colleague relations when their relationship moved beyond their role or task towards knowing the individual. During the AAR process, staff identified that attending towards others (Sub-theme 5.2.3) and knowing about their colleagues' lives beyond the stroke unit (Sub-theme 5.2.2) supported knowing their colleagues more. This is exemplified in the following quote,

"I feel I know colleagues better now. And I do sit back and listen now....normally I wouldn't want to know, I'm not normally somebody that wants to know what that person does in the evening, when they go home and stuff like that. But actually I do sit back and listen now. And even without possibly realising myself that I am doing it it's kind of going in. So it's knowing individuals I work with, a bit more" (S05 Therapy assistant, Discussion group, Site 1).

Some staff identified that their relational practice, “stems from knowing who you’re working with” (S05 Therapy assistant, Discussion Group, Site 1). Another described the connection as,

“Like a whole circle, like a chain isn’t it? If you know the individuals you work with, and the way that they work, and then you go to the patient with them, it just makes it easier to function together. It’s relationships” (S14 Therapy assistant, Discussion group, Site 1).

One site had role vacancies in all teams and many of the staff described a constant adjustment because of temporary staff, rotational posts, and new recruitments. The lack of continuity was significant for staff, described by one staff member as,

“I find it difficult to work with ‘new faces’ every day” (S21 Healthcare assistant, Discussion group, Site 1).

Getting to know new colleagues was described as taking time and required existing to staff to give more,

*“We all **welcome** them but I think you give them more. You ask them if there is anything that you need to know, you ask lots of questions. It’s just making them feel very relaxed from the beginning, and **then**, woodpecker or worm your way in and really know them. Yeh, to find out about them” (S05 Therapy assistant, Discussion group, Site 1).*

As well as the similar themes that were discussed in Theme 1 ‘Knowing who I am’ (Section 5.2) in last chapter, staff described two additional sub-themes that were specific to colleague relationships: (i) ‘The private person and the professional person’ and (ii) ‘Someone who understands that’s how I feel’ (Table 32).

6.2.1 Sub-theme: ‘The private person and the professional person’

All of the MDT, regardless of whether they were a registered professional or not, described an expectation ‘to be professional’ at work. Staff appeared to affix

different meanings to the concept of professionalism. It appeared to be an expectation of conduct; a demarcation between patient/relative and staff, described by one as a, *“professional friendship”* (S03 Physiotherapist, Observation notes, Site 1) that encompassed both the closeness of friendships along with recognition of the relationship being created for professional reasons. Finally, professionalism was referred to as a personal line in which giving of self is held back in order to carry out their work, for example,

“I’m professional; I can draw a line and carry on” (S20 Nurse, Observation notes, Site 1).

Many staff described a dichotomy between the expectation to be professional and how this affected their freedom to be themselves and connect with others, including their colleagues. One nurse described this dichotomy,

“I find it quite uncomfortable if people ‘don the professional hat’, and I know that one has to be professional in one’s conduct and core standards, but I find it really difficult when there’s the private person and the professional person. I think that there is danger of a certain falsity beginning to appear in your personality there. Particularly in nursing and other aspects of health-care work, I think you need to give... some kind of your essential self to be really doing the job, otherwise I think that you are just going through the motions a bit” (S32 Nurse, Interview, Site 1).

This nurse described how they perceived professionalism in others affecting giving of one’s ‘essential self’. They saw this as obscuring from others the healthcare worker as a person. The nurse described the risk of staff becoming detached, leading to a loss of meaning to their work, which they described as ‘going through the motions’. One ward clerk described her surprise when a colleague showed a more human side after a patient who had been on the ward for months died,

“We were all sharing the same feeling, we went home feeling sad, and you think, gosh they’re human after all!” (S08 Ward clerk, Reflective story, Site 1).

Understanding colleagues' human experience of work and sharing common experiences, as illustrated in the above quote, was important for many staff participants. The data is explored further in the following sub-theme.

6.2.2 Sub-theme: 'Someone who understands that's how I feel'

In reflective discussions, some staff described how they assisted or sought out particular colleagues to work with. This was during occasions when they had an especially strong embodied or emotional response towards what seemed to be personally significant moments in their work. For example, laying out a deceased patient; responding to a patient who was highly distressed; or receiving a complaint about their practice. In the following example, Joanna described how she felt seeing a patient in distress,

"I get very emotional about how somebody's feeling when they're not being seen to, or they look as if they are in pain, or if I know that they are suffering in some other way, you know, mentally. And if I can find someone who understands that's how I feel, and that I'm concerned about that patient, I will go to them" [to ask them to help] (S14 Therapy assistant, Interview, Site 1).

Joanna described that if she knew of a colleague who resonated with her emotional response to the patient's distress, she would seek them out to help her in her work. The underpinning personal connection with colleagues who understood how she was feeling supported her in alleviating the patient's distress. It ultimately enabled Joanna to feel more at ease with the situation which supported her own well-being.

There were occasions when staff described how recognising similar values to their own in others brought a strong positive emotional or embodied response. The following excerpt exemplifies this, in which staff nurse Moira had just observed another staff nurse with a patient,

Moira: "Can I just say that was lovely, treating that lady with compassion, it was lovely."

Researcher: *I then asked Moira how she felt watching another nurse give compassionate care.*

Moira: *"It made me feel warm, seeing a person with the same heart (as me), they have a genuine interest in people" (S31 Nurse, Observational notes, Site 1).*

While Moira was describing her response to me, she was patting her chest suggesting that her embodied response was in her chest. It appeared to be positive moment for Moira as it reinforced her values as a nurse. Another staff member described how she felt when her values did not align with colleagues,

*"They are **all** my patients, not just the ones that are allocated to me. I find it bad when others say, 'that's not my bay!'" (S19 Healthcare assistant, Discussion group, Site 1).*

For this healthcare assistant, when others may not have the same values or priorities as she and they only focussed on their allocated patients, her sense of well-being was threatened and she felt 'bad'. This example could link to feelings of lack of support from others in her team, which will be explored more in the next theme.

6.2.3 Summary and discussion of Theme 1: Knowing individuals a bit more

The data presented in this theme demonstrate that, similar to Theme 1 in the preceding chapter, understanding colleagues as a person and their feelings at work were important for the stroke teams. Through this understanding there appears to be a strengthening of their sense of belonging or togetherness as a group. This analysis is consistent with Burton et al.'s (2009) case study findings, where successful stroke unit teamwork relied on the development of relationships among team members, as much as the use of team communication systems and structures. The data supports Seneviratne et al.'s (2009) ethnographic study that described familiarity among nurses on a stroke unit helped them to know each other's rhythms at work. It also supports the literature from a RCC perspective that emphasised staff must experience relationship-centredness at work in order to deliver it (Nolan et al. 2006; Patterson et al. 2011). Although social well-being and a

sense of belonging are recognised for good inter-personal relationships in stroke teams, it is not previously been given much attention (Burton et al. 2009; Clarke 2010; Cramm and Nieboer 2011). The focus has been instead on collaboration, communication, MDT goal setting, role clarification and joint education programmes (Gibbon et al. 2002; Kilbride et al. 2011; Gustafsson et al. 2014; Clarke and Forster 2015; Burau et al. 2017).

When discussing colleague relations, staff referred to a dichotomy between professionalism and getting to know their colleagues. Previous studies have described professionalism as distancing staff being relational through reinforcing hierarchical relationships and an emotional detachment; these are barriers to person-centred care and team relationships (Gibbon 1999; Watkins et al. 2001; Gibbon et al. 2002; Seneviratne et al. 2009; Clarke 2010; Liberati et al. 2016; Moore et al. 2017). This sub-theme builds on the overlapping Theme 1 (Section 5.2) which described that it was focussing on the person, rather than their role (or being professional), that supported human connectedness. This sub-theme offers a different insight where 'being professional' appears to also obscure the person for colleagues. From a lifeworld perspective this could be perceived as professionalism limiting staff freedom to be their 'essential self' in co-creating colleague relationships, which may diminish authenticity in the relationship and also the sense of belonging or togetherness in the team.

In the second sub-theme, the data highlighted that colleagues who understand how they feel, and share similar values, enhanced their human experience at work. With the study's focus on appreciating human relationships, staff recognised their common value or goal of 'being human' supported their team relations and brought a sense of belonging or togetherness. Shared values and a common purpose support MDT collaboration (Gittell et al. 2013; Bennett et al. 2015). Often these values are cited to be person-centred care in the NHS (McCormack et al. 2015; Moore et al. 2017; Karam et al. 2018). The literature on MDT working in healthcare

reports both synergies and tensions in team working, where team members have different priorities and differentiated professions have ideological differences on patient care and person-centredness (Pound and Ebrahim 2000; Suddick and De Souza 2007; Kitson et al. 2013a; Jesus et al. 2016; Liberati et al. 2016). The literature advocates mutually respectful relationships in effective multi-disciplinary team working (Pound and Ebrahim 2000; Watkins et al. 2001), and Clarke (2010) described a concern for persons as part of effective team working in stroke units.

Analysis of these data suggests that a mutual goal of 'being human' can provide an alternative perspective of MDT relationships. Focussing on a mutual goal of 'being human' does not negate the differences in inter-professional working, but the data suggests that it may present a basis on which colleagues can be open to holding multiple professional and personal perspectives along with shared understanding, through a commonality of 'being human'. This supports previous studies where focussing on collective humanising values, for example compassion or concern for the person, were important for sustaining team relationships (Clarke 2010; Dewar and Mackay 2010). 'Being human' within colleague relationships also broadens the conventional patient focus for relationships conceptualised in patient-centred care to include colleagues that aligns more closely with the principles of RCC (Tresolini and The Pew-Fetzer Task Force 1994).

Liberati et al.'s (2016) study described stroke unit inter-professional relationships in which professions relied on tacit knowledge of a history of shared experiences that orientated them towards similar ways of thinking and perceiving. Additionally, a closeness or familiarity with colleagues has been described as supporting their understanding of how others feel and their rhythm of work, described as, *"you feel an understanding from the others"* (Persson et al. 2018, p.5). The data presented here reflects these studies' findings and further develops this evidence for specifically for stroke MDT relations. By staff recognising their emotional or embodied response towards their human experience work and their colleagues'

work, it appeared to reinforce a collective sense of belonging through co-constructing human connectedness within the team, and with patients and relatives.

6.3 Theme 2: ‘I’ve got your back’

Support from colleagues was highly valued by all staff participants for their own human experience of work.

“I need to feel listened to and supported, to feel like someone has got my back at work” (S106 Therapist, Observation notes, Site 2).

Colleagues who supported others appeared to value them as a person and their human experience at work through showing them genuine concern. Examples observed included taking a colleague a glass of water, checking in with them on a busy day, or debriefing with them after an emotional event.

Predominately, the therapy team described supporting each other through an open, enabling team that made them feel safe, comfortable and valued.

“We are well supported. It is safe to ask questions, this team is really good for this” (S38 Occupational Therapist, Discussion group, Site 1).

This appeared to enable staff to personalise their work, for example,

“If there was something we needed to mention (in the team meeting) about a patient, or something had changed, or we wanted to focus on something with a particular patient, then we had the opportunity to say something” (S102 Therapy assistant, Observation notes, Site 2).

Nursing and medical teams tended to describe support for each other differently to therapists. Differences between the sub-teams may be linked to how much control each sub-team has over their caseload, especially during colleagues’ absence from the stroke unit. Nursing and medical teams tended to emphasise either emotional support or empathy for each other’s workload,

“Because we haven’t a registrar, this SHO has had to take on the responsibility, he’s stepped up very readily but he’s been expected to do that every day. And the next week comes along and it’s the same situation because nothing’s resolved itself yet. But the consultants give him as much support as they can, by being there, being available. I bought him a bottle of wine the other day as well. I am asking him constantly and I can sense in a way how he’s feeling, and he’s quite open with me so that’s a way of providing that emotional support on a day to day basis” (S36 Doctor, Interview, Site 1).

Taking time to understand how colleagues were feeling was important for all staff participants. It was often described as creating discrete moments outside of their routine work to talk to their colleague, for example having a brief private conversation out of ear-shot of the team; arranging to have a coffee in the hospital canteen; speaking to them outside of work; or sending them a text.

Data on feeling supported and where colleagues ‘have got your back’ had two themes: (i) mutual respect within the MDT and; (ii) the voice of experience.

6.3.1 Sub-theme: Mutual respect

“You can’t have a preference with who you work with. You do need to respect them. Be open and inclusive” (S38 Occupational Therapist, Discussion Group, Site 1).

Mutual respect within the team enabled staff to act on what they felt was right to support their human experience at work. For example, a consultant was observed discussing with the junior doctors how they tailor their ward round so that it is not, *“too onerous and takes too long” (S117 Consultant, Observation notes, Site 2)* for the other professions who attend. Mutual respect was often observed as a subtle emphasis on the person rather within usual stroke unit activities. Examples include: greeting a person as they entered a room; or, using polite terms like ‘please be mindful’ during handover. In another example, a junior doctor needed to get some medical notes out of the trolley that a nurse was leaning on to write her notes,

“Hello Sue, how are you? Did you have a good weekend?” They both proceeded to have a brief conversation about what they did at the weekend. The doctor then asked if he could retrieve some notes out of the trolley (S24 Doctor, Observational notes, Site 1).

Although the intention for this interaction was to retrieve a patient’s notes, through having a social and friendly approach, it demonstrated that the doctor was considering his colleague as well as completing his task. Social conversation underpinned a lot of the interactions that appeared to convey mutual respect within the team. The second sub-theme is regarding how those with more experience support more novice colleagues.

6.3.2 Sub-theme: The voice of experience

In the context of support, staff described the amount of experience in their roles as important. Many described longevity of experience, or the experience of colleagues, as helping balance work pressures,

“The more experienced you are, the less you care about your task list” (S05 Therapy assistant, Discussion group, Site 1).

During the AAR cycles, staff reflected that most of those who were less experienced tended to have more structure to support their newly developed skills and knowledge, which may lead to difficulty looking past their workload and tasks that needed to be completed. This, along with them possibly not yet feeling part of a cohesive team, could result in them having less freedom to respond relationally (see also Sub-theme 5.3.3), and therefore require more support. One senior physiotherapist reflected,

“They (those less experienced) need to ignore the pressure ‘to do’ something and think ‘how you are’” (S03 Physiotherapist, Observation notes, Site 1).

In this next example a student nurse, who also worked as an agency healthcare assistant (HCA) on the stroke unit, reflected on her structured practice in both of her roles,

“In University and as a HCA it is very focussed on tasks, we are told ‘this is how you should or must do it’. They put the fear in you” (S39 Healthcare assistant, Observation notes, Site 1).

Some novice staff appeared to find a balance more quickly than others between needing structure and being able to respond relationally. One occupational therapist that had been qualified for two months discussed her reflection on a family meeting,

“Because I am less experienced I like structure, but that meeting wasn’t structured. I need to learn to trust myself, be more confident in my training. ...I take the good points from those that are more senior and make it into my own style” (S124 Occupational therapist, Observation notes, site 2).

6.3.3 Summary and discussion of Theme 2: ‘I’ve got your back’

This theme, ‘I’ve got your back’, staff valued colleague relationships in which they felt supported, listened to and that had mutual respect. These attributes are apparent in the literature as inter-personal team relationships (Cramm and Nieboer 2011; Dewar and Nolan 2013; Karam et al. 2018; Persson et al. 2018). Data analysis suggested that these feelings contributed to a sense of togetherness or belonging within the team. These attributes appeared to be ‘more than’ effective team working or good team pathways and contributed to a positive human experience and connectedness at work. Belongingness in the context of team relationships has been defined as,

“...a deeply personal and contextually mediated experience that evolves in response to the degree to which an individual feels (a) secure, accepted, included, valued and respected by a defined group; (b) connected with or integral to the group; and (c) that their professional and/or personal values are in harmony with those of the group” (Levett-Jones and Lathlean 2008, p.2872).

Similar concepts to belongingness are cited in the literature as an aspect of staff social well-being, and a characteristic of both relationship-centredness and humanising values (Nolan 2002; Levett-Jones and Lathlean 2008; Cramm and Nieboer 2011; Galvin and Todres 2013). Research into stroke unit teams have

described social-wellbeing as important for MDT relationships but suggested it is difficult to achieve (Clarke 2010; Cramm and Nieboer 2011; Kilbride et al. 2011). One study found that some stroke MDT staff became disengaged, often as a subconscious response, when not feeling confident, if they focussed on service (rather than patient) requirements, or to protect the staff member from the emotional aspects of their practice (Bright et al. 2017). This analysis has provided examples of how belongingness through mutual respect and support can lead to social well-being within the MDT.

The second theme on 'the voice of experience' within team relations, although widely discussed in the nursing literature, has had scarce attention within the stroke literature. Data analysis of staff reflections on their relational practice identified that novice staff tended to be more structured, or have a task-focus, in their approach, and that those with more experience felt more freedom to act relationally with colleagues and service-users. This analysis is consistent with the seminal Novice to Expert theory of Patricia Benner (1984) , in which Benner describes experience as adding nuanced and skilled know-how of relating to others in a responsive way. The data are also consistent with other studies focussing on relationship-centredness. For example, Brown Wilson's (2009) findings on developing a relationship-centred approach in care homes that described three types of relationships very similar to those described in this study: (i) pragmatic and task-focussed; (ii) personal and responsive and; (iii) reciprocal relationships that support a sense of community and belonging. Being overly pragmatic and task-focussed can distance staff from their experiential knowing and being relationally responsive (Galvin and Todres 2013). This is summarised by one staff participant, *"It is not what you do, but how you are"* (S03 Physiotherapist, Discussion group, Site 1). Data are consistent with conceptual writings by Benner (2000) and Galvin and Todres (2013), who both draw on Aristotle's Phronesis, in which multiple understandings from a lived human life, giving of one's essential-self and experiential knowing of experience are interwoven into clinical practice, in particular relational practice (Benner 2000; Galvin and Todres 2013).

Through this study valuing relational knowing that supported human connectedness, experienced staff identified that their more novice colleagues may need support to respond relationally at work, and the need to develop a collective attentiveness towards responding relationally, that incorporates the three types of relationship described by Brown Wilson (2009) above. The need for support for staff relational practices to flourish that moves beyond the individual to the collective (Williams et al. 2009; Dewar and Mackay 2010); and practical and emotional support for novice staff workloads (Hoeve et al. 2018) has been recognised previously. Analysis of data from this study offers different insights within the context of stroke unit MDT relationships and their sense of belonging/togetherness to support their freedom to respond relationally at work. The final theme in this chapter will explore data regarding organisational influence on staff human experiences of work.

6.4 Theme 3: Atmosphere of possibility despite adversity

Contextual factors on the team both at a ward level, and at an organisational level, shaped the staff member's possibilities to respond relationally and maintain human connectedness at work. When contextual factors, for example being short-staffed, were moulded to support their human experience of work, staff described a sense of well-being in the workplace. However, there was a prevailing threat to well-being from: high workloads and associated lack of time, targets and management, constant staff movement and sub-teams within the stroke MDT. Despite these threats, through using an appreciative focus for data generation that valued relationality, staff described that they were able to co-create relational connectedness, and experience well-being. Data analysis developed three sub-themes of: (i) 'Despite great adversity'; (ii) Despite targets and management and; (iii) 'You need to quieten the list' (Table 32).

6.4.1 Sub-theme: ‘Despite great adversity’

“The work that the staff put in towards the care of the patients, despite great adversity in terms of staffing levels and all the other things is just outstanding” (S36 Doctor, Interview, Site 1).

Through observing two stroke units over 21 months, it was notable that there were significant hour by hour, and day by day, variations in staff workload. These were for a variety of reasons: high staff vacancy rates in all teams; staff sickness; lack of beds in the hospital; high patient turnover and fluctuations in patients’ care needs. These demands could significantly change the atmosphere on the ward, illustrated in the following extract from my observational notes,

‘The ward feels busy today. Everyone has their heads down; there is no conversation or eye contact with each other. I asked the nurse in charge if they are short-staffed. She said that they are fully staffed, but the hospital is on black alert.’ (Observational notes, Site 1).

A severe shortage of hospital beds to accommodate new patients, resulting in a ‘black alert’ (meaning there were not enough beds to accommodate the number of patients in the hospital), appeared to alter the balance between being task-focussed and being relational-focussed. The lack of resources appeared to compromise staff relational practice. In the above example, staff appeared to have ‘their heads down’ focussed on their individual tasks and were less open to social dialogue, which has been shown to be important for patient, relatives (Sub-theme 5.3.2) and colleague relations (Theme 1, Section 6.2). Another extract from my notes illustrated the individual impact of a high workload,

‘There are lots of agitated patients today. One patient is screaming all the time and requiring sedation. A nurse approached me and said that she was leaving because she finds the workload too much and does not enjoy how acutely unwell the patients are’ (Observation notes, Site 1).

A few staff members enjoyed being short-staffed, provided they felt supported by their seniors. For example, a junior doctor described her experience of doing a ward round on her own,

"I like it when it is short-staffed. I see it as a positive experience. It is an opportunity to see patients and manage them myself. I feel well-supported, that the consultants are accessible if I need help" (S29 Doctor, Observational notes, Site 1).

Staff identified that feeling supported by their team can alter their perspective of their workload; and this was discussed in the previous Theme 'I've got your back' (Table 32).

The high workload was recognised by many seniors in the team and all hospital managers. One hospital manager described how she tried to support staff by being in dialogue with them, and an openness to understand their human experience of work,

"I do engage people in conversation when I am out and about, I do try and understand their world, um, but in terms of formal support and their resilience, and everything else, um I don't think we don't do it any way near well enough. That's not unique to here either" (S34 Hospital manager, Interview, Site 1).

This quote suggests that the manager did not consider 'understanding their world' as formal support for staff. However, this is different to staff descriptions in Themes 1 (Section 6.2) and 2 (Section 6.3) where staff described connecting with colleagues (including social conversation) and knowing more about them as important for their positive human experience at work and sense of belonging.

6.4.2 Sub-theme: 'Despite targets and management'

Staff spent a significant amount of effort balancing their individual human experience at work with organisational demands. Several of the more senior or experienced staff talked about providing the care that they valued, *"despite the targets and management"* (S03 Physiotherapist, Observation notes, Site 1) where the person mattered and the team worked together to understand all the person's needs, not just what the organisation prioritised,

“And we do despite targets, and management trying to scupper everything, we do still manage to... treat people as people” (S36 Doctor, Interview, Site 1).

In this quote a doctor described a tension between what the stroke team regarded as important and what his perception of management’s agenda was. Some staff described that they had learnt how to justify providing care in which the person (both the patient and the member of staff) matters, and colleagues worked in relation to support this within the organisational context,

“Being able to justify if you need to keep them in longer, having seniors who listen and support your clinical decision, even if this not in line with the operational needs” (S06 Therapy assistant, Discussion group, Site 1).

Staff regularly described that performance monitoring, and in particular the Sentinel Stroke National Audit Programme (SSNAP), a national audit of performance and outcomes for stroke services, had a pervasive influence on the culture of care. For example, a physiotherapist talked about her idea for a nurse and therapist to team-up for an entire day to support collaborative working and a more holistic approach for the patient,

“We wouldn’t be allowed to do that. There would be resistance from the managers and consultants. We have just got the SSNAP statistics up, we can’t let them fall again.” (S03 Physiotherapist, Observation notes, Site 1).

She perceived that trying out new ways of working may temporarily reduce efficiencies, which would impact negatively on the SSNAP measures. A nurse who had worked on the same stroke unit for over 10 years reflected on his perception of how expectations of care had changed towards being more superficial,

“But, I think things are a lot less holistic now and a lot more geared towards targets and the patient seeming to be ok rather than they actually being ok” (S32 Nurse, Interview, Site 1).

The study’s relational focus opened possibilities for staff to place more value and attention towards their relational practice, despite adversity, targets and management. Many responded to this by saying that they needed to quieten the

pragmatic task and target list in their heads to enable human connections to happen, which is the final sub-theme.

6.4.3 Sub-theme: ‘You need to quieten that list’

Staff participants of all roles described how the amount of tasks that were required of them every day impacted on their relational practice and their human experience of work. Again support from colleagues was key, for example,

Jane: “Today I was in Bay 5, and all I could think about was that I had nine patients to wash.”

Researcher: “What helped you to focus on the patients rather than all you had to do?”

Jane: “I had help. Another HCA was floating, and she based herself with me as she could see it was heavy. Sometimes we don’t get help.”

Researcher: “What happens if you ask for help?”

Jane: “It depends who it is. I don’t always get help. It is important to remember that it is 24 hour care, if the patient doesn’t mind, I will leave some washes until the afternoon”

(S19 Healthcare assistant, Interview, Site 1).

Within the stroke MDT there appeared to be a culture that valued, “*getting the jobs done*” (S24 Doctor, Observation notes, Site 1) or, “*doing the donkey work*” (S32 Nurse, Interview, Site 1). There was a sense among most of the staff that they aspired to be less task-focussed, even if the reality was difficult because of other colleagues’ expectations. This junior doctor described the pressure from her seniors to complete her patient rounds,

“I’ve been told to be quicker with my rounds by the registrar, but I can’t if I’m going to sort out everybody’s muddles” (S29 Junior Doctor, Observation Notes, Site 1).

Here the doctor used the word ‘muddles’ that had a wider meaning than purely physical medical problems, and suggested that she was trying to consider the

patient more holistically on her rounds, but this was not always valued by her registrar.

Staff often described feelings of worry about being able to complete their tasks. Their worry could be alleviated by support from their colleagues,

“Clara has helped me to stop worrying and looking at all the tasks that need to be done. Wrap around treatment is important so that the tasks don’t overwhelm me. We can always get to it tomorrow.” (S14, Therapy assistant, Discussion group, Site 1).

A task focus appeared to diminish their openness to listen and attend towards others that was recognised by staff as important for human connectedness. Staff described that they were aware of this cognitively; yet practically, many staff described ‘quietening the list’ as difficult to do. Although all participants had described the negative impact of task-focussed relationships; there were equally moments when staff were observed or described pausing, even momentarily, from their task-focus to respond relationally. To avoid repetition, a discussion of these data is within Theme 1 (Section 5.2).

6.4.4 Summary and discussion of Theme 3: Atmosphere of possibility despite adversity

Staff described constraints on their time and availability to get to know patients and relatives. In the last decade, this is being increasingly recognised in the literature, where an emphasis on the pace of care and tasks, linked to organisational need, is described as hindering relational and responsive practices (Williams et al. 2009; Patterson et al. 2011; Dewar 2013; Dewar and Christley 2013; Lawton et al. 2016). The data presented in this theme reflects findings from a small number of recent stroke studies that highlighted the impact of a task and target focus on stroke care and rehabilitation (Bennett 2012; Ryan et al. 2017; Taylor et al. 2018; Suddick et al. 2019), exemplified in the following quote,

“Members of the MDT reported frustration ... citing an increasing emphasis on hyper-acute models of care and increasing organisational task-oriented demands as the source of this. It is argued that the changes that have occurred in stroke acute care may have compromised the potential to maintain high-quality interpersonal practices” (Ryan et al. 2017, p.8).

Patterson and colleagues (2011), informed by the Senses Framework and RCC, have developed two models of cultural change in the NHS: ‘Perform or perish’ and ‘Relational and responsive’. Characteristics from both these models were present in the data. Staff described organisational and team expectations to ‘perform’, and yet there was evidence that staff aspired to be ‘relational and responsive’. Staff described how they tried to protect and maintain their focus on the person with the perceived competing agendas from targets and organisational objectives, which is consistent with previous research (McCormack et al. 2010). Although staff were unable to greatly influence expectations to perform, through the AAR cycles, staff described that their relational activity was supported by a subtle change in the MDT’s ways of working described in the previous two themes (‘Knowing who I’m working with’ and ‘I’ve got your back’ - see Table 32) staff were able to mould their team culture towards being more ‘relational and responsive’. Through appreciating and adding value to relationality within their team and their practice, staff developed a context in which they had more freedom to act relationally at work, and reflects the practice changes described in a similar study by Dewar (2011; Dewar and Nolan 2013).

6.5 Chapter summary

This chapter explored data to address the research question, *‘How does the stroke unit MDT describe positive inter-colleague relations that enable them to create and maintain relationships in clinical practice?’* In the NHS, little attention has been given to micro-level drivers (also described as unit or ward-level workplace cultures, (Table 8) to improve care quality, when compared with NHS investment in clinical leadership and patient safety on wards (Patterson et al. 2011; Manley et al. 2014). Ward-level workplace culture is described in the literature as a primary influence on healthcare teams’ capacity to build and sustain relationships (Bridges et al. 2013).

This chapter described micro-level aspects of the stroke unit culture and context of care (Table 8), and their impact on staff participants' openness to create, and value, human connections with one another.

Data analysis generated several themes illustrating that colleague relationships were significant for their individual and collective human experience of work within the lived space of the stroke unit. The MDT's human experience at work appeared to centre on their sense of belonging or togetherness, exemplified in the first and second themes 'Knowing individuals a bit more' and 'I've got your back'. The experiences presented in this chapter, through the lens of lifeworld-led theory and relational constructionism, provide a different perspective of humanising team relationships. The stroke MDTs described that though understanding colleagues' lifeworld and supporting them as a person, they had feelings of comfort, familiarity and belonging in the team. This led to possibilities for human connections with others, in particular with patients and relatives.

There is a general consensus that MDT relations and collaborative working remains poor, that it is not necessarily given much attention, and instead the focus is on operational processes or inter-personal qualities to support effective stroke team working (Watkins et al. 2001; Burton et al. 2009; Clarke 2010; Cramm and Nieboer 2011; Kilbride et al. 2011; Karam et al. 2018). Studies have found that stroke MDT collective identity and sense of belonging can be achieved through relationships and connectedness between colleagues, and vice versa (Kilbride et al. 2011; Bennett et al. 2015; Persson et al. 2018). This chapter has described the nature and connectedness in stroke MDT relationships through valuing colleagues' human experience of work, and reflects similar themes described by staff in Dewar and Mackay's (2010) study into compassionate care on older persons wards.

This chapter builds on the literature in older persons and stroke care that describes services with a prevailing focus on metrics and increasing pace of care impacting on

the atmosphere of care, and overriding the voice of people's lifeworld (patients, relatives and staff). Individually and collectively, through valuing and attending to human relationships, staff described how they were able to mould the context of their workplace and maintain possibilities for human connections within a climate of clinical tasks, fast pace and performance targets. Valuing relationships grew awareness among the team on the need to support less experienced staff in creating relational possibilities. There remained a complex inter-play between their context, professionalism, culture (team and organisational levels), support and sense of belonging on their freedom to respond relationally.

Through the AAR cycles staff increased their awareness and value placed on their relationships with colleagues, and therefore their sense of belonging. This supported their relational practice and human connectedness within the lived space of the stroke unit. Some of the processes that facilitated human connectedness, and valuing their human experience at work, have been referred to in this and the previous chapter. The next chapter will describe certain practice themes, or 'know how', developed through AAR cycles (Figure 5) that provided the staff participants with generative practices for meaningful relationships on the stroke units.

Chapter 7: Knowing-in-action that centres human relationships

“The webs of relationships and shared meaning of who we are with each other (e.g., what it means to be a nurse, a resident, a nutritionist....etc.) are all a reality we can create in creative collaboration” (Wasserman and McNamee 2010, p.314).

7.1 Introduction

The previous two chapters described the experiences of patients, relatives and staff co-constructing meaningful relationships on two stroke units. All participants described meaningful relationships that led to a sense of belonging and feelings of well-being through human connectedness. MDT relationships that valued one another’s human experience of work, also led to a sense of belonging that opened up possibilities for human connectedness with one another, including patients and relatives. Overall, there appeared to inter-dependent web of relationships that co-constructed shared understandings on whom, and how, participants were with each other, for example, what it means to be a person who cannot make sense of language after their stroke, and what it means to be a nurse supporting that person.

This chapter aims to address the final two research questions:

What are the processes that enrich humanising relationships for all, in particular focussing on patients with limited verbal communication ability?

What needs to be in place for change to happen?

This chapter will present themes, which kept on re-emerging from the data, that exemplify the practices to orientate participants towards valuing and nurturing human connectedness. These themes could be used as generative resources for future practice development.

The data presented in this chapter have a slight change in focus of analysis and data sources. The way in which data were generated and analysed reflects the move

towards articulating the generative processes at work that nurture the experiences described in the previous two chapters. Data analysis continued to be informed by both lifeworld-led and relational constructionist perspectives (Table 24). Additionally, an extended epistemology of ways of knowing in AR (Heron 1996; Heron and Reason 2008), and the principles of AI (Cooperrider et al. 2005), were used (Table 29) to help focus on, and articulate, the processes at work within the AAR cycles conducted in the study.

The main data sources for this part of the analysis were from reflective and reflexive discussions with staff, or from my reflective research diary. Much of the knowing-in-action was entwined within reflections on meaningful relational experiences, shaping collective knowing that developed and changed through the duration of the study. My research diary was useful as a record reflecting my personal changes that occurred and as to why certain directions of inquiry were taken over the duration of the study.

There were less data from relatives and patients for this part of the analysis. This was likely to have been because relatives and patients changed regularly, which made it difficult for them to reflect on any changes in practice in the short amount of time they were on the stroke unit. Although patients and relatives were offered the opportunity to continue participating in the study after discharge from the stroke unit, they all declined, mainly because they wanted to focus on their recovery after going home. Some data showed that patients and relatives had an important role in the processes to enrich relational knowing and this will be presented when data were available.

Firstly, this chapter will provide an overview of the specific elements and processes that supported humanising relational practices. Secondly, suggestions for orientating themes that may be used as generative resources for relationship-

focussed practices will be presented. Finally, there will be a discussion on transferring knowing to support practice developments in other stroke units.

Overall, knowing-in-action co-created possibilities and freedom to connect with others, mostly through changing staff participants' own perspectives of their self, and how they related with others, within the stroke unit. The data were organised into themes that reflected the main generative processes at work during the study, and are summarised in Table 33.

Main Themes	Sub-themes
1. Start with your 'self'	
	2.1 Being the process
2. Facilitation and Animation	2.2 Being open & reflective
	2.3 Being provocative through appreciation
	2.4 Beyond words
3. Voicing emergent narratives on relational knowing	3.1 Appreciative noticing
	3.2 Voicing affirmation
	3.3 Reflection & reflexivity
	3.4 Creating opportunities for emergent narratives
4. Freedom to act relationally	4.1 Pace and space to be relational
	4.2 "How we are, not what we do"
	4.3 Counter-cultural nature of 'How we want to be'

Table 33: Thematic categories for the generative processes supporting knowing-in-action that centres human relationships

It is important to highlight two key points regarding the processes to support relational practice:

- i. The experience of change was complex and non-linear, with many processes from different stages happening concurrently. For ease of presentation the processes are presented here in a linear fashion;

- ii. By having a constructionist stance to the appreciative action research cycles, the inquiry was the intervention – also known as the Simultaneity Principle in AI (Table 12). Therefore, this chapter is also summary of the inquiry, which was the intervention that enabled the stroke unit team to co-construct new ways of relating with each other.

7.2 Theme 1: Start with your ‘self’ – engaging with relational knowing

Staff participants, who were closely engaged in the study, reflected that they had expanded their knowing-of-self. This knowing-of-self was expanded through reflections on their response to meaningful connections within their human experience at work, which many described simply as, ‘being more human’. Staff initially described a, *“change in mind-set” (S03 Physiotherapist, Discussion Group, Site 1)* that seemed to reflect a change in attention towards how they feel and respond relationally (the relational process), which then supported further development of their relational practice. Many described a need to slow their pace, or take time to pause, for a change in attention. One participant described it as a, *“kind of mindfulness” (S104, Occupational therapist, site 2)*, and another described it as, *“letting your guard down” (S14 Therapy assistant, site 1)*. For me, in order to be open to other experiences, I needed time when first arriving on the ward to ‘tune in’ before I was able to collect data. I reflected that I needed to quell my over-active clinical mind-set and be attuned to my embodied response. I wrote during the start of the study,

“Whilst observing I find it really hard not to enquire more about the patients’ clinical management plans. This is a key time for me to change my thinking and what I notice. Sometimes I feel uncomfortable and my hands tingle because I so want to get involved and help with the nursing care!” (Reflective research diary, April 2016).

Many staff described similar personal challenges of attending to the experiential aspects of their work, because they saw themselves as not being, *“touchy feely” (S25 Physiotherapist, site 1)*. Another said,

"I'm not good at the more subjective side of care, I see myself as a 'black and white' evidence-based therapist." (S03 Physiotherapist, Observation notes, site 1).

For some, a change in mind-set appeared to be effortful. For example, when a staff member, who had recently joined the study, was asked if she had noticed any meaningful or positive experiences, she said,

"No, I've had days off and then I'm not right, I'm not in the right frame of mind at the moment. I'm tired." (S104 Physiotherapist, Observation notes, site 2).

Some staff participants needed to participate in the study for several months before they developed an openness and sensitivity towards their relationality with others on the stroke unit. For others, their relational sensitivity appeared innate and was shown through their language and demeanour. For example, a doctor concluded a conversation with a patient in which he had told the patient of their stroke diagnosis. The doctor concluded with, *"How is this news affecting you?" (S36 Doctor Interview, site 1).* For me, this observation was notable as I usually observed doctors conclude with, 'Have you got any questions?' This slight change in choice of words provided an opening for the patient to talk together about how his diagnosis felt, rather than prompting a rational response.

Demonstrating relational openness did not only occur through words. In this next excerpt, a healthcare assistant (HCA) showed her openness non-verbally as well as verbally,

'The HCA knelt down next to the bed of a patient who was very agitated, shouting and trying to climb out of bed. The HCA established eye contact with the patient and asked if she was in pain. The HCA held her hand and the patient leant forward towards her and gave her a hug.' (S39 Healthcare assistant, Observation notes, site 1).

This observation shows that openness to connect was not always reliant on language but also took on an embodied nature where openness was reflected through how the nurse presented herself in a physical way.

For some participants who found relational engagement with others less innate, there appeared to be a moment when the study ‘clicked’ for them. This was a realisation that noticing and engaging with their response to being-in-relation (through the AAR cycles) could support their practice and led to them feeling energised to engage more. It was engaging in the process of discovering, noticing, valuing and affirming relationships within the stroke units that enabled this realisation to occur. The following two quotations are examples from two members of staff when the study appeared to ‘click’ for them,

“You feel choked up when you are writing them (meaningful experiences). You remember the way the patient reacts, and their emotions. You realise that even though you are just doing your job, how important you are to them. When they said, ‘thank you’ I kind of just brushed it off, but I realise now that is really important to them. You kind of just take it for granted” (S21 Healthcare assistant, Observation notes, site 1).

“No, I can see the value – if being a bit more human helps us to feel better about what we do” (S03 Physiotherapist, Discussion group, site 1).

7.2.1 Summary and discussion of Theme 1: Start with your ‘self’

The data presented in this theme have shown that by engaging with their relational knowing through the AAR cycles, staff recognised a change in self that supported their human relationships on the stroke units. Self-awareness and knowing of self are often cited as being a pre-requisite, or even a competency, for person or relationship-centred practice (Hughes et al. 2008; McCormack et al. 2010; Dewar and Cook 2014; Scholl et al. 2014; Soklaridis et al. 2016). Doane and Varcoe summarised its importance,

“When (staff members) are not self-aware to the relational element, they are likely to be practicing in relational oblivion” (Doane and Varcoe 2007, p.200).

Many qualitative studies have described knowing self as mutuality and a deep internal state of engagement with patients, and also how it informs practice (Sundin et al. 2001; Payne et al. 2010; Reinders 2010; Prosser et al. 2013; Dewar and Cook 2014; Scholl et al. 2014; Bright et al. 2018). Evidence on how to support practitioners’ knowing self appears to have grown from an individualist perspective. Recommendations focus on self-awareness as individual practitioners’ competencies to develop, for example being aware of their emotional response in practice, being clear on their beliefs and values, and their individual contribution towards centredness practice (Tresolini and The Pew-Fetzer Task Force 1994; Hughes et al. 2008; McCormack et al. 2010; Kitson et al. 2013a). More recently, constructionist perspectives have highlighted the value of reflexive dialogues and reflective teaching *with others* to support knowing of a shared meaning of self-in-relation (Wasserman and McNamee 2010; Dewar and Cook 2014; Soklaridis et al. 2016).

This theme contributes towards the evidence for supporting practitioners’ knowing self through reflexivity, and introduces two processes at play that were firmly rooted in experiential ways of knowing. Experiential knowing is defined as,

“Feeling engaged with what there is, participating, through the perceptual process, in the shared presence of mutual encounter” (Heron and Reason 2008, p.369).

This shared presence of an encounter, and reflexive conversations to learn its meaningfulness for oneself and others, is a similar process that described by Roddy and Dewar (2016) that they describe as leading to relational responsibility.

The data described a shift in attention towards the relational process of human connectedness. This reflects what both Gergen (2009) and McNamee and Hosking (2012) have described, that once relational processes are centred, rather than

individuals, it opens up possibilities toward the re-thinking of self within the context of relationships. For most participants, knowing-of-self relationally, and affirming human connections with others, was a transformative moment that resulted in feelings of well-being and increased their capacity to support further meaningful relationships - which was the main outcome of the study. This theme illustrates two AI principles at work: firstly, the Simultaneity Principle that the inquiry (into knowing and valuing one's relational self) was the intervention (to support meaningful human relationships). Secondly, the Anticipatory Principle where creating possibilities for human connections that led to feelings of well-being was their generative image (Cooperrider and Whitney 2005; Bushe and Storch 2015). The way in which staff participants came to a place of knowing more of their relational self, and maintained their openness towards being in relation, will be described further in the subsequent themes.

7.3 Theme 2: Facilitation and Animation

My role as a facilitator, defined as, *“a person who facilitates an action, process, result, etc.”* (Oxford English Dictionary 2018), was recognised by staff as key throughout the study. This role was fluid and had different emphases as the study progressed, from sensitising participants towards knowing their relational self (Theme 1, Section 7.2) to engaging them with practice developments. My aim, through adopting a relational constructionist and lifeworld-led stance to the study, was to facilitate the co-participatory spirit of AR through an open communicative space for participants to work together as co-researchers and co-participants (Heron 1996; Bradbury et al. 2008). This has been described previously in Section 4.3.4. My focus for facilitating co-participation was enabling non-hierarchical ways of working, enabling multiple voices for collective learning and production of relational knowing through the AAR cycles (Sharp et al. 2016; Sharp et al. 2018). For example, this participant reflected on her experience of the study,

“This project has been more diverse, rather than on this, sort of, flow chart, it's thinking outside the box, exploring a little more isn't it?” (S05 Therapy assistant, Discussion group, Site 1).

I often reflected on my facilitator role by questioning, ‘How do we begin making together?’ and ‘Who are we becoming or aspiring to become?’ in order to pay attention the relationships and knowing that would be co-created through the study (Hosking and Pluut 2010).

On reflection with supervisors after completion of the study, there was another dimension to my facilitation role – my presence as an animateur. ‘Animateur’ is defined as, *“a person who enlivens or encourages something”* (Oxford Living Dictionaries 2018). This definition has been elaborated on by describing it as a highly contextualised inspiring activity that accesses and uses life experiences, based on reflexivity (Boud and Miller 1996; Dewar and Sharp 2013). For example, this assistant described my role in the study,

“For the first time you were coming in and saying we want to look at what you're good at doing” (S14 Therapy assistant, Discussion group, Site 1).

My focus as an animateur in this study was to enliven and encourage experiential knowing and reflexivity of interconnectedness of self in relation to other, which will be explored through the data in the sub-themes.

The effectiveness of facilitation/animation appeared to be influenced by the quality of relationships formed between the facilitator/animateur and the staff participants. Therefore, the foundations of facilitation/animation were attending to the process of relationship construction with participants. At times, staff discussed openly with me team dynamics or how they were feeling at work and I reflected that, through ‘being the process’ (Theme 1, Section 7.2), I was holding a communicative space for staff. Often these conversations originated from negative emotions but, through facilitation and animation, I aimed to re-frame our

conversations towards being affirmative and generative. For example, Healthcare Assistant Flo approached me while I was observing in the bay that she was working in,

Flo: "I'm fed up with this cliquey team. There is no team working here. I'm always put in the heaviest bay, why should I just because I'm good?"

Jane (HCA) entered the bay and joined the conversation.

Jane: "I've just been singing with one of my patients while cleaning his teeth."

Flo: "I need some happy, someone to buoy me up."

Another staff member Beryl overheard Jane and entered the bay.

Beryl: "Can I help you with some of the patients?" (Patient care is not her role)

Jane: "Are you allowed to do that?"

Beryl: "What sister doesn't know won't hurt her. I used to be a HCA before this role."

Researcher: "Jane, I wonder what strikes you about what has just happened?"

Jane: "I feel thankful; I think this is team work. Thank you Beryl, I think you've made my day."

Researcher: "How does this make you feel?"

Jane: "I feel thankful, supported".

(S21 Healthcare assistant, S19 Healthcare assistant and S08 Ward Clerk, Observational notes, Site 1).

Later that same week Flo reflected with me,

"I enjoyed the way that I really had to think about my job from such a positive aspect. I liked that, I was picking up more positive things rather than it just being a stressful day on a ward in a very busy environment" (S21 Healthcare Assistant, site 2).

By the end of the study a small number of staff (approximately 7% of total staff participants) had taken on the role of co-facilitators illustrated in the following quote,

“Well I think, I think because Sophie (staff member) has been so engaged in it, I think, she's going to be our prompt - other than Joanna and myself. Because Sophie is so mindful of it, she is even trying to bring it into things like our training, and using our ideas and things to change our practices” (S05 Therapy assistant, Discussion group, Site 1).

In this quote Sophie, a co-facilitator, is creating opportunities within the therapy team to support relational knowing, and showing how it can be included in all aspects of their work. Sophie appeared to have changed through participating in the study so that she is described by Christine as, *“being so mindful of it”* that she is trying to bring a relational perspective to all aspects of the team’s practice, learning and development. Through Sophie, Christine and Joanna being co-facilitators, they contributed to change to relational practice that had the potential to be sustained in the longer term.

Eventually my facilitator/animateur role developed into an aide memoir, a prompt for the co-facilitators to maintain their relational focus and to continue animating and facilitating relational practice. One therapy assistant said to me,

“Well if I see you it just, it just feels like you just get in the flow again” (S14, Therapy assistant, Discussion group, Site 1).

Therefore, the combination of facilitating co-participation and collective learning, along with animating relational practice through experiential leaning and reflexivity, appeared to be significant for developing relational practice on the stroke units. There were four characteristics of facilitation and animation that are presented in the following sub-themes: (i) Being the process; (ii) Being open and reflective; (iii) Being provocative through appreciation, and; (iv) Beyond words.

7.3.1 Sub-theme: Being the process

While being a facilitator/animateur, co-facilitators needed be authentically engaged with the relational processes at work. 'Being the process', and being authentically engaged, drew on experiential knowing of being in relation that aligns with knowing-of-self to support humanising relational practice. Knowing-of-self has been common thread throughout all of the research questions, suggesting its importance whether practicing or facilitating relational practice.

Sophie's reflective notes recording some of the processes of how she supported relational approaches within her team illustrated her 'being the process',

"Working together, treating the person as an individual, gaining a trustful relationship, a two-way conversation and trust" (S03 Physiotherapist, Personal notes, May 2017).

On reflection, I similarly learnt that when I focussed too much on the actions (doing) and less on the relational processes (being with others), it was then that the study lost its energy and participant engagement. Therefore, 'being the process' for me was widening my focus towards the processes at work in co-creating relationships through being more reflexive. This was illustrated in the following excerpt from my reflective diary,

'While observing, I found it very hard not to talk, challenge or suggest clinical options. This is a key time to change my thinking and my lens towards facilitator and animateur. I find clinical problems exciting and intriguing and I'm energised by trying to fix them. How am I going to let go of being a fixer? Here the expectations of me are different as I do not have a clinical role. There are fewer expectations to be a fixer or doer! So I need to learn to be more of listener, facilitator and enabler' (Reflective diary, April 2016, Site 1).

Outside of this study, when I was concurrently working in clinical practice, I was surprised to find how difficult it was to have a relational focus while conducting my usual clinical work, and I was mindful that this challenge maybe similar for the staff participants. This experience is explored more in the fourth theme in this chapter.

There were times when there were competing demands on co-facilitators' time due to high workload or staffing vacancies (see Section 6.4, Theme 3). When this occurred, I adopted a role that I described as being a 'positive presence' to animate briefly to staff when I noticed (or a patient or relative commented to me) humanising relational practice. The aim of this was to support others' awareness, and continue conversations, of relational or embodied knowing when their focus may have been more medical, operational or technical. For example, I fed back to a ward sister (who was co-ordinating the ward while the hospital was on black alert and short of beds) that I had observed her waiting by a bedside for a nurse to finish with a patient before telling the nurse about a new admission, which suggested that ward sister was mindful of the relationship between the nurse and the patient, and between herself and the nurse, that respected that demands on patient flow when the ward was under pressure did not supersede the nurse's work. The ward sister's response to this was surprise, as she had not previously reflected on the significance of waiting and the 'hidden' messages that this may convey to others.

During times of high workload, for example, when there were patients with unpredictable aggression, or periods of poor staffing, another aspect of 'being the process' included empathising with their workload and not demanding too much of their time, hence I held no expectations of the staff participants to engage with the study. Here my nursing background was beneficial. Being a positive presence was offered as a gift during their high workload and, in empathy, I also offered my assistance as an extra pair of hands by answering call bells or the telephone. The table below outlines the different focus I took depending on the staff's perceived workload.

Perceived workload	Research focus
High	<ul style="list-style-type: none"> • Supporting staff through being a positive presence and helping out practically • Holding an appreciative mirror to relational practice • Maintaining relational discourse within a heavily medical and operational atmosphere • Holding a relational space when others are unable
Medium	<ul style="list-style-type: none"> • Appreciative feedback with reflective conversations with one or more staff participants, often after a time of observing practice • Impromptu reflexive conversations • Longer conversations with patients or relatives
Low	<ul style="list-style-type: none"> • In-depth reflexive conversations • Interviews • Focus Groups • Co-creating relational spaces and trying out new relational practice

Table 34: Research focus in response to perceived workload

‘Being the process’ that entailed drawing from, and acting upon, experiential relational knowing altered my and the co-facilitators’ approach to facilitating and animating practice. As the initial facilitator and animateur, I was acutely aware of how experiential and relational knowing was articulated through language chosen in conversation. One form in which experiential and relational knowing was articulated was through co-creating conversations that were open and curious, which is the next sub-theme.

7.3.2 Sub-theme: Being open and reflective

Co-creating and maintaining an open communicative and reflective space was a significant aspect of the facilitator/animateur role. They are likewise aspirations of the co-participatory, appreciative action research approach (Kemmis 2008). In my reflective diary in the first month of the study I wrote,

‘I have been very conscious about how to pose initial questions; I have been reading a lot on appreciative inquiry and how to create an appreciative space. I need to practise my questioning’ (Reflective diary, April 2016, Site 1).

I wanted to represent through my language that I was open, curious and sensitive to the perspectives of others which, alongside supporting an open communicative space, are core attributes of humanising values (Dahlberg et al. 2009). Therefore, 'being open and curious' is also another aspect of knowing-of-self and being the process (Table 33).

Being open and reflective started with knowing-of-self through valuing multiple perspectives and openness to what may unfold in relation with others or, more simply, openness to connect with others. In this study, it was mainly achieved through ongoing reflective and reflexive conversations around what was meaningful (see Section 7.4 Theme 3 'Voicing emergent narratives'). Through one of these reflective conversations, a staff member said,

"You can't have a preference over who you work with just because of their different values. You need to respect them. You need to be open and inclusive" (S38 Occupational Therapist, Discussion Group, Site 1).

Openness and valuing differences as aspects of positive humanising relationships between patients and colleagues are described by a staff nurse who was reflecting why she had been put in the bay with what she thought were the most dependent patients on the ward,

"I think that I have been put in here because I am a little mad too! We all have different strengths and we can learn from each other. I'm open to when things have gone wrong; I can be honest and open with the team. There are lots of different personalities, especially in the bay. You need to build up a rapport quickly, find something familiar, normal even. I talk about my family too." (S27 Nurse, Observation notes, Site 1).

Openness included being open to what is unknown, and never assuming. In this next excerpt, HCA Jane illustrated her openness towards others not being defined by her own experiences and judgments. Part of this excerpt has been previously used to illustrate Theme 1, Section 5.2 'Knowing who I am, not only why I am here', in which Jane was congratulating a patient who she had just watched walk across

the bay for the first time since her stroke. Jane was delighted for the patient's recovery and yet did not assume that the patient was feeling the same. Jane reflected with me,

"It is hard not to sound demeaning when saying, 'look at you walking!' They're not a child taking their first steps, they've walked all their life, but we are genuinely happy for them. I don't know how I would respond if I had a stroke and a nurse congratulated me. I'd be like, 'Yeh, I've walked all my life!' It depends how bitter you are I suppose" (S19 Healthcare assistant & P06 Patient, Observation notes, Site 1).

Through facilitating an open communicative space with Jane, she could be curious and explore the patient's experience of what Jane thought was a positive milestone.

A few staff participants demonstrated their awareness of language within the processes of openness and curiosity that could support their relationships with others. One doctor talked about his conversation with a patient observed on a ward round,

"It is learning the right questions, allowing somebody to talk, and from experience, knowing what the indications are from that particular, where the story has gone. And having those pauses, and, reinforcement, and just really trying to explore...." (S36 Doctor, Interview, Site 1).

This doctor drew on his experiential knowing and recognised his language, that he described as, *"learning the right questions"*, as important to create a space for the patient to tell their story or explore their perspective.

Another staff member described how the team's openness, curiosity and humanising relationships had led her to understand that her colleagues may not have similar language or means of expressing their relationships, and that this did not necessarily make her colleagues any less caring,

"We were talking about that (openness) in our team and there are just certain people in our team who just are not responsive to that. And you can't change them, that's their character, you can't change them. I think that we're perhaps, I don't know, it's not that we're more caring, it's just a

different way of ...expressing things about patients” (S14 Therapy assistant, Discussion group, Site 1).

In this quote language appears to be significant for the therapy assistant to understand her colleagues’ relational practice. The therapy assistant (also co-facilitator) described how some of her colleagues’ language was, “*a different way*” to her own, and they were less responsive to openness in the team. Through the therapy assistant’s openness, she developed a new way of knowing that they were all caring in the team but presented this in ways different to the language they used.

Throughout the study, being purposefully and actively appreciative was a powerful approach to create open communicative spaces for discovering new perspectives and supporting participants’ openness and understanding of others in relation.

7.3.3 Sub-theme: Being provocative through appreciation

Adopting AI’s Positive Principle (Table 12) that was intentionally and explicitly appreciative was, for the vast majority of staff and relative participants, novel and hence provocative. At the study start-up phase, staff participants described the novel aspect of a research study adopting an appreciative approach,

“I like the appreciative element, we have never seen research like this before” (S36 Doctor, Discussion group, Site 1).

Within the hospital context, practice developments, research studies and conversations on care experiences are usually problem-orientated. This was illustrated after I provided positive feedback to a discharge co-ordinator, Karen, on how she balanced individual patient need alongside the organisation need to expedite discharges,

Karen: "I am objective, I have no emotional attachment to the ward. I can challenge whether perceived risks by the staff are preventing discharges, and whether they are really risks."

Researcher: "And I noticed that you also have a patient focus, and can support the ward team as you appreciate the pressures that they are under. I appreciate that this can take a lot of skill to balance both these priorities."

Karen: "Thank you. I don't hear that from the managers. I think that that is one of the problems, they don't give us positive feedback any more, they've forgotten"

(S40 Discharge co-ordinator, Observational notes, Site 1).

The novelty of appreciation challenged participants', and my own, usual deficit orientation that had become ingrained in how healthcare experiences were mostly framed by staff and relatives. An example of the organisation's deficit focus was how the ward sister on one of the stroke units received only negative comments from the patient and family feedback survey. In another example, I noticed during my interviews with relatives, most offered negative feedback regarding their experiences until they were specifically asked to focus on their positive experiences on the ward.

For example, during the orientation phase, I observed a Therapy assistant assisting a patient to wash his face, she said,

"Use the hand that's more aware of the sensation to test the water" (S14 Therapy assistant, Observation notes, Site 1).

I noticed that she did not use negative language often used by the MDT that could emphasise his disability, for example, his 'unaffected' or 'good' hand. She reacted with surprise that I was not giving negative feedback. My appreciation was also provocative in that she did not expect me to see this as something meaningful and significant to talk to her about, which then led onto a discussion as to how her choice of words could impact on how the patient perceives his disability.

In contrast to the predominately negative focus of staff and relatives, patients tended to describe positively their experiences and relationships on the stroke unit, which appeared to align with their sense of gratitude towards the staff.

Being appreciative opened up new possibilities that supported being relational that illustrated AI's Simultaneity Principle, in which the inquiry is the intervention (Table 12). Through animating positive relational experiences, staff and relatives appeared to be more aware of the power of appreciation within, and also being, relational. For example, this therapy assistant described the new possibilities that had opened up for her,

"And I think that's what's come across more about the project, is that for the first time, you were coming in and saying we want to look at the good things, we want to look at what you're good at doing, and it's rubbed off onto and what is the patient good at doing by you praising them. So saying to them, 'oh that's really good you worked really hard on that' and members of staff saying it to other members of staff. So that's been nice" (S14 Therapy assistant, Discussion group, Site 1).

In other examples, a ward sister reframed negative comments from a relative into positive comments that supported more of the type of care that the relative desired; the MDT rephrased a health and safety poster to affirm positive behaviours rather than focussing on negative ones; and patient's husband decided to write a thank you letter to the staff *before* the patient went home, rather than waiting to write only once the patient had left the ward. These examples illustrate how some participants developed their positive focus on relational experiences into new ways of interpreting their experiences on the stroke unit, which aligns with AI's Poetic Principle (Table 12). The examples above also illustrate that choosing an appreciative and affirmative lens to relational practice led to some participants developing new forms of presentational knowing (Table 29) - that is how they symbolised and articulated their value of relationships within the stroke unit.

Not everyone saw the value of an appreciative approach. One nurse was sceptical after his experience where his concerns were not acknowledged because of his seniors being overly-positive and not acknowledging concerns.

"I just don't think that they're you know, there seems to be this artificial high that some people seem to be riding that I- a bit of a touch of the Emperor's new clothes? In fact, that you know, it's sort of, that's probably quite a good way of describing it. Not that there's anything mega wrong, but, that there's sort of things are kind of, you know, there's sort of like two different realities" (S32 Nurse interview, site 1).

This nurse described the 'artificial high' constructed by his seniors who did not align with his lifeworld. His seniors believed their description of 'everything being fine' was the reality, and their positivity limited their openness to other realities like this nurse's. This quote illustrated that when appreciation is reduced to a technique, rather than an authentic relational process (Sub-theme 7.3.1) with openness to others' perspectives (Sub-theme 7.3.2) that also includes negatives or concerns, it did not have the desired transformational change.

7.3.4 Sub-theme: Beyond words

The final characteristic of facilitation and animation of humanising relationships was attending to experiential ways of knowing that I have described in this theme as 'Beyond words'. 'Beyond words' were revealed during reflective and reflexive discussions of the relational processes at work during the study, and was described as, *"more than words" (Reflective research diary, Site 1); "behind the words" (S03 Reflective diary, Site 1);* and being, *"unable to put it into words" (S14 Interview, Site 1).*

An AI approach supports participants to connect emotionally with their experience of work and relationships. In this study, with its humanising lifeworld-led lens, there was a greater emphasis on experiential ways of knowing that attended to a felt or tacit sense of what was unfolding in relation with others, which appeared to be pre-cognitive. It entailed being fully present both physically and emotionally to

understand, and respond to, the shared embodied experience of connecting with others which could not be explicitly articulated. It also highlights the weakness of this thesis presenting the data using words alone, as it does not fully capture our tacit or embodied understanding of what we experienced and how this informed, and was part of, the relational process.

Near the end of the Discovery Phase in site one; I felt that we were still only 'scratching the surface' and that our conversations did not fully reflect our felt experience of being in relation with others on the stroke units. Both I and staff participants appeared to frame and present our relational knowing within our usual norms and discourse, which included connecting emotionally with the data. In my reflective diary I wrote,

'I feel that I am not yet getting deeper data. I need to look more at the processes that have led up to experience as well as the experience itself. I am still spending time with the staff, putting up posters on the ward for data. It is the emotional data that seems to get the most interest.' I have discussed with my supervisor how lifeworld theory resonates with my appreciative inquiry into healthcare. If my study is going to align more with lifeworld-led research, then I need to try and capture and understand feelings rather than describing them' (Reflective diary, July 2016, Site 1).

While discussing these challenges during an external workshop, I was asked, "Had I not been as open and curious as I could be?" My reflection later was,

'Am I quick to affirm that I understand others' experiences because of my nursing background, and it closes down the space to explore further because I presume to know?' (Reflective diary, May 2017, Site 1).

It appeared that in my endeavours to generate 'concrete' data (descriptions of experiences) for the study, alongside the dominant cultural norms and discourse for presenting experiential knowing within the team, and within usual hospital clinical practice, I was limiting openness to hold a space within which we could attend to 'more than words', emotions and felt sense. It required me to realign my lens to focus less on asking about a participant's experience, that is their reality, and

instead focusing on creating spaces in which we could co-create and share realities together.

The following example illustrates how some staff participants tended to lean on their clinical knowledge as a form of presentational knowing. They used their clinical knowledge to structure and describe what they were experiencing. This did not always attend to emotions and felt sense within relationships. In this example, which is my reflective note of the conversation, Sophie had written two stories from her practice earlier in the week that she had felt were meaningful to her,

‘Sophie had collected two stories. We discussed this together. Initially she described the story as a clinical case, but with curious questioning, we were able to tease out her motivations, feelings and why she did what she did. We explored why she found the interactions meaningful and how she felt during the encounter. I think that was useful for both of us as co-facilitators to see how we can explore what is really meaningful for others’ (Reflective diary, December 2016, Site 1).

Through ongoing cycles of reflection within the AAR process alongside a lifeworld-led perspective, together we developed sensitivity towards the lived experience of meaningful relationships or connectedness that was beyond what words could describe. Continuing on from the above example, after further reflection, Sophie said,

*“It’s hard to describe, it **felt** like a different relationship” (S03 Physiotherapist, Discussion group, site 1).*

In another example, a therapy assistant tried to find the words to describe how she felt when she saw a distressed patient,

“Um, a bit of empathy I suppose. I feel people’snot feel, that’s the wrong word. I can’t put it into words of what I feel like when someone’s in pain” (S14 Therapy assistant, Interview, Site 1).

In another example, a speech therapist described her encounter with a patient with aphasia,

"I felt I had a connection with her, I was willing her on to do well." (S106 Speech therapist, Observation notes, site 2).

The previous two quotes suggest that participants' felt sense included paying attention to what it may be like for the patient within a healthcare-type relationship, and their bodily felt sense guided their response or relational act. Within the facilitator/animateur role, it was important to animate these nuanced responses of human relationships. Reflecting on humanising lifeworld-led theory steered me to develop my appreciative noticing with an explicit emphasis on listening and noticing in an embodied way, that I have previously described as 'embodied listening' (see Section 5.2 Theme 1: Knowing who I am). For example, I focussed on observations or conversations that were physically sensed as humanly meaningful. I used my body as a generative capacity to understand what was deeply important, even if could not be said, and as a guide to where to focus the study. These processes of noticing along with connecting with one's felt sense and emotions were described by two participants,

"You feel choked up when you are writing them (meaningful experiences). You remember the way the patient reacts, and their emotions. You realise that even though you are just doing your job, how important you are to them. When they said, 'thank you' I kind of just brushed it off, but I realise now that is really important to them. You kind of just take it for granted." (S21 Healthcare assistant, Observation notes, site 1).

*"I think we've learnt that it is more than just getting a history from the family – it's a **feel** for the family isn't it?" (S05 Therapy assistant, Discussion group, site 1).*

Animating participants' responding to their pre-cognitive felt sense while being in relation with others relationships created a space in which nuanced and tacit aspects of their stroke unit relationships could be reflected on and developed as alternative ways of knowing to support human connectedness on the stroke units. Using encounters, in which patients had limited communication ability and being unable to rely on verbal communication to support relationships, provided

significant opportunities to focus on participants' embodied response to being in relation.

7.3.5 *Summary and discussion of Theme 2: Facilitation and Animation*

This theme has described the characteristics of facilitation and animation to support relational practices on the stroke units. In order to facilitate and animate meaningful relationships, the facilitator/animateur also needed to value them and have a relational approach, described as 'being the process'. This is consistent with other studies that described facilitation and animation to develop caring practices needed to be done in context of relational connectedness between the facilitator and participants (Dewar and Sharp 2013; van Lieshout and Cardiff 2015).

Another characteristic of facilitation/animation was using the Positive Principle in AI (Table 12) to intentionally animate and affirm positive relational experiences. The AI literature extensively describes the provocative nature of appreciation. It is described as counter-cultural, disrupting the usual norms and rituals of healthcare (Dewar and Sharp 2013; Trajkovski et al. 2013b). It is also generative as it stirs-in-action to move towards what communities value or desire (Bushe 2008; McKeown et al. 2016), which was consistent with what was described in the data from this study where staff felt energised when positive relational experiences were affirmed and animated, leading to further reflexivity and sensitivity towards their relational practice, also known as the heliotropic effect of AI's Anticipatory Principle (Bushe 2008).

Some authors have raised concerns about the simplistic approach in AI, called the 'Pollyanna effect' in which facilitators are blindly optimistic and do not meet genuine concerns of participants (Rogers and Fraser 2003; Bushe 2012b; Duncan and Ridley-Duff 2014). The data described staff experiences of both authentic and non-authentic appreciation and affirmation. It was important to be authentic in

what was being animated, to address Gervais Bushe's concerns that *"the inquiry has to go beyond simply focussing people on the 'best of' to focus on what is truly meaningful"* (Bushe and Storch 2015, p.15), and the need to explore what Bushe (2011), and Barrett and Cooperrider (1990), describe as the spiritual aspect of human inquiry. This study has shown that when the facilitator/animateur developed relationships with participants, it enabled open sharing of who we all were, our needs and desires, including those that were negative, and reframed them into focusing on what was hoped framed within what we considered to be humanly meaningful.

Creating an open reflexive space to explore and co-create new knowing was a characteristic, and outcome, of facilitation and animation. In the literature, openness is described a key feature to support RCC (Beach et al. 2006; Hughes et al. 2008; Dewar and Nolan 2013; Arntzen and Hamran 2016). Many types of AR, including AAR, are founded on creating open communicative spaces, aligning with its critical emancipatory and co-participatory stance. Qualities of an open communicative space are: being open to other local-emergent perspectives; mutuality and breaking down hierarchy; improvisation and spontaneity; and new possible ways of being in relation or 'going along together' (Aveyard and Davies 2006; Kilbride et al. 2011; Trede 2012; McKeown et al. 2016). Openness from a humanising lifeworld-led perspective is described as 'open-heartedness' – a relational responsiveness in-the-moment, rather than pre-conceived or pre-planned, that aligns with the improvisation and spontaneity within open communicative spaces described in the AR and AI literature (Galvin and Todres 2009). Many of these qualities aligned with what was described in this study. A smaller number of AI studies in healthcare have described the AI process enabling similar open communicative spaces to support healthcare relationships (Dewar 2011; Galvin et al. 2016; Curtis et al. 2017; Dewar and MacBride 2017). Dewar (2011) developed the 7Cs Caring Conversations which provides a framework to create open communicative spaces for RCC, and specifically describes 'being open

and curious’ and ‘being emotionally connected’ as part of relationship-centred conversations, which is consistent with the data from this study.

Previous research has described the need for practitioners to be self-aware of their emotional and tacit responses to being-in-relation (McCormack et al. 2010; Dewar 2011; Scholl et al. 2014). Embodied knowing has been described in phenomenological research studies as informing communication and relationships with patients who have limited or no verbal communication (Sundin et al. 2000; Hydén and Antelius 2011; Kontos and Martin 2013; Gjermestad 2017). Apart from one study by Galvin et al. (2016), embodied knowing has not been explicitly referred to in AR, AI, or practice development research. The data from this study has confirmed previous research describing the value of animating and affirming emotional connectedness to develop relational practice. Additionally, this study described facilitation/animation informed by a lifeworld-led approach, in which there was accentuation of the human experience, including embodiment, alongside other forms of relational responsiveness. Using their felt sense to inform what was meaningful at an existential level, the facilitator/animateur co-created an open reflexive space enabling staff to hold a sense of meaningful connections in a way that our bodies know more than can be explicitly described (Benner 2000; Todres 2007; Galvin and Todres 2013). Naming Sub-theme 7.3.4 ‘Beyond Words’ illustrated that some aspects of the study were constrained by language and could not fully capture the experience of being-in-relation. Data generated with those patient participants who had limited verbal ability provided a unique opportunity for the facilitator/animateur to explore with staff embodied knowing-of-self in relation. The analysis contributes to the emerging evidence that facilitation/animation of open communicative spaces has the potential to create fertile ground for staff to develop relational openness that is responsive at different levels, from the very practical to the most existential.

The next theme will present data on how stories were co-constructed within the context of the stroke unit, and through facilitation and animation, led to reflective and reflexive conversation on relational knowing.

7.4 Theme 3: Voicing emergent narratives on relational knowing (storytelling)

Sharing experiences, often recalled as stories, was the way staff participants voiced, reflected on and co-created meanings of their relational knowing. This was a way in which participants developed presentational knowing, that Heron and Reason (2008) regard as a fundamental part within the AR cycles and pre-cursor to propositional knowing (Table 29). Sharing experiences appeared to develop participants' relational knowing through gaining insights into each other's lifeworld and their different understandings of what were meaningful relational experiences. One aspect of understanding each other's lifeworld was through viewing the work on the stroke unit through another perspective, illustrated in this example,

"End of life care – I was interested reading these. Therapy do not get involved in end of life, it gave me an insight into what nurses do, their perspective." (S05 Therapy assistant, Discussion group, Site 1).

Sharing was predominately through conversations within participants' usual working day, supported through creating open communicative spaces (Sub-theme 7.3.2). As the study progressed, the participants identified that they needed to keep the story-telling alive with new experiences that reflected their local-contextual and constantly changing knowing. Finally, in the spirit of constructionist principles, staff connected to the stories in different ways, depending on how and who with the narrative was being constructed. Therefore, different methods of voicing the emergent narratives on relational knowing were used to enable as many participants as possible to collaborate within the study. The different methods were all centred on appreciative noticing and sharing these with others.

7.4.1 Sub-theme: Appreciative noticing

Appreciative noticing was where participants actively attended more to their observed or experienced meaningful encounters within the context of stroke unit relationships. Appreciative noticing was how the majority of staff, and some relative participants, engaged with the study: noticing and occasionally telling me or others about what they had noticed. Many did not collaborate further with subsequent stages AAR cycles, and yet appreciative noticing was on its own transformational at a personal level. Appreciative noticing appeared to enable staff participants to break from their usual perspective or practices to notice and value positive relationships which could therefore be classed as provocative (see Sub-theme 7.3.3). For example, a nurse approached me on the ward after he had observed the behaviour of two security guards who were supervising a patient who staff found aggressive,

“I want to tell you about two security guards in particular who are great. This is part of your project” (S32 Nurse, Observation notes, Site 1).

For another staff member, the appreciative noticing opened up other perspectives of her own practice, to view her practice more positively,

The project really helped me...I have a wider insight on how I work with people, on a daily basis. I enjoyed the way that I really had to think about my job, from such a positive aspect and not just a professional one (S21 Healthcare assistant, Interview, Site 1).

As a facilitator/animateur, and as part of my data collection, I gathered many stories and examples of positive experiences that I displayed on the wards' notice boards. These regularly led to further dialogue and co-constructions of new meanings and knowing that I used to make more explicit the process. For example,

Nurse: *“I noticed your board yesterday it's really good.”*

I explained that this can be a good way to start conversations with the team. A housekeeper then walked past the board and I asked her if she had read them.

Housekeeper: "No, not yet. I like this one (about chatting with patients who are unconscious at the end of their life). I do that when I'm cleaning their rooms, I chat away to them."

Nurse: "I do too! It's just what you do without thinking."

I then shared with the nurse that this conversation is the type of thing that I would notice, and how we could have reflected further on the meaning behind talking to patients who are at the end of their life.

Nurse: "Oh you notice everything don't you!"

(S111 Nurse & S123 Housekeeper, Observation notes, Site 2).

A small number of staff (the co-facilitators) took the study further and started to experiment with appreciative noticing in a more deliberate way that drew in other team members to start a dialogue,

'And, and I think it is using those skills to highlight to people actually, you may have a negative here, but there are positives from it that you can either learn, or you can use or to sort of counteract that negative feeling. And I think that the project has kind of highlighted to me because I've done quite a bit of counselling training, the fact that I didn't use that enough, that skill enough. I do it with the patients because that's what I do, but to colleagues it's very difficult to - during sessions when I reflect on it, at the end of the session, saying to colleagues that was really good! [laughter] That really worked! What made you think of that?' (S05 Therapy assistant, Discussion Group, Site 1).

This therapy assistant described that she already had her skills that included affirmation, but that she tended to only use these with her patients. Through participating in the study, she could now see the value of using these same skills to support her relationships with colleagues.

In the context of voicing narratives on meaningful relationships, appreciative noticing was the foundation and/or starting block for co-creating these narratives. Appreciative noticing appeared to increase value of relationships within the local stroke unit context and, being appreciative in its intent, supported an open communicative space to explore others' lifeworld (Sub-theme 7.3.2). As illustrated

in the last quote, an important part of the process within appreciative noticing was giving feedback to open up dialogue in which co-creation of new relational and presentational knowing can occur, which leads onto the next sub-theme.

7.4.2 Sub-theme: Voicing affirmation

The process of participants voicing to others their appreciative noticing not only supported a new emergent narrative that valued stroke unit relationships: it was also a part of the relational process itself, thereby illustrating AI's Simultaneity Principle (Table 12) namely the inquiry is the intervention. Voicing affirmations sometimes led to reflection and co-constructed learning that informed their relational approach, often leading to more affirmation. Sharing appreciative noticing heightened others' awareness of the meaning ascribed to their habitual practices by patients, relatives or colleagues. It enabled staff to reconsider what was taken for granted and led to them experiencing things differently. This is illustrated in the next quote where a healthcare assistant reflected on her appreciative noticing during the study,

"It's all about looking at the good things that we all do, whether it is something really small or something that's really big. But even the littlest things to us, are a huge thing to other people" (S21 Healthcare assistant, Interview, Site 1).

Often 'small things' went unnoticed by staff or were obscured by other aspects of care that may have held more value and attention within the local context of the stroke unit. Through voicing these 'small things' through the interview, they were attributed more attention. Once voiced, the healthcare assistant reflected on the 'small things' from the perspective of the patient's lifeworld, even if they were not that significant to her.

Voicing affirmation through feedback was regularly offered to staff by patients, relatives and colleagues; with continued discussion and reflexive learning mostly happening when facilitated as part of the study. Sometimes voicing affirmation was

as simple as saying thank you, which many staff described as important to support their well-being at work. For example, this newly qualified nurse described how she felt when a relative visited the stroke unit to thank her,

“A few weeks later she (the relative) came to the ward; she saw me and immediately gave me a big hug and a lovely card. I was tearful. It meant a lot to me because of all that I had been through (in my nurse training). I am a good nurse. It made me feel good.” (S33 Staff Nurse, Discussion group, Site 1).

This feedback through being grateful opened a space for the nurse to reflect on her unique contribution and resulted in her improved sense of well-being. Voicing affirmation was a presentational form of participants’ relational knowing and appeared to create a communicative space to be reflexive.

Often voicing affirmation did not lead to immediate opportunities for further reflection and learning with those directly involved in the encounter, as illustrated in my notes,

‘I had a discussion with Jane about a story gathering experience. Jane had fed back to an agency nurse that what she did with a patient was lovely. The agency nurse said ‘it was nothing’, but Jane had noticed that it meant a lot to the patient and wanted to tell her’ (S19 Healthcare assistant, Observation notes, Site 2).

Although the agency nurse had a neutral response to the feedback, Jane could see the importance to the patient and wanted to reinforce this to the agency nurse. Through this conversation with the agency nurse, she was sharing both her own and the patient’s perspectives on the agency nurse’s actions. I explored with Jane the possibilities created through sharing what she had noticed: it reinforced the ward culture through noticing what was important to the team; the nurse may reflect on it later; and finally we wondered how much opportunity for positive feedback temporary staff have. This excerpt illustrated that sometimes staff needed to be bold to voice affirmation and to be aware of unseen and unknown possibilities generated as a result of sharing.

Initially, staff found it difficult to receive feedback because feedback they had received in the past was usually negative. The expectation of feedback being negative is illustrated in the following observation,

‘After I had observed Joanna assist a patient with a wash and dress, I asked if I could tell her something that I had observed. She responded with a grimace on her face and asked if she had done something wrong.’ (S19 Therapy assistant, Observation notes, Site 1).

Staff also described similar feelings when sharing their appreciative noticing with others. This occupational therapist described to me her first experience of appreciative feedback,

“It is difficult. Some of us have tried it a little playfully to start with. The nurses seem a little bemused.” (S105 Occupational therapist, Observation notes, Site 2).

Humour appeared to be a common way to try out voicing affirmation, in another example I asked a physiotherapist how she could feedback something that she saw as negative in a more appreciative way, she said,

“It’s lovely that you are here to take his blood, and it’s lovely that a patient can independently use a bottle, but not necessarily at the same time!” (S03 Physiotherapist, Observation notes, Site 1).

Once participants realised that the study was intentionally and explicitly affirmative in nature they became more at ease with the process of voicing and receiving affirmation as their expectation of feedback being negative had changed. At the end of the study, Joanna (who had previously responded with a grimace when approached to give feedback) reflected,

*“Well because of what you came in with was, we want to see **the best** in people we don't want to be moaning about things, so the fact that that was flagged up was great” (S19 Therapy assistant, Discussion group, Site 1).*

Staff described that not all affirmation felt meaningful to them. Sometimes this was when affirmation was perceived as inauthentic, which has been discussed previously in sub-theme 7.3.1. Many, including myself, used our emotional and embodied response to inform what was authentically meaningful to us and therefore to share with others. For myself I noted this in my reflective diary,

“When I am feeding back, or noticing positives I do become emotional. This surprised me. I felt like I needed to share with someone my positive experience straight away.” (Reflective diary, April 2016, Site 1)

In another example, a nurse described how she had varied embodied responses to the stories shared during the study. She talked about a group of stories that had been shared on the stroke unit,

“I feel that these stories are not as ‘strong’ as the others. Some of the first set of stories meant more to me.” (S121 Nurse, Observation notes, Site 2).

This is similar to what has been previously described in sub-theme 7.3.4 ‘Beyond words’, where emotional and embodied responses were doing the recognising of what was meaningful for those involved. These examples also suggest that the stories need to be relevant, alive and within the context of the recipient.

Immediately sharing with others who were involved in an encounter seemed to enable them to hold onto the emotional and embodied feeling of human connectedness within the experience, which supported reflexive learning. Sharing in the moment appeared to be a particularly powerful opportunity for those developing their sensitivity towards their experiential knowing, as the feeling of the encounter appeared to be easier to recall and reflect on. For example, I fed back to a nurse immediately after I had observed her with a relative. I had noticed that she was very relaxed and chatty with the relative. I was interested to understand how she knew it was appropriate to put her arm around the relative. She responded to me with,

“Well I’m a huggy person. I feel it in here (pointing to her chest) if it is alright. I know her too. I also know what it feels like with my dad when he is

in hospital and I am the relative. It's important for them to know that we care for them too" (S20 Nurse, Observation notes, Site 1).

Not all opportunities for voicing affirmation occurred in the moment and, often due to the nature of on-call and shift work, not all staff participants were available every day. Therefore feedback often happened much later (days or weeks). Even if they were not involved in the original encounter, some staff participants described how they had an emotional or embodied response to hearing and sharing a story. For example one nurse, who was also a co-facilitator, shared with me,

"Oh I've got some stories for you. Mrs. Smith's family, she died last week. They asked me to thank Peter (a junior doctor). Peter talked through the end of life pathway with them and they just wanted him to know that he was really lovely. When I told Peter, he said that he really appreciated that, it meant even more when it is about a patient dying, because you really want to get that right. I felt proud telling him. Proud that he did it" (S121 Nurse, Observation notes, Site 2).

In another example, a manager had received a letter of thanks from a patient,

"In terms of feedback, well the senior nurses have offices just down the corridor, so with that letter, I was straight down there and said, 'Oh look at this, hurrah!'" (S34 Manager Interview, site 1).

Although both these participants were not involved in the original encounter, the stories remained relevant and within the context of the person receiving the feedback. By voicing the affirmation with others, they co-created a sense of well-being and togetherness.

7.4.3 Sub-theme: Reflection and reflexivity

Relational knowing was developed while affirming meaningful stories and experiences, and when the dialogue included reflective and reflexive opportunities. Reflection and reflexivity appeared to be important processes in moving from experiential to presentational and practical knowing of human relationships within the stroke units. Reflection and reflexivity were not discrete activities; instead staff

participants appeared to move along a continuum of reflective and reflexive conversations.

There were personal and group reflections that were not captured within data generation for this study. Staff participants often mentioned to me times outside of work when reflections occurred including: while going for their daily run; talking to a partner on the drive home from work; or calling a colleague when not at work. Although these data were not captured, staff participants often brought their reflections into later conversations that were included in the data. In one hospital, there appeared to be more formal opportunities created for senior staff to reflect. This was mentioned by many of the senior clinicians and managers,

“I think we're good at that. I have quarterly half day sessions with all of the senior nurses where it's their time away from the day to day operational pressure to think about what next, where do we want to be going, as a profession, in this organisation” (S34 Manager, Interview, Site 1).

Staff members who were not considered part of the senior team relied on local team-based opportunities for reflection, with the nursing team having fewer opportunities than other professional groups within the stroke MDT.

(i) Reflection

At the reflection end of the continuum, reflective conversations appeared to support several possibilities for relational practice: firstly, it supported maintaining an appreciative stance; secondly, it enabled staff to focus on the relational aspects within the context of the stroke unit; and thirdly, it supported openness, which has been previously discussed in sub-theme 7.3.2.

Reflective conversations with staff mainly happened ‘on the hoof’ during conversations that occurred immediately after appreciative noticing of an encounter. Conducting reflection in this way was initially for pragmatic reasons to fit with the ward routines and high staff workload limiting opportunities for

dedicated time for discussion. ‘On the hoof’ reflections reinforced the value of appreciative noticing during their day-to-day work (see Sub-theme 7.4.1), and kept the process dynamic and locally emergent. Joanna described her increased awareness of positive care experiences through reflection,

“Your project has already changed things. Focussing on the positives, helping us reflect. Usually we wait for the thank you cards after the patient has been discharged. I found the posters you put up useful; it really helped me reflect on the positives” (S14 Therapy assistant, Discussion group, Site 1).

In this second example from my observation notes, my reflective conversation with Flo supported her developing an appreciative focus,

‘Flo was struggling with her workload because of staff shortages, and it was overwhelming her. Through a reflective discussion that included my observations of how her colleagues were supporting her, she reflected that the appreciative feedback had changed her perspective on her day by highlighting what was working rather than dwelling on her frustrations’ (S21 Healthcare assistant, Observation notes, Site 1).

Secondly, reflection focussed around relationships within the stroke units sometimes led to developing their knowing and change-in-action. This was illustrated by Joanna and Flo (both co-facilitators in the study) who described a widening of focus for their reflection. For Joanna, hearing Connie’s story led her have a different perspective on Connie’s relationality,

“Hearing or reading about other people's experiences since the project, so one of the ones that interest me was Connie. And her little touch of putting bed socks on a patient after she had laid them out, and I saw her in, quite a different light. Because the way I see her, was seeing Connie as she means well but she's quite immature and always come across with saying the wrong things, and I sometimes I want to step in and help her. But reading that, I thought actually she doesn't need any help! She does do the right things, at the right time for the right people. And that she actually works better when she's in a situation when she's got time to do it and, yeh, she was able to do what she was best at, in that situation. So that was nice” (S14 Therapy assistant, Discussion group, Site 1).

Through the story she understood Connie’s intentions behind her actions, and what helped Connie to work at her best. Connie’s intentions aligned with Jane’s and through reflecting on the story, Jane had come to an understanding that although

she and Connie have different behaviours, their intentions are similar. It challenged how Jane had related to Connie in the past and offered new possibilities for relating in the future. In Flo's example, she described her perspective widening from a clinical or 'technical' focus towards being more relational,

"Writing the stories down – it was nice to acknowledge the non-technical side of the session – the two-wayness of the session. Acknowledging that you don't have to stick to your boundaries" (S21 Healthcare assistant, Discussion group, Site 1).

In Flo's quote, she mentions new knowing through reflection, "you don't have to stick to your boundaries", that had the potential to change her relational practice. Flo's reflections were personal reflections while writing her experiences to share with others. In the next excerpt Ester described how personal reflection alongside reflective discussions with her team supported her in experimenting with new ways of being with her patients,

"I wasn't achieving what I needed, so I thought I'd try something new. It was because of my own reflection and feedback from others in the team. (S38 Occupational therapist, Discussion Group, Site 1).

Finally, reflection supported staff participants' openness to other perspectives, described as, *"I feel I know others better now" (S14 Therapy assistant, Discussion group, Site 1)*, and *"It helps me not assume" (S05 Therapy assistant, Discussion group, Site 1)*. The data on being open and reflective has already been presented in sub-theme 2.2 and, to avoid duplication, will not be discussed further here.

Staff participants' reflection of their stroke unit relationships was grounded within their experiential knowing, voiced predominately through story-telling that enabled them to develop new narratives around relational practice, reflect on their practice and experiment with new practical ways of knowing to change practice. There was, however, a different, sometimes concurrent, personal change of self that appeared to be less of a cognitive process than described above that moved towards the reflexive end of the continuum between reflection and reflexivity.

(ii) Reflexivity

Through being reflexive and reflexive dialogue, staff participants described new knowing-of-self in relation to others that included attending more towards how their bodies meaningfully communicated their self without words.

Within the reflective conversations described in the previous section, the focus of relationships, and in particular human connectedness, sometimes developed towards the reflexive end of a continuum between reflection and reflexivity. Engaging reflexively with the stories was a time for staff participants to draw on the meaning of their stroke unit relationships (described by participants as human connectedness), and re-thinking of self as a relational self. The data on knowing-of-self has already been discussed in Theme 1 (Section 7.2). The following example illustrates how Paula, through being reflexive, developed her knowing-of-self in relation to the family members. Paula reflected on her being open to suspend certainty in her pre-planned approach to a family meeting once she was in that present moment of being in relation with the family,

“Before the family meeting I wrote out a long essay about what I was going to say, but I didn’t use it. Once I was in there it wasn’t right....I was aware of the power element and I needed to give them the same control, sometimes being in uniform doesn’t help. I’m human at the end of the day. It’s just being human and friendly. Because I am less experienced I like structure, but that meeting wasn’t structured. I need to learn to trust myself, be more confident in my training” (S124 Occupational Therapist, Observation notes, Site 2).

This is an exemplar of being reflexive and deepening knowing-of-self that supported staff being relationally engaged with others. In another example, Joanna described how she was teaching a wife to use a hoist to lift her husband out of bed, but the wife was taking longer than usual to be confident in using it. Through a reflexive discussion, Joanna considered her relationship with the wife was significant in supporting the wife’s confidence to care for her husband within the context of the

husband and wife's relationship. This altered her view that the wife's difficulties transpired from learning the technical aspects of using a hoist,

"I suppose it was just much more personal, I just got to know them both (the patient and his wife) a lot more. I think he (the patient) felt probably uncomfortable and embarrassed that she (the wife) was having to do all this because he had previously been this man with a boat and everything, and in charge of everything" (S14 Therapy assistant, Interview, Site 1).

Joanna also reflected that she was able to form a deeper relationship when they were all more relaxed and open,

"I built up a relationship with her, being in their home was relaxed for all of us then. She (the wife) wanted to be helped, and I felt very comfortable with that. Before when I was teaching her on the ward, it was our territory, and it felt like there was a barrier between me and the wife" (S14 Therapy assistant, Interview, Site 1).

In the next excerpt, Steve described how being reflexive enabled him to consider what was meaningful to him at work. For Steve, this was reflecting of how nurses prioritised their time and energies towards what is most meaningful and 'real', and for this not to be obscured by political, professional or organisational agendas,

"A lot of my friends say that I think too much about everything! Fair enough, but I think that if you don't, there is a slight sense that you are just going through the motions really. I think one of the problems we have as nurses we do tend to think about the job in a little bit of a bubble. I personally think that is a mistake. You can't really make sense why you are doing it or what you are doing it for.... we need to focus on what is real, rather than what we imagine to be real" (S32 Nurse, Interview, Site 1).

Additionally, being reflexive about human connectedness opened possibilities for staff to think about how they are humanly relational in the context of their work that can be full of different meanings. For example, how to word posters that were less directive and more relational, or to value more social conversations within staff meeting to connect with each other. Meanings of human connectedness drew on all aspects of the lifeworld and what it means to be humanly relational (Table 6), and also included beyond words (Sub-theme 7.3.4). Meanings of human

connectedness, where the emphasis moved beyond verbal discourse, were highlighted more often when reflecting on connecting with patients with cognitive or communication difficulties.

At the beginning of the study, most staff described that they were aware of their how they felt, their lived bodily responses towards meaningful human connections with patients, yet had little opportunity to explore their meaning and possibilities of to inform and guide their relational practice,

*“It **felt** like a different relationship” (S03 Physiotherapist, Discussion group, Site 1).*

*“That time **sits** with me quite a lot, we were engaging **them**... it almost like opened up the conversation for those who have got difficulty in their language skills” (S14 Therapy assistant, Discussion group, Site 1).*

‘The doctor asked the patient (who was unable to communicate verbally) about whether she was in pain. The patient looked to the doctor, frowned and screw up her face. The doctor immediately mirrored the patient’s facial expression’ (S36 Doctor & P09 Patient, Observation notes, Site 1).

Reflexive conversations, within the context of exploring stroke unit relationships, were an opportunity to explore these felt bodily (termed embodied) responses, to attend to, and become more sensitive towards, how they can inform and guide being in relation. These conversations moved beyond the usual cognitive approach of developing relationships towards emotional and embodied aspects. This supported openness and responsiveness to connect in a way that draws on complex, tacit and aesthetically textured knowing of human relationships. For example, an occupational therapist, speech therapist and I had a reflexive discussion after observing a patient with communication and cognitive difficulties make a cup of tea in the therapy kitchen. In my reflective diary I wrote,

‘The patient had difficulty recognising the kettle, cup and milk jug and what they were used for. We all described a strong embodied response while watching the patient, willing her on, with a sense of excitement when she recognised what to do. We all agreed that through this shared experience we felt a connection with the patient. Through our reflexive discussion trying

to understand our strong embodied response, we realised that the encounter was more than a functional task of making a cup of tea. We gained a different perspective of the meaning of the kettle, cup and milk jug within the context of being in relation with place and things. The objects no longer had the same meaning for the patient and illustrated to us one aspect of how the patient's lifeworld had changed as a result of her stroke. We could not fully understand what it was like for the patient, nor could she tell us because of her communication impairment, but we all had a felt sense of the objects' significance for her as a person' (Reflective diary, Site 2).

These types of reflexive discussions animated the explicit value of emotional and embodied expressions or responses for all involved. Using the illustration above of making a cup of tea, before the reflexive discussion, we were aware of the patient's communication and cognitive problems, how that may impact on her ability to be independent in making a cup of tea and how we could plan to support her emotionally and practically. The reflexive discussion focussing on relationships that drew on our embodied response to the encounter led us to appreciate what it must feel like for the patient not being unable to recognise everyday objects like a cup and its significance in her lifeworld. It didn't necessarily change what we did, so the outsider observer may not have noticed any change. However, it did change our perspective of the encounter and how we felt towards the patient that supported a feeling of connectedness and meaning for the encounter. It moved the encounter beyond, *"going through the motions"* (S32 Nurse, Interview, Site 1) of making a cup of tea towards a, *"focus on what is real"* (S32 Nurse, Interview, Site 1) or meaningful.

For a small number of staff participants, the type of reflexive dialogue described above sensitised and placed value on their pre-cognitive, intuitive responses to being-in-relation and connecting with others. For example, some staff were observed immediately mirroring patients' with communication difficulties facial expressions without the staff member consciously using this as a form of connecting with the patient, or; intuitively placing a hand on an patient who is unconscious or confused to move towards connecting with them physically, and to help them have

a sense of what is real within the patients' potentially confusing lifeworld. The reflexive discussions helped staff participants to explore the meaningfulness of these actions, not only as non-verbal communication but also relating to others through using their body as a powerful form of human connectedness and knowing others. It challenged their usual practices of getting to know others that relied on verbal discourse and gave possibilities to rely on other ways of forming relationships. These type of reflexive discussions were not a usual part of the stroke unit culture and only happened as a result of the study.

Reflexive conversations that increased individual's sensitivity towards emotional and embodied aspects of being in relation, and more attuned towards a felt sense of connectedness, supported staff to be more at ease in holding the unknown and the known together and co-creating a connectedness in that moment.

"I sometimes forget that she can only say yes or no because we have a good conversation" (S06 Physiotherapist, Observation notes, Site 1).

"I like this story about sometimes forgetting that that patient has communication difficulties. If I have 15 minutes just to sit with them, not treat them with pity or if they have had a stroke, but with dignity and compassion. If I can get them to smile if they have had a bad day, that is really amazing" (S20 Nurse, Observation notes, Site 1).

"But it is something about your demeanour - being warm and open. For example, Betty (patient) can't communicate at all, but we communicate with her, it feels comfortable because we know her" (S37 Nurse, Discussion group, Site 1).

In summary, staff participants gave more value to feeling having a relationship with a patient, even if there was no verbal understanding. Often in the reflexive conversations, embodied responses were difficult for participants to describe and capture using verbal language suggesting limitations of the forms of data generation used for this study and limitations in language when moving from experiential to presentational forms of knowing.

7.4.4 Sub-theme: Creating opportunities for emergent narratives

Creating opportunities for emergent narratives on human connectedness to continue within the stroke units aligns with AI's Constructionist and Narrative Principles, in which meaning is continually co-constructed in relation through conversations. It was notable that the study led to more conversations around the person with a focus on supporting relationships. Initially opportunities were created through facilitation and animation (Theme 2, Section 7.3) by different methods: stories displayed on ward notice boards, emotional touchpoints, photo elicitation and discussion groups (see Section 4.4.4). Using the display of stories on ward notice boards as an example, the excerpt below demonstrates how it created opportunities for conversations,

'There was a group of staff (a consultant, ward sister and three junior doctors) around the board which they had passed during their ward round. The team were all talking about the stories.'

Doctor - "Oh it makes me well up to read them."

Consultant – "Thank you for doing this (the study) here. It will affect the staff, how do you measure that - less use of antidepressants by the staff?"

Doctor – "That story is really good, about staff being kind."

We then had a discussion about the stories and how they can be a prompt for conversations with others about what the team values on the stroke unit.

Sister – "They are doing that - the nurses are looking at the board and we are talking about it" (S109, S112, S117, Observation notes, Site 2).

Most staff participants described that they found the posters valuable as they could engage and reflect on them in their own time. Relatives also read the posters which occasionally prompted positive feedback to staff on their experience of the stroke unit, again illustrating the Simultaneity Principle in AI where inquiry was also the intervention. For example, a patient's relative wrote a note next to the stories,

"I think all the staff are FANTASTIC, so nice on the phone when I call from Gosport, and so nice when I am here visiting. THANK YOU." (Observation notes, Site 2).

Over time, staff started experimenting with ways in which they could change conversations towards focussing more often in their day-to-day practice on the person and the co-created relationship,

"You haven't learnt a new skill, but you are more mindful to use that more of the time" (S05 Therapy assistant, Discussion group, Site 1).

Creating opportunities varied significantly between the two sites depending on the physical space, local culture and how the team already communicated with one another. Creating opportunities led to new ways of presenting relational knowing that included: staff changing the language used on posters to relatives on the ward after they reflected that they could be more friendly; a ward sister flipping relatives' negative feedback into affirming positive practices after a conversation on how negative feedback can demoralise staff; and, in the following excerpt, a relative wrote an open letter (addressed to all staff and displayed in the staff room) while the patient was still being cared for on the stroke unit,

"The family has especially valued the opportunity to visit whenever family members could; this has helped our family cope with the difficult prospect of my wife's early demise, and then to work with staff to assist her as she gradually regained some of her capabilities....I would like to record our gratitude. My wife was in a very dark place when she came onto the ward, and you have kept her positive and even happy during her recovery" (R10, excerpt from a relative's open letter to the ward staff, Site 1).

In this example, the writing of this letter was instigated after he had explored the positive elements of his care experiences during an interview for the study, a clear example of the Simultaneity Principle in AI where the inquiry itself is the intervention that creates change.

Experimenting with opportunities did not always have the intended outcome, but staff showed a willingness to give it a go. For example, a physiotherapist tried to

bring more a relationship focussed narrative into a weekly MDT meeting. A nurse who attended the meeting said,

"It was a bit of a non-starter. The consultant was sarcastic and dismissive. His only suggestion was, 'let's have tea and biscuits and sit down and discuss each bay and finish at 8pm!' I was disappointed with his reaction - I thought he was supportive of the project" (S40 Nurse, Observation notes, Site 1).

Whether these opportunities were created by me or by staff, we learnt that creating opportunities needed to be relationally responsive to that moment, which aligns with the worldview of relational constructionism. Opportunities needed to: (i) be opportunistic and ready to respond to conversational openings; (ii) connect with others' experiences. These processes were mostly learnt through trial and error and co-facilitators' reflections.

(i) Opportunistic and responsive

Each day that I attended the stroke units (usually three times a week), opportunities for observations and informal conversations varied. Limited time to have conversations, staffing and workload had a big impact on the teams' openness to engage in conversation beyond immediate clinical or operational needs. For example, in my reflective diary I wrote,

'The ward is busy after a bank holiday weekend. It has a 'down to business' feel on the ward. There are some patients with confusion and require constant supervision that increases the workload for staff. It was difficult to start any conversations today. Everyone has their eyes down, there is hardly any talking between the staff' (Reflective diary, May 2016, Site 1).

On other days, some staff sought me out to share new positive experiences or there was more social talk by staff members, which were opportunities to explore their relational experiences. Being opportunistic in moving the narrative toward relationships and the person was described by Christine below as a dynamic and natural process,

“Having it more as natural chit-chatty kind of way, like, ‘Do you realise that she likes being called so and so?’ It just brings a bit more individualism about each person into the conversation. In a nice way, instead of having it as a task” (S05 Therapy assistant, Discussion Group, Site 1).

Similar to Christine, I found that most opportunities occurred while standing with the team by the nurses’ station or during staff coffee breaks. Often conversations were with one or two people with other staff members listening and hearing what others valued about their relationships on the stroke unit. Opportunities for discussion appeared to be associated with the person’s openness, described by Christine as,

“I think not everybody's engaging with it, or would engage with it, as it's not everybody's thing to be that open” (S05 Therapy assistant, Discussion group, Site 1).

This was reinforced by another staff member who valued more individual discussions rather than formal discussion groups,

“I do not like the photos and group work, it felt a bit like Alcoholics anonymous all sat together. I would rather have less group work and more one to one” (S25 Physiotherapist, Interview, Site 1).

Staff valued conversations as a group or individually, depending on how they feel most comfortable. Therefore, the co-facilitators needed to be ready to respond relationally to opportunities that arose, reinforcing Theme 1 – the need to start with your relational self.

(ii) Connect with others’ experiential knowing

The stories or conversations (as a form of presentational knowing) needed to connect with and reflect participants’ experiential knowing, often described as an emotional connection. It appeared to deepen understanding of the lived sense of what it felt like for all involved. This was described to me by Flo after she had written some stories about her memorable experiences on the stroke unit,

“You feel choked up when you are writing them. You remember the way the patient reacts, and their emotions.” (S21 Healthcare assistant, Interview, Site 1).

When participants reflected on their feelings and their lived sense, it appeared to make the conversations more transformational. Using emotional touchpoints during reflective conversations were particularly effective at enabling participants to connect with their feelings while telling stories of their relationships with others. For example, during a coffee break this nurse used emotional touchpoints shared her feelings of working with a healthcare assistant (HCA),

“I’ll choose ‘Let down’ and ‘Guilty’. On Monday I felt I let the HCA I was working with down, and I know I let her down. Because I had been doing all the medical things, I didn’t get a chance to do the washes. I’d kept touching base with her. You sometimes feel as if you have to justify it otherwise the HCA will say that I’m slacking. I’ve never heard that though. Some HCAs ask when you are going to help them. I feel guilty that I have to do the medical things. I think that some of the HCAs would be surprised if they knew how we feel.” (S27 Staff Nurse, Discussion group, Site 1).

Even patients with limited expressive communication ability found emotional touchpoints useful, provided they had good written comprehension.

Creating opportunities for conversations around human relationships were openings to affirm, value and reflect on relational knowing within the context of their stroke units. This sub-theme presented data on how I and the co-participants created opportunities to us all to voice these narratives more often. It required being creative with ways to voice these narratives to enable others to connect with the stories. It also required to be relationally responsive as to when to have the conversations. Within AR’s extended epistemology (Heron 1996; Heron and Reason 2008) this process can be seen as developing practical knowing of ways to present experiential and relational knowing.

7.4.5 *Summary and Discussion of Theme 3: Voicing emergent narratives on relational knowing (Sharing stories)*

The data presented in this theme illustrated that sharing stories and informal conversations that have a relationship focus can lead to staff noticing, valuing and having reflective or reflexive conversations on their relationships with others on the stroke units. This can be interpreted as sharing stories being transformative for relational practice that aligns with the Poetic Principle in AI - in which stories that focus on relationality and the values and beliefs about who participants were as relational beings, enhanced the collective ability to co-create new relationships based on those values or beliefs (Barrett and Fry 2005; Cooperrider et al. 2005).

The data are consistent with previous research that has described the value of storytelling for healthcare relationships. Patient stories have been cited as enabling staff to see experiences from the patient or relative perspective, personalise care and enable emotional understanding (Blickem and Priyadharshini 2007; Brown Wilson et al. 2009; Branch and Frankel 2016). For Stroke MDTs, sharing stories have been described to support trusting team relationships, developing a common bond, and understanding each other's roles (Gibbon and Little 1995; Clarke 2010; Cramm and Nieboer 2011; Kilbride et al. 2011; Bennett 2016).

The sub-themes have described processes that enable opportunities for storytelling with a relational focus and how further knowing and opportunities are locally developed within the day-to-day routines on two stroke units. The processes enabled staff participants to broaden their perspective beyond cognitive knowing of communication models for transactional communication towards a relational emphasis. Storytelling with a relational focus explored emotional and embodied connections as meaningful expressions of relationships that added value and affirmed forms of connectedness other than verbal communication. It was less about what was said and more about what participants were co-creating together. This is consistent with the lifeworld-led concept of storytelling, in which listening to the story and the words that work for other participants, not only deepens one's

own understanding but also awakens a 'lived sense' of their situation (Todres 2007). The themes develop the current evidence on stroke unit relationships through demonstrating the co-creation of human connections within the context of stroke units and reflecting on how patients, relatives and staff felt within these relationships.

Appreciative noticing and affirming human relationships through storytelling challenged, or provoked, the usual stroke unit discourse that tended to centre on clinical and operational needs, and often with a negative or problem focus. Appreciative noticing and voicing affirmation could be interpreted as the first steps of 'possibility creating' within AI's Narrative Principle, based on constructionist views, where valuing and talking about strengths and possibilities can create that reality (Barrett and Fry 2005; Wasserman and McNamee 2010; McNamee and Hosking 2012). Wasserman and McNamee (2010) advocate a 'dialogic culture' which supports ongoing conversations that lead to creating relational possibilities among professionals. This study has described that a dialogic culture on stroke units is possible.

Appreciative noticing and voicing affirmation created a reflective and reflexive open communicative space to explore their practice from the perspective of human relationships. This data is consistent with several papers by Dewar and authors who describe similar processes to support RCC (Dewar 2011; Adamson and Dewar 2015; Roddy and Dewar 2016; Dewar and MacBride 2017). The data also supports Suddick & De Souza's (2007) findings where they described shared spaces for colleagues encouraged 'soft' chatting that were important for team communication and reflection. The importance of reflective and reflexive cycles to support relational knowing within the AAR process is consistent with Dewar's model of AAR (Dewar et al. 2017b). A collaborative, reflective and reflexive approach enabled participants to further develop knowing of their relational self that was no longer focussed on individual responsibility or control and, instead, supported collective

relational responsibility (Hosking and Pluut 2010; Wasserman and McNamee 2010; Roddy and Dewar 2016). The reflection described in the data is consistent with that described in the relational constructionist literature, in which reflection is seen as moving to alternative and multiple domains of relatedness that subsequently gives voice to further relationships (Gergen 1999; Hosking and Pluut 2010).

The co-operative and affirmative nature of AAR enabled staff to feel secure to open up to honest reflections and co-learning. A sense of security is cited as important for exploring and learning about other's lifeworld and RCC (Nolan et al. 2006; Galvin and Todres 2013; Hörberg et al. 2014). An overtly appreciative stance to relational knowing therefore had two concurrent benefits: creating a safe open communicative space that could then be used to explore other's lifeworld and one's relational self. There was also a third benefit: being actively appreciative was part of the relational process itself, supported by this quote,

"through appreciating others' words and actions, we enhance the value within and among our relationships, the organisation, the community and beyond" (Wasserman and McNamee 2010 p.315).

Similarly, Dewar, McBride and Sharp (2017b) highlighted the benefits to team relationships in which an actively appreciative and caring stance as part of AI can improve colleague relationships. Maintaining a dialogic culture that valued relationships and supported relational responsibility balanced the stroke unit discourse between clinical, operational and relational.

This analysis, that included a lifeworld-led lens to analysis, built on the discourse emphasis of constructionism and AAR to include uncovering, feeling, describing and acknowledging participants' own embodied felt sense and how this informed the direction of their relational knowing. These were *feelings* of well-being experienced as part of voicing affirmation; their *felt sense* of what was meaningful; and their felt sense of another's lifeworld. Galvin and Todres (2011) have defined this felt sense of another's lifeworld as 'embodied relational understanding'. Being reflexive with

a lifeworld-led lens supported sensitivity beyond a cognitive understanding of feelings towards embodied relational understanding. It was both talking about, and experiencing, a lived sense of human connectedness that energised participants to further knowing of their relational self and collective learning.

Finally, the data described ways in which participants experimented with creating opportunities for relational dialogue on the stroke units with others within their daily practice. These processes were consistent with what is described in the AI literature as generativity, that Bushe (2015) refers to as micro-innovations, which are an aspect of AI's Anticipatory Principle (Barrett 1995; Bushe and Storch 2015). Data on generativity described relational processes in which creating opportunities needed to be relationally responsive to what was unfolding in-the-moment. Being relationally responsive to what is unfolding at that present-time is also described by Todres (2008) as a core value of humanising care. This aspect of relational practice could be inferred from other studies that have described how opportunistic dialogic, that is more responsive in-the-moment, supported closer relationships with MDTs (Watkins et al. 2001; Burton et al. 2009; Clarke 2010).

The final theme in this chapter will present data on participants moving from experiential (appreciative noticing and being fully present, beyond words) and presentational (storytelling and voicing affirmation) ways of knowing to practical ways in which staff participants co-created freedom within the stroke unit space to act or respond relationally with others.

7.5 Theme 4: Freedom to act relationally

This next theme develops sub-theme 7.3.4 (Table 33) to being responsive *beyond* conversations and storytelling, to behaviours and a way of being with others that ultimately supported a stroke unit culture in which participants felt freedom to act relationally. The data presented here will be used to discuss, for example: what

enabled a nurse to sing an Irish song to a patient? What enabled a housekeeper to pause from cleaning to sit next a crying patient? Or, enabled a speech therapist to have a lived sense of what it must feel like for a patient who cannot make sense of a cup?

Three sub-themes were developed on participants' freedom to act relationally: firstly, concerning co-creation of a different pace or rhythm in order to act relationally; secondly, a culture that values human relationships; and thirdly, demonstrating the value of relational practice to others not directly engaged in the experience.

7.5.1 Sub-theme: Pace and space to be relational

Staff participants who were co-facilitators identified that nurturing relational practice required a unique pace to their other experiences of practice development, which seem to reflect the relational nature of the change process. The gradual nature of change was described by staff co-facilitators in a discussion group at the end of the study,

"Our care, not just us but also the nurses, is very structured so you have to make changes gently, you do just have to almost worm your way in.....and it's slow. You can't just do it on that occasion, it's remembering, next time I see that happening perhaps I could say this" (S14 Therapy assistant, Discussion group, Site 1).

"Sometimes it just needs some ... woodpecker [laughing] effect on it, and making people realise deep down everybody's got it in them" (S05 Therapy assistant, Discussion group, Site 1).

The gradual nature of change was the experience for themselves as well as when facilitating others in the team. Several participants described how their change in self (Section 7.2 Theme 1) then impacted on their relational approach with colleagues, patients and relatives, which then enabled them to support wider changes in the stroke MDT. In some instances, change in participants' perspectives or practices were immediate and responding in-the-moment, but these changes (in

self and in the team) were small and incremental over months, rather than an epiphany moment resulting in a large transformation.

The work and activity performed on the stroke units had a direct impact on the participants' freedom and openness to connect with others. There were many days, or specific activities on the ward, when the MDTs were firmly focussed on their organisational tasks and delivery of clinical care. Being aware of the pace and rhythm of work allowed for opportunities for individuals to be more relational with others, described by myself and others as needing to pause from a task focus and move towards focussing on being. The freedom to pause and slow the pace overlaps with the previous themes in this chapter: being more mindful and sensitive towards being relational creates opportunities for changes to the pace or space on the stroke unit.

Finally, the lived space (spatiality) within the stroke unit also had an impact. A space that created feelings of comfort and being at ease were important for freedom to respond relationally. Staff participants described how different areas of the stroke unit could facilitate connecting with others in different ways, for example a physiotherapist (S03) described taking a patient to the day room with fewer people and ambient noise which helped her zone out the ward pressures, and to be more attuned to the patient during a therapy session. Others confirmed this by describing having no interruptions, or no call bells ringing, enabled them to focus more on the person. Communal areas were equally valued as a space for social interaction and peer support, giving others opportunities to join in if they want to. Some participants described how the stroke unit décor affected them, for example,

"This ward is a bit older, a bit tatty around the edges. It makes it friendlier and I feel it helps me to have a bit of fun and banter with the patients. When I've visited other wards that are all modern and sleek, I feel I should be smarter, a bit more professional in the way I am with the patients" (S14 Therapy assistant, Observation notes, Site 1).

“I printed off lots of photos of Shelley’s (the patient) daughter and put them on the wall next to her bed. I did that to make her bay more homely when she moved. The patient cried when she saw them.” (S17 Healthcare assistant, Observation notes, Site 1).

Often the overcrowded and noisy stroke unit environments limited mutual opportunities for conversations, and was not always conducive to the different rhythm or pace required for relational practice (Section 6.4, Theme 3).

7.5.2 Sub-theme: “How we are, not what we do”

Staff participants’ freedom to respond relationally was nurtured by the culture constantly being co-created by the MDTs. Human relationships that were valued and amplified within the MDTs, and staff participants who felt supported and valued, co-created a local culture with space for staff participants to respond relationally. The cultures were more explicit of this is “how we are” (S03 Physiotherapist, site 1) – that is a relational focus and valuing human connectedness. One manager described her perspective in supporting the team’s freedom to act relationally,

“Those ward leaders, I want them to feel they have the freedom to - there will be a line [laughing] that I won't don't want them to drop below- but have their own creativity and to lead those wards and care for the patients in the way that they see as fit. Because they know that better than I do. They're out there, every day” (S34 Manager, Interview, Site 1).

In another example, a nurse described how as a mentor for nursing students he created a place for students to value human relationships while being open to other approaches to relational practice,

“I suppose I show those values partly by how I try and treat them (the student nurses). I try and give as much of myself, and my knowledge, that I can.... But I’m not saying my approach is the correct one” (S32 Nurse, Interview, Site 1).

Another nurse recalled a time that demonstrated a healthcare assistant’s freedom to respond,

“One patient was sobbing and sobbing. We were all really busy, short staffed. Yvette asked if she could phone the husband. She recognised that the patient was upset and went and did something about it” (S121 Nurse, Discussion group, Site 2).

Staff participants often gave examples of when they felt freedom to move towards connecting with another even though they may have felt vulnerable in doing so; often described as feeling silly, awkward or less professional. Many examples have already been presented in these chapters including talking or singing to a patient who is unconscious; or demonstrating yoga moves on the floor in a bay. Sharing stories of times when staff felt vulnerable in moving to connect was an important part of the co-created culture of ‘who we are’. This was one aspect of an additional narrative focusing on human relationships within the stroke unit teams’ day to day discourse that affirmed what the teams most valued about their relationships on the stroke units, and nurtured a sense of freedom to respond relationally.

7.5.3 Sub-theme: Counter-cultural nature of ‘how we want to be’

Development of the stroke teams’ culture and practice towards a human relational focus appeared to be counter-cultural to that which prevailed in both hospital organisations. Both organisations appeared to value practices that were observable and measurable in demonstrating and evaluating practice alongside a ‘quick fix’ approach to practice development.

The longer timescales of change required to develop humanising relational practice became evident from the study on the second stroke unit. Here the study was conducted over four months in comparison to 16 months at the first site. There appeared to be less transformational change described by site two participants both individually and across the team. This is contrast to the first site which continued to co-create new ways of working and share their experiences of practice development over a year after completion of the study.

With regards to demonstrating and measuring practice changes, staff participants described that they were not always necessarily changing their behaviour or actions as a result of the study; instead it was changes to their perspective, their intentions, and their way of being-in-relation with another that *felt* different. Sophie's final reflections of the study illustrated this,

'What has changed? It is how you are, not what you do. I need to ignore the pressure to do something and think about how you are. I have more awareness of positivity in developing relationships. I think outside the professional box – patients are people with a life outside of hospital, with their own individual needs and own personality' (S03 Physiotherapist, Personal reflective notes, Site 1).

In another example, Violet described from her relational perspective, how it was her intentions, feelings and her relationship with a patient that underpinned her actions,

"I try to help Bert (a patient) feel comfortable, I feel sorry for him, he has been through so much and he recognises me each time I'm on duty. He is grateful, gives me a kiss to say thank-you" (S12 Nurse, Observation notes, Site 1).

A relative also reinforced this in her interview,

"It's not just because they run to get him something when he asks, it's just they kind of look at him and smile, treat him normally, sort of treat him like a human being" (R01 Relative, Interview, Site 1).

Very occasionally, staff described an overt change in behaviour by colleagues. This could have been an actual change in behaviour by their colleague, or it could have been an example of how colleagues saw others differently through appreciative noticing,

'I had a discussion with a physiotherapist about me shadowing a consultant on the ward round. The team had noticed that the consultant's behaviour

had changed to being more patient focussed and taking time to listen to the patient when I was observing the ward round. I reflected that it was great that he had demonstrated that he was able to be more patient focussed. We then discussed how this could be enabled to happen even when I am not there' (Observation notes, Site 1).

Any changes to colleagues' behaviour the staff found difficult to confidently attribute to the study, for example, Joanna said,

"Sometimes I find it difficult to know, whether or not, they are changing because of that (the study) or because of something else.... and they realise that this is the way you can, not the way you should be, but you can be like this and it works. And they found it works. So, it's quite hard for us to analyse within our own team [sigh] I don't know" (S14 Therapy assistant, Discussion group, Site 1).

It seemed as if relational practice development needed to be held in a different space and nurtured from a different perspective to other forms of practice development. It was deeply personal, fully grounded and responsive to the experience of being-in-relation. It needed to draw on the tacit, intuitive, creative and 'in the moment' dimensions of human relationships. This learning was developed within the design and action phases of the AAR cycles, during which some of the practice changes, for example, specific behaviours such as remembering to welcome each visitor to the ward, appeared to lack the dimensions of relational practice described previously. Once relational practices were described as a specific behaviour or task instead of a way of being-in-relation, the energy for the study dwindled and staff members started to comment that the study should not add more tasks to their workload,

"We can't take on any more to do" (S26 Healthcare assistant, Observation notes, Site 1).

"It needs to be conversational and informal, not made into 'a thing'" (S03 Physiotherapist, Observation notes, Site 1).

Ensuring that relational practice was not another ‘thing to do’ was also the case when the co-facilitators considered how to share changes in their practice with their wider hospital organisations. Describing an observable behaviour, task or checklist had the potential to narrow possibilities for being-in-relation. The co-facilitators recognised the need to value and nurture the difference, rather than try and develop measures to align with the prevailing organisational and healthcare cultures. Sophie reflected on not attributing specific outcome measures to the study,

‘What are the outcomes? Don’t try to formalise it – just be aware of the outcomes, but be fluid. The outcomes are how the person was involved and their satisfaction’ (S03 Physiotherapist, Reflective notes, Site 1).

One aspect of describing and demonstrating to others the value of human connectedness could be well-being. Throughout the data presented in the last three chapters, enhanced well-being has consistently been described by all participants when there is a human relationship focus. For example, one staff participant, along with her improved job satisfaction and experience for relatives and patients, described an overall a sense of well-being for all involved,

“For relatives this project reassures relatives that we are getting on with them (the patient), that we know them. Patients have a better experience..... I feel like I’m doing a better job, I know the patient well” (S25 Physiotherapist interview, Site 1).

The potential for well-being to be used to reflect practice changes was not explored with the co-participants, as this theme was developed through the secondary immersion/crystallisation analysis conducted away from the field (Section 4.6.2). This is therefore an area for further research.

7.5.4 Summary and discussion of Theme 4: Freedom to act relationally

This theme has described the learning by me and the co-facilitators on what the enablers were to have the freedom to act, or respond, relationally to others. The

freedom to act relationally is similar to that described in the lifeworld-led approach - an immediate pre-cognitive response described by Todres (2008) as 'being with that', and not distancing oneself in some, "*neutral consciousness*" (Todres 2008, p.1569). The main enablers for freedom to act described in this study were: creating a different pace and space to be relational; recognising being relational as a way of being, rather than requiring observable change to practice, and; navigating within their organisation and wider healthcare the counter-cultural nature of being relational. These enablers will now be briefly discussed to place this data within the context of the existing theory and evidence.

The importance of the lived space of the stroke unit is described in the Humanising Values Framework (Table 7) as Sense of Place, and described more indirectly within the RCC literature, for example a Sense of Security in Nolan et al.'s (2006) Senses Framework (Table 4). It has also been supported by research specifically on stroke units. Jones et al. (1997) study confirmed that the staff relationships with patients were affected staff members' ability to control their environment, when required, in the interests of patients. Suddick et al. (2019) described the stroke unit as a meaningful space for practitioners to relate, connect and support patients that were fundamental to their sense of self. This study contributed further evidence of the importance of the lived space on stroke units through describing how staff participants created the pace and space within stroke units so that they could relate and connect with others.

Staff participants' freedom to respond relationally was founded on a recognition of relational practice was a way-of-being rather than their behaviour. Having the freedom to be relational was grounded in knowing their relational self, and having confidence in the possibilities of new ways of being-in-the-moment with others – it did not require a set of competencies, skills or specific knowledge because, by the nature of being human, they already had human understanding. Within the context of lifeworld-led healthcare, Ellis-Hill (personal communication) has described this as

‘being-doing’, and not ‘only-doing’. Todres (2008) similarly described relational understanding as not complete or stable, but constantly changing in living practice situations, and mixed with not knowing or the unknown; it is alive, open, ongoing and always unfinished. This aligns with the AI process of improvisation, recognised as enabling people to hold and attend to multiple perspectives instead of what they do (Bushe and Kassam 2005).

Freedom to act relationally required staff participants to navigate the prevailing positivist culture and clinical discourse and equally value their experiential knowing. This aligns with the ‘Free Choice Principle’ described in AI where people are more committed and perform better in organisations when they have the freedom to choose how and what they contribute (Whitney and Trosten-Bloom 2010). The data described that staff well-being improved when they were able to be more humanly relational within their daily practice. Tensions between organisational and personal aims in healthcare have been described previously (Coghlan and Casey 2001; Patterson et al. 2011; Hebblethwaite 2013). Rosewilliam et al. (2016) described bureaucratic cultures restricting patient-centred practices and staff autonomy. Additionally, the longer timescales described in this study, and confirmed in the literature, that support cultural change do not always align with the pace agenda and quick fix solutions of NHS organisations (Patterson et al. 2011; McKeown et al. 2016).

Part of the teams’ freedom to act was finding ways in which the value of this type of practice development can be presented to others who have not directly experienced it in order to achieve wider team and organisational support for their relational way of being. The data supports previous research that describes the challenges of trying to measure human and relational dimensions of healthcare and the distinctions between feedback and relational evaluation with measurements and fixed value criteria (Wheatley and Kellner-Rogers 1999; Dewar et al. 2011;

Hesselink et al. 2013; Rafferty et al. 2015; Galvin et al. 2018). This aspect will be explored further in the discussion chapter.

7.6 Chapter summary

Hoping that it will work

Learning that uncertainty and ambiguity are my friends

At times my appreciative antenna needs re-tuning

And then wonderful moments of humanity are there

Learning that uncertainty and ambiguity are my friends

Positivity has become a friend

And then wonderful moments of humanity are there

Nursing is still where I want to be

Positivity has become a friend

At times my appreciative antenna needs re-tuning

Nursing is still where I want to be

Hoping that it will work

(‘My Wonky Appreciative Antenna’ - A poem drawn from my personal reflective piece of writing from the Discovery Phase of the study)

This final chapter, presenting the data ‘Knowing-in-action that centres human relationships’, aimed to address two research questions: what are the processes that enrich meaningful relationships for all, in particular focussing on patients with limited verbal communication ability? And, what needs to be in place for change to happen?

The themes from this chapter have been developed into four orientations that have the potential to develop relational practice on stroke units which centres on human connections. Orientations, rather than a model, were developed to be consistent with the relational constructionist and lifeworld-led worldviews. Both these

worldviews stress the importance of freedom of the human occasion, expressing possibilities, essences and themes, not absolutes or common attributes often used in models and frameworks (Todres 2003; McNamee and Hosking 2012). The orientations of humanising relational practice are grounded within knowing-of-relational-self. The four orientations of humanly relational practice are:

- Sensitising towards human connections
- Valuing human connections
- Sharing, reflecting and energising
- Freedom to act relationally

The relationship of the orientating themes to the data is summarised in Table 35

Main Themes	Sub themes	Orientating themes
1. Start with your 'self' – engaging with relational knowing		Sensitising towards human connections
2. Facilitation and Animation	2.1 Being the process 2.2 Being open & reflective 2.3 Being provocative through appreciation 2.4 Beyond words	Valuing human connections
3. Voicing emergent narratives on relational knowing	3.1 Appreciative noticing 3.2 Voicing affirmation 3.3 Reflection & reflexivity 3.4 Creating opportunities for emergent narratives	Sharing, reflecting and energising
4. Freedom to act relationally	4.1 Pace and space to be relational 4.2 “How we are, not what we do” 4.3 Counter-cultural nature of ‘How we want to be’	Freedom to act relationally

Table 35: Orientating themes supporting humanising relational practice developed from original themes.

Overall, increasing staff awareness of their relational self, and sensitising to meaningful human connections, supported a change in the type of discourse on the stroke units. A more relational, or relationship-centred, dialogue was increasingly dispersed among the previously more dominant clinical and operational discourse of usual stroke unit care. This subtle, yet significant, change in discourse led to staff being more attuned, and having more freedom to respond, to relationships in practice. Staff participants highlighted the need for the processes towards relational knowing to be emergent, flexible and different to other practice developments and not formalised into a framework that could be seen by colleagues as a ‘tick-box exercise’. This reflected its different, constantly changing, way of knowing. The study demonstrated that the MDTs were able to develop and sustain a new space for relational practice.

The orientations of humanly relational practice (Table 35) have been described in previous research, from different care contexts including stroke units, into RCC and relational practice (Daaleman et al. 2008; McCormack et al. 2010; Dewar and Nolan 2013; Dewar and Sharp 2013, p.314; Bennett 2016; Dickson et al. 2017; Feo et al. 2017). The processes described in this study align closely with Dewar's (2011, 2013) 7C's Caring Conversations Framework which outlines key attributes in interactions to support compassionate RCC (Table 5). The association between the orientating themes from the study, humanising lifeworld-led concepts and similar terms used in the literature are summarised in Table 36 below. From Table 36 it can be seen that many concepts already in the literature are similar to those included in a humanly relational practice, however, the underlying nature of the approach provides new understandings for practice: (i) understanding of relational self; (ii) embodied relational knowing, and; (iii) freedom to act. These concepts are all interdependent, and will be discussed further in the next chapter.

Orientations of humanly relational practice	Humanising lifeworld-led concepts linked to the themes	Similar terms in the literature
Human connectedness	Understanding of relational self	Making a connection/ 'clicking' Meaningful engagement Being fully present/'tuned in'
Sensitising & valuing human connections	Embodied relational understanding	Valuing individuals Knowing self Connecting emotionally Sympathetic presence Clarity of beliefs & values
Sharing, reflecting and energising		Openness Mutuality Respect for other perspectives Being collaborative Trust Non-hierarchical
Freedom to act relationally	Situated freedom	Creativity Collaboration Empowerment Being courageous
Facilitation and Affirmation		Being celebratory Positive emotion Feedback Reflection

Table 36: Orientations to relational knowing and their associations with other terms

The relationships between the five orientations of humanly relational practice are illustrated below through the image of an unfurling fern (Figure 8). A fern was chosen to reflect the emergent, natural unfurling of relational knowing within individuals and within the wider MDT, grounded within the 'roots' of human connectedness. These orientations could be used as generative resources to support any stroke unit relationship, for example staff to patient; staff to staff etc.



Figure 8: Illustration of orientating themes supporting humanly relational practice

In the above diagram, relational reflexivity is characterised as the sun. Creating open spaces in which collaborative reflexivity could occur was a continuous, active process required to nurture humanly relational practice. Similar processes have been described within Dewar's (2011; 2013) Caring Conversations Framework using appreciative noticing and dialogue (Table 5). The Caring Conversations Framework has recently been broadened to include relational reflexivity and questions on relational self (Roddy and Dewar 2016). Relational reflexivity was confirmed by my study when, I and co-participants, used appreciative facilitation and animation to co-create openings for reflexive discussion around one's relational self. My thesis contributed an alternative perspective in the relationally reflexive process – the animation of embodied listening that opened opportunities to explore embodied

relational knowing-of-self. This highlighted the role of silent, embodied dialogue in human connections, particularly relevant for people who are unable to rely on verbal dialogue to develop relationships. My study suggests that reflective and reflective conversations, also encompassed in the Caring Conversations Framework (Table 5), are a place for staff to explore and act on their relational knowing. Within these conversations, my study animated and valued embodied relational knowing in which there were 'more to' human relationships beyond what is known, or able to be fully captured and described by language alone (Todres 2007).

It is the underlying nature of the approach used in my study, informed by humanising lifeworld-led theory and relational constructionism, which provides alternative theoretical foundations for relational practice when compared to previous research. It has developed relational knowing to inform future stroke unit practice based on what it means to be human, and contributes towards existential well-being for patients, relatives and staff. The contribution of humanising lifeworld-led theory and relational constructionism to broaden existing evidence on relational practice will be explored further in the next chapter.

Chapter 8: Discussion - Possibilities for relational practice in stroke care

“The real voyage of discovery consists of not seeking new landscapes, but in having new eyes” (Proust 2000, p.291).

8.1 Introduction

In this study I set out to generate new understandings from four research questions:

1. How do patients with stroke, their family and staff on stroke units describe their meaningful relational care experiences, in particular noticing experiences of patients with communication difficulties after stroke?
2. How do the stroke unit team describe colleague relationships that enable them to create and maintain valued relationships in practice?
3. What are the processes that enrich relationship-centred care for all?
4. What needs to be in place for these processes to inform other stroke unit settings?

The specific responses to these questions have been discussed in Chapters 5 to 7.

I will discuss how understandings from my research, and a humanising lifeworld approach, confirm and develop the theoretical understandings from RCC (Tresolini and The Pew-Fetzer Task Force 1994; Wylie and Wagenfeld-Heintz 2004), the Senses Framework (Nolan et al. 2006), and Caring conversations (Dewar 2011; Dewar and MacBride 2017) applied within an inpatient specialist stroke unit context. This research has made several contributions to knowledge that will be explored in this chapter. These are:

1. Describing the key processes that can support human connections on stroke units.
2. Describing the processes that enable human connections when patients are unable to rely on verbal communication.

3. Highlighting that human connections between colleagues in the stroke MDT can support their ability to be more relationship-centred with patients and their family, and contributes to staff well-being at work.
4. Describing the contribution of embodied knowing to meaning in human connections, and recommending expansion of the RCC model to include embodied relational knowing within healthcare encounters.

I will start by focusing my discussion on the understandings from patient participants with cognitive and communication difficulties and move on to discuss key ideas in more depth. These key ideas are: (i) a relational self; (ii) mutuality, including vulnerability; (iii) embodied knowing, and; (iv) freedom to act. These are all interdependent but separated out for ease of reading. I will also highlight how this study has supported the development of humanising lifeworld research from theory into practice. The last section of this chapter will reflect on the study's strengths and limitations, so that the reader can evaluate for themselves its quality and relevance. The chapter will conclude with a summary on how this study has contributed to new ways of knowing and the possibilities for future healthcare practice, policy and research.

8.2 Applying Humanising Relational Practice: openings for people with cognitive and communication difficulties

This study had a focus on relationships with patients who had limited or no communication, either as a result of their brain injury after stroke that affected their cognitive or language centres in the brain, or due to general low levels of consciousness associated with severe stroke. This particular focus accentuated the contribution of the humanising values of insiderness, sense-making, embodiment and agency to RCC and the Senses Framework (Figure 2).

Woefully few studies conducted in acute stroke units include patients with cognitive and communication problems or low levels of consciousness, citing concerns over

data quality or obtaining consent (Brady et al. 2013; Bronken and Kirkevold 2013). The person with communication difficulties after stroke can experience existential loneliness with feelings of alienation, shame and inferiority (Nyström 2006). Negative feelings of fear and discomfort are also felt by healthcare staff and relatives when attempting to communicate with patients who have communication difficulties after their stroke (Jones et al. 1997; Lawrence and Kinn 2011). Negative feelings can result in staff and relatives avoiding, or excessively controlling, the interaction that can lead to further isolation for the person with communication difficulties (Gordon et al. 2009; Hersh et al. 2016).

In order to support the specific needs of people with communication difficulties after stroke, stroke unit staff usually receive communication partner training in which strategies and communication resources are learnt to support total communication that focusses on the overall message rather than the literal meaning of verbal language (Simmons-Mackie et al. 2016). The training is aimed at supporting people with aphasia but many of the total communication strategies can inform interactions when the person has other forms of communication impairment, for example learning disability and dementia (Jones 2000; Murphy et al. 2016). The training, based on a social-functional approach, aspires to support social relationships and co-constructing identity through conversations. Yet the main focus is on observable transactional communication skills rather than relationships and the insider experience (McVicker et al. 2009; Murphy et al. 2016; Pound and Jensen 2018). In my study, staff participants reflected that the realities of communicating with patients who experience cognitive and communication difficulties were more complex and nuanced than that provided through conventional communication partner strategies, including total communication. This is supported by a recent systematic review of communication partner training in aphasia, in which the authors recommend further research into the most effective methods in complex systems, including patient-staff communication in acute healthcare settings (Simmons-Mackie et al. 2016).

My study, in part, generated data that were consistent with previous evidence summarised above. My study confirmed the negative feelings of patients, staff and relatives around communication when cognitive or communication difficulties were present in the encounter. Significantly, alongside these negative feelings, there were many examples from the data where meaningful human connections happened that led to feelings of well-being for all involved. It would appear that a data generation method that was actively seeking positive experiences of meaningful relationships, alongside a humanising lifeworld-led perspective instead of a perspective focussed on transactional communication, were together responsible for generating data that has the potential to further inform how staff and relatives interact and develop relationships with patients who have limited verbal communication. This is achieved through the three main orientations towards relational practice: (i) meaningful relationships unfolding through human connectedness; (ii) possibilities beyond words and; (iii) freedom to act relationally that encompass the humanising values of insiderness, sense-making, embodiment and agency (Table 7).

8.2.1 *Relational self and human connectedness*

Developing a 'soft' or relational self to support human connectedness is consistent with previous qualitative studies into healthcare professionals' perspectives of supporting people with communication problems. Researchers described the need for the professional to start with their self – supporting mutuality and a reflective openness to connect with the person with communication difficulties (Sundin et al. 2002; Sundin and Jansson 2003; Nyström 2009; Gjermestad 2017). Although lifeworld-led theory or humanising values were not explicitly stated by the authors, they described many of the values of humanising care – security, uniqueness, sense of agency, insiderness, togetherness, sense of journey, and mutuality. In this study, grounding relational practice within human connectedness, rather than relationships based on role (for example, healthcare worker- patient relationships seen in RCC), or successful transactional communication (as seen in communication

partner training), gave mutuality and meaningfulness to the relationships constructed. Using human connectedness as a focus increased sensitivity to their sense of how things are for the other person, for example, how it may feel when one cannot make sense of an everyday object like a kettle and then not able to communicate this loss of meaning to another.

8.2.2 Possibilities beyond words

The intention within the relational encounter, and embodied listening, were both significant in human connections when verbal communication could not be relied upon.

(i) Intention – alternative openings for human connectedness

Reaching towards, and the feelings of well-being as a result of reaching out, was meaningful for all involved (staff, relatives and patients). It was a relational process of reaching out with the intention to understand one another's 'insiderness'. It relates to accepting a vulnerability of not fully knowing, or understanding, the other's insiderness, and yet still intending to connect through a common humanity. Phenomenological studies involving people with aphasia have confirmed similar experiences in which there are no demands on those involved to achieve understanding and yet meaning is co-created through their attempts to connect (Sundin and Jansson 2003; Bronken et al. 2012; Todres et al. 2014). Therefore, achieving understanding was less important for participants than the meaningful relational experience or connection unfolding through the process. Again, it appeared that having a humanising relational approach, reaching out from one human to another, provided openings for these relational opportunities.

(ii) Embodied listening

Grounding relational practice in human connectedness opens possibilities to draw more widely from the human experience, and a 'thicker pattern of knowing'

(Gendlin 2004), that supports, constantly changing, relationally unique and holistic ways of connecting with others, including embodied listening. Qualitative research that included people with many different forms of communication impairment has described how being fully present and using emotional, embodied and wordless narratives, alongside verbal communication, have contributed significantly to the interaction and understanding between those involved (Sundin et al. 2001; Sundin and Jansson 2003; Hydén and Antelius 2011; Bronken et al. 2012; Gjermestad 2017). The data from my study confirms these findings, highlighting the importance of being sensitive and responding to embodied relational understanding, in particular when verbal communication cannot be relied upon.

8.2.3 *Freedom to act relationally*

Finally, focussing on human connectedness can offer a freedom and mutuality within healthcare interactions when the patient has communication difficulties. The success of the encounter is no longer judged on successful transactional communication, as there is a wealth of different opportunities to humanly connect, including beyond words. This removes sole responsibility from the communication partner (staff or relative) and the potential power inequality that this may foster in the encounter. Human connectedness in all its forms and characteristics opens possibilities for the person with communication difficulties to mutually respond relationally within the limitations of their communication impairment, acknowledging both their vulnerability and agency.

Pound and Jensen (2018) have written about the opportunities of humanising theory for communicating with patients with aphasia. My study contributed to their paper by providing empirical evidence that stroke teams can develop their own humanising relational knowing in order to support all their healthcare relationships, including those with communication difficulties (Figure 8). My study offers new perspectives for supporting patients with communication difficulties and those with reduced levels of consciousness (and as a result, limited or no communication) that moves away from communication and transactional

encounters towards a relational focus of human connectedness. Connecting and relating co-created through embodied listening could move towards reducing the sense of existential isolation, and enhance well-being, for people with communication difficulties, as many participants described a sense of well-being when they connected with others. Humanising and lifeworld-led theories provided an alternative philosophical and theoretical stance for embodied and tacit knowing that was more explicit in their contribution within being-in-relation with others and was particularly relevant in wordless encounters.

8.3 Meaningful relationships unfolding through human connectedness

Although the focus of my discussion so far has concerned relationships with people with communication difficulties, the key orientations arising from these understandings can be broadened to all relationships on the stroke units. This study was able to reframe how relationships were perceived within the stroke unit culture. It led to the MDT placing more value on human connections and mutuality within these connections, rather than focusing on the outcome of the relationships or the roles of the persons involved, for example, an occupational therapist (role) rehabilitating the upper limb (outcome) of a patient (role). Placing more value on human connectedness in relationships aligned with what patients and relatives described as most meaningful for them and gave staff a greater sense of well-being at work. There were four key orientations of human connectedness that I would like to explore further: (i) insiderness and a relational self; (ii) mutuality, including vulnerability; (iii) embodied knowing, and; (iv) freedom to act. These will be discussed in turn below.

8.3.1 *Insiderness and understanding the relational self*

The vast majority of studies on healthcare relationships within stroke services are described within the context of a person-centred approach and seldom as relationship-centred. Person-centred approaches are seen to focus on the

individual person (the patient) for the benefit of that individual (Nolan et al. 2004), and suggest a bounded or 'hard' self-other relationship a sense of 'them' and 'us'. The onus is on the skills or competence of the clinician (for example, their leadership style, information-giving skills, being emotionally engaged, compassion, and taking account of service users' needs and views) to determine the success of healthcare relationships (McCormack and McCance 2006; Brander et al. 2012; Constand et al. 2014; de Silva 2014; Cardiff et al. 2018).

Relationship-centred and humanising lifeworld-led approaches both highlight the mutual arising of relationships in the moment. RCC, and in particular the Senses Framework (Table 4), highlight interdependence in relationships that promotes the Six Senses for *all* involved in caring (patients, family and healthcare workers) (Nolan et al. 2006; Ryan et al. 2008). Mutual arising of relationships described in my study aligns with relational interdependence in the Senses Framework, although it has different origins. In my study, the focus of mutuality had arisen from shared understandings of what it means to be human, whereas RCC and the Senses Framework are primarily grounded in the concept of practical healthcare (Tresolini and The Pew-Fetzer Task Force 1994; Nolan et al. 2004; Nolan et al. 2008). Understandings from the humanising lifeworld approach are drawn from existential philosophy acknowledging the creation and re-creation of reality moment by moment – giving a flow to life (Galvin and Todres 2013). The focus is on experience, before it is separated, broken up and separated into words or concepts and, therefore, has the potential to protect against the reduction and fragmentation seen in the literature where person or patient-centredness are conceptualised into components of care (Todres et al. 2007; Kitson et al. 2013a; Constand et al. 2014).

This shift in perspective, where self is viewed as a relational (soft) self, rather than a bounded (hard) self, resulted in attention away from individuals, their competence, their role or abilities towards an awareness that there is not one fixed reality that they are working within but that they have the power to share their own realities

with the person they are working with to create new realities and possibilities in that moment (McNamee 2012). This is summarised in the following quote,

“the focus of understanding becomes relational in its gaze and acknowledges how the cared for condition is partially constituted by how they are treated by others” (Todres et al. 2014, p.9).

A relational (soft) self supports relational responsibility in the process of present-centred encounters that enables being open to ‘how we are going on together’ (Hosking and Pluut 2010; Roddy and Dewar 2016). This was described in my study as mutuality.

8.3.2 Mutuality-in-relation rather than relationship skills

In my study, mutuality arose from shared understandings of what it means to be human and creating new realities in relation through a (soft) relational self. Mutuality has significance for concerns over tensions in power between professionals and patients or relatives that are at odds with centredness practice (Haidet 2010; Hebblethwaite 2013). Many of the negative experiences of both service users and staff on stroke units occurred when there were ‘hard’ self-other relationships leading to one with power-over other (Jones et al. 1997; Pound and Ebrahim 2000; Kitson et al. 2013b; Luker et al. 2015). However, an individualistic (hard self-other) view of patient autonomy where service users need to be given control continues to be advocated in the literature, and does not always reflect the complexities of relationships in clinical practice (Morris et al. 2007; McCormack et al. 2010).

A ‘soft’ relational understanding of self may release some of the expectations placed on healthcare staff to ‘empower’ service users (Constand et al. 2014). A ‘soft’ relational self does not infer that clinicians’ ‘power-over’ a patient or relative is wrong, if it is co-constructed in relation. It can transform the nature and experience of relationships through patterns of interconnected relating that unfold over time, in different but equal ways. No one perspective or dialogue has power-

over another. This supports multiplicity and negotiation that more appropriately reflects real-life clinical practice where 'power-over' ebbs and flows depending on what is negotiated in relation. Mutuality recognises the offerings and contributions from patients and relatives towards the co-creation of meaningful healthcare relationships. RCC describes this as reciprocal relationships in which the experience of relationships by all groups (patients, relatives and staff) are considered (Nolan et al. 2006). Relational self within the reciprocal and interdependent relationships of RCC, and particularly recognition of the relational self of the patient, has recently been started to be conceptualised in the literature (Ryan and Nolan 2019). This study contributes to this development by describing that relationships grounded within what it means to be human (humanising lifeworld-led), can support mutuality-in-relation.

Mutuality-in-relation encompassed a sense of belonging, interdependence and equal sharing of emotions and values through an embodied (felt) sense. John Leicester Warren's writings from *'The soldier of fortune: a tragedy'* captured the essence of mutuality through embodiment as,

"We breathe together, move together, sigh and laugh in unison...in such a blended mutuality" (Leicester Warren 1876, p.340).

The significance of mutuality in human connectedness was described by participants as strong, reciprocal feelings of existential well-being around 'being human'. Reciprocal feelings described as emotional well-being in mutual relationships are highlighted in previous research, in particular within RCC studies using the Senses Framework (Ryan et al. 2008; Brown Wilson et al. 2009; Dewar and Nolan 2013; Bennett 2016). My study appeared to describe a well-being grounded in being human and aligned more with existential well-being described by Suddick (2019). My study described that this existential well-being created a certain vitality and energy for all involved. This has also been described by Galvin & Todres (2013) as an embodied motivating energy. Therefore, mutuality-in-relation may contribute

energy which can be used in alleviating some of the existential challenges described after experiencing a stroke (Nilsson et al. 1999; Nyström 2006; Ellis-Hill et al. 2008). It may also be a motivating energy to support staff at work and contribute to job satisfaction.

(i) Vulnerability and mutuality

Openness to the unknown, and accepting the vulnerability that this is part of all human relationships, was important in creating possibilities for mutuality and human connections. Lifeworld theory has an existential view of vulnerability that acknowledges that limitations and vulnerabilities are in an ongoing balance with the freedoms and possibilities of being human within the world (Galvin and Todres 2013). In my study, staff participants described a key aspect of vulnerability from lifeworld theory. Staff described the need to feel comfortable with their vulnerability of not knowing (Todres 2008), releasing them from their personal and professional expectations of requiring a successful outcome, or maintaining control of the encounter. Instead, staff moved towards a focus on the *process* of connecting. This enabled staff to feel able to be creative, to ‘muddle through’, and to work out the best way to co-construct some form of relational understanding. My study confirms what was described by Dewar’s (2011) Caring Conversations in RCC – the importance of ‘Being Curious’ to actively consider others perspectives and, ‘Being Courageous’ to act on this consideration (Dewar and Nolan 2013).

(ii) Mutuality unfolding within multidisciplinary team (MDT) relationships

MDT working is the cornerstone of quality stroke unit services and patient outcomes (Stroke Unit Trialists Collaboration 2013). Previous research into MDT relationships on stroke units has described practical skills needed - the importance of sharing of knowledge and skills between disciplines; effective communication, joint working, and shared education and training (Watkins et al. 2001; Monaghan et al. 2005; Clarke 2010; Kilbride et al. 2011; Burau et al. 2017). Qualitative studies

have described the importance of mutuality of relationships, or social well-being, between colleagues in the MDT. There is limited evidence of the relational processes needed to develop stroke MDT relationships, apart from recommendations to communicate effectively and understand each other's roles (Watkins et al. 2001; Burton et al. 2009; Cramm and Nieboer 2011). Several studies, predominately including nursing teams with a smaller number of other healthcare professions, have described that a RCC approach can support colleague relationships (Nolan et al. 2006; Dewar and Nolan 2013). Although the Senses Framework is aimed at an MDT audience, and has been applied to a rehabilitation context (Nolan 2002; Nolan et al. 2006), it has rarely been used in stroke services.

My study contributed further insights into MDT relationships and involved a diverse range of staff involved in stroke MDTs, including non-healthcare and non-professional staff, which is different to previous stroke studies that tended to focus on professional groups in the MDT. My study described mutuality through human connectedness that traversed the often-quoted hierarchy and professional boundaries in stroke MDT working. Mutuality through human connectedness within MDT relationships appeared to foster feelings of existential well-being, comfort and belonging, which is consistent with findings from two recent qualitative studies on stroke units. Both studies, using a lifeworld lens, described staff experiencing authenticity and belonging through their colleague and MDT relationships (Galvin et al. 2016; Suddick et al. 2019). The Senses Framework clearly has relevance here, also describing a sense of belonging and security within relationship-centred teams (Nolan et al. 2006).

A sense of belonging and comfort provided a balance to the negative impact of high workload and 'professionalism', a term used by many staff participants to describe the emotional detachment of their relationships at work. Attending to professionals' lifeworld to avoid professionalism leading to emotional detachment has been advocated by Prosser et al. (2013). Therefore, my study has shown *how*

humanising relational practice can also lead to the Senses experienced in RCC (Table 4), and how this approach can enable staff member's lifeworld to be valued within the workplace, leading to existential well-being. It is possible that a humanising relational approach may offer a relational alternative to conventional staff well-being strategies used in the NHS, such as resilience training or mentoring (Boorman 2009; Sizmur and Raleigh 2018; Workforce. 2018) and this is a potential area for future research.

8.4 Possibilities beyond words for human connectedness

“Scientific language that omits our embodied access to the world is silent about the human experience of illness, recovery and health. Such a scientific language also leaves out perceptual capacities that enable reasoning and acting as moral agents in particular lifeworlds” (Benner 2000, p.6).

Humanising lifeworld theory makes more explicit, and provides a discourse for, embodied (felt sense) knowing, insiderness and agency as part of healthcare relationships. I refer back to Figure 2, which highlighted the similarities and differences of the Humanising Value Framework and Senses Framework. Embodiment, insiderness and agency are not explicitly conceptualised within the Senses Framework supporting RCC.

Embodied knowing brings to the fore how we relate to one another through our felt sense in our bodies which, in my clinical experience and through observations during this study, is rarely part of the conventional healthcare discourse on stroke units. Tacit knowledge and intuition are familiar discourses in nursing theory, and are accepted as part of the psycho-spiritual aspects of nursing practice, but can be overlooked within the dominant medical model of inpatient care. Additionally, these aspects of clinical practice are less familiar in other disciplines and the multidisciplinary literature (Polanyi 1967; Häggström et al. 1994; Benner 2000; Reinders 2010).

Most papers informing RCC and relational practice focus on verbal forms of relationship co-construction and emphasise the importance of affect and emotion with relationships (Tresolini and The Pew-Fetzer Task Force 1994; Beach et al. 2006; Nolan et al. 2006). When considering non-verbal aspects of RCC, studies within the field of dementia care are developing a knowledge base of relationship-centredness that has less reliance on the person with dementia's verbal communication ability (Kontos and Martin 2013). Similar to those with communication difficulties after stroke, getting to know the person with dementia can also be obscured. The vast majority of research of RCC in dementia care has been conducted in the context of care homes and most recommendations focus around staff and relatives collaborating to maintain the personhood of the person with dementia through sharing personal information, for example, by using memory boxes (Aveyard and Davies 2006; Ryan et al. 2008; Brown Wilson et al. 2013). Most notably, a recent study by Watson (2016) of RCC in palliative dementia care recommended expansion of the Senses Framework to include embodied selfhood and inter-embodied selfhood, which is consistent with my recommendations in this thesis.

Embodied knowing is less explicit in qualitative studies into relationships on stroke unit settings. Instead, similar to the RCC literature, researchers describe the experience of relationships as knowing the person holistically, having compassion or empathy, engaging emotionally and being collaborative (Dewar and Nolan 2013; Bennett 2016; Bright et al. 2017). When the term embodiment is referred to within the stroke literature, it mainly refers to the person with stroke experience of their disrupted physical body or body image (Ellis-Hill et al. 2000; Murray and Harrison 2004; Lawrence and Kinn 2012). Embodied knowing in the context of lifeworld/humanising care theories has been described within a small number of phenomenological studies into stroke care and rehabilitation (Sundin et al. 2002; Sundin and Jansson 2003; Nyström 2006; Nyström 2009; Hydén and Antelius 2011; Suddick 2017). The majority of these researchers worked with people with communication disability to explore alternative perspectives in healthcare

relationships, as previously discussed in Section 2.7.1. However, with the exception of Galvin et al. (2016; 2018) and my study, there have been no other studies to research the practical translation of embodied knowing to inform stroke unit relationships using action research methods. Within my study, there appeared to be two characteristics described when participants' drew on their embodied relational knowing: (i) pausing to connect, and; (ii) embodied listening.

8.4.1 *Pausing to connect with others*

As part of understanding their relational self, staff became more attuned to their experiential knowing. A common experience described by participants in my study was a slowing down of time, or a feeling of a change pace, when they were immersed in meaningful human connections that were happening in-the-moment. This supports Suddick et al.'s (2019) findings where participants described moments of relating and connecting happened when the usual rhythm of daily activities paused, even if only momentarily. These type of pauses also resonate with Galvin and Todres' writings on existential dwelling in which they describe dwelling as being present, *"to hear what is there, to abide, to linger, and to be gathered there with what belongs there"* (Galvin and Todres 2013, p.74). In my study, these pauses appeared to be linked to a focus on the experiential aspects of being in relation, and supported sensitivity to embodied aspects of being-in-relation, that I have described as embodied listening.

8.4.2 *Embodied Listening*

During the study, staff participants became more aware of, and hence sensitive to, what it *felt* like when reaching towards or connecting with others. I have described this as 'embodied listening' (see Section 5.4.4). Both Sundin et al. (2000), in their study on patients with aphasia, and Galvin & Todres (2011) described openness as a prerequisite for carers to move towards embodied connections. Both papers refer to Emmanuel Levinas' openness: a pre-reflective or pre-cognitive and unguarded

openness to others. In my study, the reflexive process that engaged with embodied (felt) sense supported openness of staff participants. It was this pre-cognitive felt sense, at an aesthetic level, that I have termed embodied listening.

Embodied listening attuned to the immediacy of the present moment: the wordless, emotional and embodied narrative of those involved, and its meaning-in-relation. Embodied listening attended to meaning held within the body, informing those involved to what was humanly meaningful. Meaning held within the body was a form of understanding of each other's' insiderness, i.e. what it is like for the other person from within their lifeworld (Todres et al. 2014). At the same time, embodied listening attended to the vulnerability of understanding, that had a constant flux of knowing and not knowing, in which one could not truly know each other's' insiderness. Attending from this place is similar to 'embodied interpretation' described by Galvin and Todres in phenomenological data analysis as,

"A deep feeling of recognition that may be characterised by the kind of ontological weight that connects us to the place where we feel both deeply ourselves as well as deeply connected to our common humanity" (Galvin and Todres 2013, p.159).

Pausing to connect, and embodied listening, illustrates the contribution of the Humanising Values (Table 7) of sense-making, insiderness and embodiment to RRC and the Senses Framework. Pausing to connect and embodied listening resonate with Galvin and Todres' (2013) description of embodied relational understanding,

"a way of knowing that is holistically contextual; that is, a form of knowledge that is attentive to the rich and moving flow of individuals lives in relation to others, is attentive to very specific situations and to the inner worlds of what it is like for patients to 'go through something'" (Galvin and Todres 2013, p.143).

Embodied relational knowing has the possibility to add vitality, a deep sense of meaning and a motivating force to prevent 'going through the motions' of being compassionate or empathetic. It is this motivating force or vitality that is transformational to create possibilities for human connections and the freedom to act relationally.

8.4.3 *Freedom to act*

The last humanising lifeworld-led concept of relational practice that could contribute to the development of RCC and the Senses Framework was freedom (or agency) to act in a relational way. Freedom to act within this study had three different orientations. Firstly, within humanising lifeworld-led theory, freedom associated with a sense of agency and vitality to move towards connections that support existential well-being (Dahlberg et al. 2009). Secondly, freedom described in the centredness literature linked to empowerment and autonomy of staff, patients and relatives to make care decisions (Hughes et al. 2008). Finally, freedom linked to social emancipation, which is integral to AR (Brydon-Miller 2008). This section will focus on the first two orientations of freedom and their contribution to the broadening of RCC and the Senses Framework. The final orientation of freedom to act linked to social emancipation will be discussed later in Section 8.6.1.

Most research into healthcare relationships on stroke units has highlighted organisational cultures of targets and tasks which negatively impact on freedom associated with empowerment and autonomy (Bennett 2016; Bridges et al. 2017; Ryan et al. 2017; Suddick 2017). Not surprisingly, authors advocate the importance of freedom, through empowerment and autonomy, to support relational practice and positive relationships for patients, staff, relatives and carers on stroke units (Jones et al. 1997; Burton and Payne 2012; Hole et al. 2014). However, apart from in phenomenological studies informed by lifeworld theory, there is less evidence on freedom to act and agency that supports existential well-being after stroke (Nilsson et al. 1999).

(i) Freedom to move towards connecting and existential well-being

Existential well-being has been defined as a subjective experience unifying feelings of home-coming, comfort and peacefulness, along with an energy of future possibilities, characterised by the phrase 'dwelling-mobility' (Gilbert 2018; Todres and Galvin 2018). A humanising lifeworld-led perspective of freedom to act may contribute, or make more explicit, a deeper existential relational knowing in RCC. In my study, existential well-being appeared to be an experience of belonging, at-homeness, within the participants' universal human condition, often quoted by participants as, 'being human'.

Once staff participants valued human connectedness to support meaningful relationships, and developed understanding of their relational self, there was a generative energy or motivation to move towards relating and connecting. It appeared that the possibilities co-created within relating and connecting led to an energising sense of well-being for all involved, which is consistent with Dahlberg et al.'s (2009) description of vitality,

"the capacity of movement in a sense of being able to move to possibilities of engagement that connects us with others, other spaces, other times and other moods" (Dahlberg et al. 2009, p.267).

In my study, moving towards, and how this felt for those involved, appeared to be as significant for well-being as a feeling of connection.

Staff or relatives, who were sensitive to a patient's possibilities of being-in-relation after their stroke, were moving towards different forms of positive relational engagement. These forms may have been the first experiences of being-in-relation for patients after their stroke. For example, sharing a story about a staff member's yoga session by demonstrating the moves in the patient's bay where, even if the patient had limited verbal understanding, could laugh with the others at the staff

member's yoga poses, may have been the first time since their stroke that they have laughed.

Hole et al.'s (2014) meta-ethnography into patients' experiences after stroke described a patients' sense of agency was linked to their ability to reconcile their sense of self after stroke. My study has shown the potential for humanising relational practice to nurture a patient's possibilities (rather than conventional focus on pathology and deficits) after stroke, which could contribute to supporting a patient's sense of self and existential well-being. A person's ability to move (that I have described as freedom to act) towards possibilities of being-in-relation (be that other times, spaces, people or moods) from the data appeared to have the potential to contribute to the restoration of existential well-being. The possible benefits of freedom to act relationally are far reaching, for example: supporting patients' recovery after stroke and reconciling their sense of self; reducing reported feelings of patient and relatives isolation after stroke and staff well-being in the workplace.

(ii) Freedom to act, empowerment and autonomy

A second aspect of a sense of freedom to act concerns empowerment and autonomy in healthcare. As referred to previously, RCC de-emphasises empowerment, individualism and autonomy synonymous with the continued debates around unequal power in healthcare relationships (Nolan et al. 2004). Stroke clinical practice has yet to fully embrace a relational worldview and mutuality which moves away from 'hard' self-other relationships. Instead, on the whole, the field of stroke care aspires to person-centred approaches through MDT working, emphasising personal or collective agency, and personal authority, achieved through organisational systems and structures, for example patient feedback or satisfaction and MDT outcomes (Luker et al. 2015; Royal College of Physicians 2016a). Unfortunately, this person-centred approach does not always

reflect the complexities around agency experienced in clinical practice (Morris et al. 2007; McCormack et al. 2011).

In RCC and the Senses Framework, agency is not explicitly described; instead it is encompassed within the senses of Purpose and Achievement (Nolan et al. 2006). Dewar's (2011) Caring Conversations Framework for compassionate RCC is more explicit on agency. Within Caring Conversations, agency is described as staff being courageous, or feeling brave to act relationally. From a humanising lifeworld perspective, agency contributes alternative concepts for RCC; it is not concerned with empowerment or autonomy, instead it views agency within human vulnerabilities and possibilities (Galvin et al. 2016). My study described a combination of personal embodied sense of vitality to move towards human connecting (possibility), along with the team together placing value on, and enabling to happen, relating and connecting as part of their usual stroke unit practice (possibility). This was developed alongside awareness of the vulnerabilities of oneself and others, for example time constraints due to workload, communication difficulties, or mood. These patterns of human relating that unfolded over time can be in different but equal ways. When connecting at a human level, no one perspective, or way of relating, has power over another, which refers back to my earlier discussion on mutuality in relation where conventional patient-staff-relatives roles and expectations diminish. This is relevant for all relationships within stroke units, including a different perspective on hierarchical practices in MDT working (Bureau et al. 2017).

It was a combination of personal and team transformation, in which human connectedness was valued more, that led to staff to be able to co-create more possibilities (freedom) to act. The humanising lifeworld-led perspective adds to both the Senses and Caring Conversations Frameworks by pointing to an existential freedom to act, in which participants' knowing of their humanly relational-self opened possibilities, with a vitality and creativity, to humanly connect with others

within the limitations of the particular time, place, and language available. For example, the nurse who sang to a patient who was very drowsy while the nurse attended to her physical needs.

All of the principles above bring us to a new way of approaching and understanding care within stroke unit which will be discussed below.

8.5 Moving beyond conventional ways of knowing on stroke units : embracing aliveness and multiplicity

Relational, humanising and lifeworld discourses are less familiar to healthcare professions than the prevailing biomedical and individualistic ones (Benner 2000; Prosser et al. 2013). During the start of the project on either site, the terms 'relationship-centred care' (RCC), 'relational knowing' and 'humanising' were unfamiliar to the participants. Therefore, I responded to the staff participants' lived experience of patient-centred care and started the project with the less alien discourse of patient-centred care so as not to isolate staff participants from the project. Using the term RCC was less of a leap for practitioners because RCC linked to patient-centred care that was a common discourse within the teams and also underpinned many of the staff participants' values. The staff participants and I found RCC and relational practice challenging to explain to others as there was no essential 'thing' common to all circumstances, to which they could point to in the project and say, "this is what relationship-centredness is". This supports Hughes et al. (2008) analysis of the challenges in defining centredness concepts. A lack of an essential, common 'thing' that co-participants could describe aligns with the constraints of language in trying to describe the lifeworld, and reflects the multifaceted, dynamic and co-constructed nature of being-in-relation (Todres 2007).

In this study, relational questioning that focussed on the process of relationship co-construction and how participants humanly felt while being in relation, rather than

trying to describing the actual relationship, helped to overcome some of the ambiguity of describing humanising relational practice, and enabled participants to acknowledge that all they were experiencing may not be able to put into words. Relational questioning created a reflexive space for the staff participants to see their own relationships and themselves (knowing-self) in relation to their work and relationships on the stroke units (Savin-Baden 2004; McNamee and Hosking 2012). This process of knowing-self took time and, therefore, nurturing relational knowing could be considered to be counter-cultural for the current NHS climate in that it cannot be a 'quick fix' change, it focusses on changes to self and nuanced human relational processes, rather than preferred objectively measured changes to systems and processes (NHS England 2015; Department of Health 2016b).

The majority of staff co-facilitators in my study asserted that their most important learning was the need to keep the process alive, and not to reduce relational practice to a framework, a set of attributes to measure, or another policy (that they described as 'a thing'). The process of developing relational knowing and practice was achieved with a nuanced and improvisatory manner through reflective and reflexive conversation that supported multiplicity and reflected the uniqueness of being-in-relation, not through formal procedures or guidelines. With each conversation there were possibilities for new knowing and experimentation of new relational practices that maintained a local-contextual relevance and aliveness (Wasserman and McNamee 2010). This different approach was imperative to nurture and sustain relational practices – it needed to be constantly changing, alive and in relation with others. Hughes et al. (2008), in their discussion on centredness in the literature, confirmed that centredness concepts do not have discrete essences or aspects. Also similar to my study, the authors cautioned against the over-simplicity in using any particular model and suggested a broader view of interrelating is required.

If the contextual and experiential nature of relational knowing is to be elevated in healthcare, I would argue that humanising and relational discourses in clinical practice need to reflect this and be a 'bridge-maker' to understanding. Examples of this already are happening: Dewar & Christley (2013) talk about human relating rather than communication; and within lifeworld theory, Todres et al. (2009) have conceptualised the dimensions for humanising values and 'embodied relational understanding' which are alternative discourses that recognise the limitations of language in describing the lifeworld, and the need for alternative human-relevant knowing, based on the experiential (Galvin and Todres 2013). My study creates other possibilities for a relational discourse through development of the terms 'embodied listening' and 'relational knowing' that aligns more with multiplicity and constantly moving experiential nature of healthcare relationships, and hence chosen to reflect the character of relationality. Therefore, the orientations towards humanising relational practice developed from this study do not recommend particular tasks, targets, frameworks or attributes. Neither has a toolkit been developed that was an original aim of the project. Instead, the orientations described in this thesis will support the transformation and sustained development of local-contextual humanising relational knowing and relational practices to other stroke units.

8.6 Methodological development of humanising lifeworld research into practice

Finally, a key contribution of this study is a methodological one. Traditionally, humanising lifeworld-led research has used phenomenological or ethnographic methodologies. This study, using an appreciative action research (AAR) approach with a relational constructionist stance, can add a different perspective on knowing in practice that can build on phenomenological understandings and support translation into clinical practice. Bringing together AAR grounded in RC, and humanising/lifeworld-led theories developed new understandings of how they can contribute and develop the other.

AR is considered to be 'real-world research' that aims to achieve personal or organisational transformation, with a focus on social emancipation and empowerment (Reason and Bradbury 2008) where,

"Persons have the capacity to direct their own lives in ways which are life-affirming and constructive for themselves and others in their social contexts" (Gayá Wicks et al. 2008, p.23).

Phenomenological research has provided evidence of humanising and lifeworld-led approaches to healthcare that can be described as, referring to the quotation above, life-affirming and constructive for patients, relatives and staff. For example, understanding and adapting to changes in self and their relationships for both patients and their relatives after stroke (Ellis-Hill and Horn 2000; Simeone et al. 2014; López-Espuela et al. 2018); and for healthcare staff finding meaning in their work through their relationships with colleagues, patients and relatives (Dreyer et al. 2016; Suddick et al. 2019).

Relational knowing and humanising relational practice can be seen as counter-cultural to the over-riding emphasis of other ways of knowing in healthcare and evidence-based practice development, summarised in Table 37 below.

Evidence-based practice	Humanising relational practice
Cognitive / propositional knowledge	Experiential / embodied / reflexive / tacit knowing
Independent, empirical truth based constructions	Multiplicity and co-construction of realities
Hierarchy of knowledge e.g. hierarchy of evidence, academic over practical knowledge	Different but equal multiple forms of knowing
Learning through conventional forms of learning (propositional)	Learning through experience (experiential)
Protocols, clinical guidelines	Local, contextual and co-constructed
Knowledge / skills / competence based	Openness / creativity / reflexive
Empirical, objective, truth measures and evaluation	Subjective, tacit, uniquely personal processes of valuation

Table 37: Different characteristics of evidence-based practice and humanising relational practice

The characteristics of humanising relational practice outlined above are very similar to those conceptualised by Benner (2000) to translate humanising and embodied knowing in nursing practice. Using an AR perspective, a humanly relational focus to stroke unit relationships could be seen as emancipating and empowering by opening new possibilities for staff to respond and relate to others that were different to conventional (e.g. professional, hierarchical, task or outcome focussed) practice.

8.6.1 Contributions of AAR & RC for translation into practice

This study used AAR, explicitly grounded in RC, to build on phenomenological understandings of humanising lifeworld-led care to provide evidence of translation into real-world clinical practice. The methodological contributions of AAR and RC for translating humanising relational knowing into practice will be illustrated through discussion of: (a) appreciative provocation; (b) emancipatory transformation, and; (c) improvisation.

(i) Provocation creating possibilities for social and organisational change

The process of AAR, grounded in RC, is a process that focuses on what is locally meaningful and valued, and in which multiple local realities are (re)created. In my study, the AAR process was considered by relatives and staff participants to be novel, and hence provocative, through being deliberately appreciative with its animation and facilitation. This has been described as a particular quality of AI and AAR (Bushe 1998; Dewar et al. 2017b). Appreciation was not just being kind or supportive, but sought to increase noticing of, and the value placed on, multiple ways of relational knowing. An appreciative lens was a strong message that the nature of practice development was different to usual. By focussing on what was working well, it underpins a key objective of AI: to give life to human systems and support human flourishing, which clearly also aligns with humanising values (Zandee and Cooperrider 2008; Todres et al. 2009).

Secondly, AAR, underpinned by RC, was provocative in that it challenged the usual dominant realities within clinical practice that were often based on modernist views of propositional and practical knowledge (Table 29). It challenged the cultural norms where problems, tasks and targets were often valued over valuing, connecting and relating. Challenging cultural norms through animating and affirming humanising relational practice led to fundamental questions about current stroke unit practice. By using a postmodernist, relational discourse about the ongoing local-cultural processes that can either close down and open up the making of multiple local realities others (Hosking 2011), it directed attention to the hidden or obscured realities often not attended to within the stroke units. Participants were able to explore and further develop experiential, human-relevant knowing and (re)create new realities within meaningful relationships (Gergen 2009; Bushe 2011). This was particularly relevant for the real-world demands of acute hospital care, as the AAR approach did not ask staff to choose, for example, relational practice over evidence-based practice, instead both could be held in equally to inform their practice in different ways.

(ii) Emancipatory transformation

AAR builds on phenomenological evidence of the lived experience of humanising relationships by moving from the personal experience towards a wider social movement or cultural change, supporting the lived experience of humanising relationships. Research has demonstrated that organisational and cultural influences on staff practices can be challenged through AR and AI (Waterman et al. 1995; Dewar and Mackay 2010; Sharp et al. 2016; MacArthur et al. 2017; Cardiff et al. 2018). However, even with the 'real-world research' of AR and AI, there are concerns in healthcare that organisational transformation is rarely realised (Waterman et al. 2001; Watkins et al. 2016). Transformational change has been described as having two qualities: changing how people think, so that there are new possibilities for change, and supporting self-organising, unsupervised, spontaneous action grown from a compelling need to act (Bushe and Kassam 2005; Bushe 2013; Bushe and Storch 2015). According to Bushe (2015), the process needs to move beyond the positive appreciation and be generative (achieved through co-creation of new metaphors, images, phrases and practical, physical representations) to realise transformational change. It is transformation that looks beyond and challenges accepted 'norms', with an awareness of the knowledge and power influences within the processes, that can be seen as an emancipatory process (Grant and Humphries 2006).

What was clear from my study was that personal transformation, through understanding of relational self, was a key orientation for humanising relational practice (see Section 7.2). Therefore, an AAR process that aims for personal transformation, and expands this towards social and organisational transformation, has strengths to support the translation of humanising values into clinical practice. Data generated from my study described transformational change as sense of freedom, or agency, to move towards being-in-relation, both personally and supported through the changed culture on the stroke units. Within the AAR

process, appreciative animation and facilitation were pivotal in creating open reflective and reflexive spaces to explore and develop humanising relational knowing, developing a relational discourse within the MDT and develop a sense of freedom to respond relationally. Animation, facilitation, and the value of appreciative spaces, have been described as building a supportive relational context alongside enlivening and inspiring the process to generate action (Ludema et al. 2001; Wasserman and McNamee 2010; Dewar and Sharp 2013; Bushe 2015; Galvin et al. 2016). RC supported the AAR process to align further with humanising values through its relational view of interconnectedness informing how open reflexive/reflective spaces were co-created. A RC approach opened up multiple possible ways of being human and supported personal transformation that grew from how staff *thought* about human relationships to how they *were* through being-in-relation, which moved the relational process more towards humanising/lifeworld-led values. Reflective practice, empathetic imagination and developing moral agency have all been suggested to support humanising lifeworld-led care (Benner 2000; Finlay 2002; van der Cingel 2009) but animation and facilitation as part of the reflexive/reflective process are new approaches in this field. The open reflexive/reflective space, created through appreciative animation and facilitation, was a practical way to place value on, and bring alive, relational experiences leading to ‘expansive thinking’ that went beyond participants’ familiar ways of thinking (Barrett 1995). The next section will explore the character of ‘expansive thinking’, and how humanising/lifeworld-led theories developed it further beyond cognitive thinking.

(iii) Improvisation

Improvisation is a characteristic of AI and has a key contribution towards supporting freedom to act relationally through the process of creating an open space for ongoing relational emergence. Improvisation in AI is often described using the metaphor of jazz,

“the skill of using bodies, space, all human resources, to generate a coherent physical expression of an idea, a situation, a character (even, perhaps, a text); to do this spontaneously, in response to the immediate stimuli of one’s environment, and to do it a l’improviste: as though taken by surprise, without preconceptions” (Frost and Yarrow 1990, p.4).

Dewar et al. (2016) and Bushe and Kassam (2005) recognise the importance of improvisation in AI to change how people think instead of what they do. Barrett (1998a; 1998b) describes improvisation requiring minimum structures for maximum flexibility to support diversity and multiple voices or perspectives. In my study, this has been described previously as pivotal to support relational practices, and is illustrated within Sub-theme 7.5.3 - Counter-cultural nature of ‘how we want to be’, in which staff participants describe not making relational knowing into concrete, general frameworks.

Within the context of humanising/lifeworld-led healthcare, improvisation appears to be described very similar to the characteristics of relational understanding, which is described by Todres (2008) as being incomplete or unstable, constantly changing in living practice situations, and mixed with not knowing or the unknown. It is an alive, open, ongoing and unfinished activity, rather than something that we *know* how to *do*. Additionally, humanising/lifeworld-led theories can develop the concept of improvisation within the AI process. Informed by Gendlin (1992), humanising/lifeworld-led theories highlight the pre-reflective way of *being*, on the edge of human thinking that emerges from the lifeworld, rather than the cognitive or *doing* (Todres 2007). This aligns more appropriately with the relational self described in my study, in which some participants described changing how they are, not a cognitive act on what to ‘do’ differently. Therefore, improvisation within the AAR process appears to be particularly relevant in the development of humanising relational knowing.

8.6.2 Contributions of Humanising/Lifeworld -led Theories to AAR

In addition to improvisation discussed above, humanising/lifeworld-led theories can contribute to the AAR process by attending to the complexities of being-in-relation other than verbal discourse, and be a phenomenological touchstone to support the process to remain humanly meaningful for participants.

(i) Beyond words to create relational worlds

A core claim of the constructionist principle in AI is ‘words create worlds’ (Table 12). Subsequently AI has focussed on language to support and generate change, predominately through generative questions and positive metaphors (Ludema et al. 2001). Recent conceptual discussions on AI have seen a move from social constructionism towards RC that, with RC’s attention to the *processes of relating*, provide openings for, *“the ‘textuality’ of all relational realities and not just written and spoken texts”* (McNamee and Hosking 2012, p.38).

From a phenomenological perspective, examining and talking about relational knowing is considered to have limited potential to deepen relational knowing, as it is more than words (Ladkin 2005; Todres 2008). Galvin and Todres (2013) described the challenges of the lifeworld becoming more elusive if we try to articulate it objectively. It is not necessarily imagining what the other person is thinking or feeling, it is *experiencing* human connectedness as a lived phenomenon that seems to lead to transformational change in relational knowing (Ladkin 2005; Todres et al. 2014). Ladkin’s (2005) discussion paper on how phenomenology might inform the AR process suggests a similar to process to that of ‘embodied listening’ described in my study, in which researchers can,

“Pay particular attention to their own ‘in the moment’ bodily reactions, or note thoughts they might otherwise judge as superfluous. Most importantly, they pay attention to the noticing itself, attempting to ‘catch’ how perceptions arise in the immediate experience” (Ladkin 2005, p.120)..

Language is seen as a bridge for attending to and articulating the implicit, felt sense of what each other is sharing in-the-moment (Todres 2008; Todres et al. 2014), and the humanising/lifeworld-led theories provide an explicit conceptualisation of relational knowing in healthcare that is more than words.

AAR, grounded within RC, can focus on the language bridge between experiential knowing of the lifeworld and a cognitive clinical discourse. It does not try to place relational practice with power-over discourse-based, cognitive and propositional ways of knowing, (or vice-versa) instead it aims to hold their value in equal but different ways. Language is used to explore relational experiences and multiple voices through story-telling, while a humanising/lifeworld-led lens can enable opportunities to attend to being-in-relation beyond words. It supports transformation that unfurls from within the self and ultimately leads to collective openness and attentiveness to the experiential and embodied nature of humanising relationships. Gergen (2009) elaborated that this collective attentiveness is intimately connected to the shared values in a culture that has the potential to move attention beyond words.

(ii) Phenomenological touchstone

Developing relational practice was not always easy to achieve in the study. Adhering to the AAR cycles too closely led to a stronger focus on what was needed to be achieved (doing something), rather than the relational processes (what is unfolding when in relation). When the focus moved away from a relational one, the project seemed to lose its energy and its meaningfulness. It felt like it was becoming a conventional practice development project, in which a clinician's change in behaviour can have a cause and effect (hard-self other) rather than the soft self-other of relational knowing (Hosking and McNamee 2007; Gergen 2009). This has been described by Ellis-Hill (2019, personal correspondence) as an 'Only Doing' culture, and in my study it was the opposite of what was needed for generativity and creating open spaces to be-in-relation (Wasserman and McNamee

2010). My study found how easy it was, within the cultural 'Only Doing' norms of the stroke units, to fall back into routinised ways of working, despite having an approach that was wholly focussed on relational processes both theoretically and practically. It was important to be authentic in what I was animating, and address Gervais Bushe's concerns of an appreciative stance that *"the inquiry has to go beyond simply focussing people on the 'best of' to focus on what is truly meaningful"* (Bushe and Storch 2015, p.15), and the need to explore what is described as the spiritual aspect of human inquiry (Cooperrider et al. 1995; Bushe 2011).

Bringing a lifeworld/humanising lens to AAR can address the concerns of authenticity and meaningfulness within AAR, and also concerns around lack of transformational change of AR and AI studies in healthcare (Watkins et al. 2016). A lifeworld perspective of experiential knowing in healthcare focussed the AAR process towards existential meanings of human well-being (Todres et al. 2014). Within lifeworld-led experiential knowing, embodied relational knowing was particularly valuable to remain connected with our common humanity during the study. It added vitality, a deep sense of meaning and a motivating force to prevent 'going through the motions' of relational practice. It is this motivating force or vitality that is transformational to create possibilities for human connections.

In summary, although AAR and RC have conceptual differences to humanising/lifeworld-led theories, when considering the development of experiential knowing within humanising relational practice, there are reciprocal methodological contributions. My research found that a RC and humanising/lifeworld-led approach to the inquiry process opened up opportunities to support 'real-world' transformational changes to relational practice that had the potential to support existential well-being.

8.7 Methodological considerations

“They are more diverse, rather than a sort of flow-chart, it’s thinking outside of the box a little more isn’t it?” (S05 Therapy assistant, Discussion Group, Site 1).

So that the reader can judge the credibility and relevance of the claims within my discussion, this section will consider the methodological issues of using an AAR approach to inquire of relational practice on stroke units and the study’s main strengths and limitations within the context of the study’s findings. The strengths and limitations of the study design have been outlined in Section 4.7 and throughout the above discussion, the methodological opportunities, challenges and new possibilities of AAR to contribute to relational practice underpinned by lifeworld and humanising approaches have been already been explored. Therefore, this section will summarise these and consider any other aspects not previously discussed.

Within the AR and AI literature, with the exception of Bushe and Kassam (2005), most authors distance themselves from a set of quality criteria and move towards some form of rational judgement of the soundness or value of the AR study (Hope and Waterman 2003). Many lean towards focussing on the moral or ethical concerns (participatory nature) and the pragmatic (action-orientated) approach of AR or AI studies, and evaluating with a constructionist lens consistent with the philosophical stance of the study (Reason and Bradbury 2001; van der Haar and Hosking 2004; McNamee and Hosking 2012). Hope and Waterman (2003), although clear to argue against any form of structure or criteria, suggest in AR that there are three main areas to look for ‘goodness’: (i) participatory nature; (ii) reflexivity and cyclical process in AR, and; (iii) practicality / relevance that all need to align with the philosophical stance of the study. Drawing from several authors (Reason and Bradbury 2001; Hope and Waterman 2003; Bushe and Kassam 2005; McNamee and Hosking 2012), and in particular from a RC perspective that aligns with this study’s

philosophical stance, there are several recurring choice points for evaluating quality in AR and AI, summarised in Table 38 below.

Points to consider	Questions to consider	References
1. Relational processes	Is the study explicit in developing a praxis of relational participation? Does it generate participatory practices? Does it ensure conceptual-theoretical integrity?	Bradbury and Reason (2001) McNamee and Hosking (2012) Lockwood et al. (2015)
2. Reflexivity	Is the project guided by reflexive concerns for practical outcomes? Does the study construct 'power-with/to' rather than power-over? Is there reflexivity within the cyclical processes of AR?	van de Haar and Hosking (2004) Bradbury and Reason (2001)
3. Multiplicity of knowing	Does it embrace complexity? Does it embrace ways of knowing beyond intellect? Does it co-ordinate the construction of multiple local realities?	van de Haar and Hosking (2004)
4. Real-world relevance	Is the study worthy of the term significant? Should we be doing the research at all? Is it grounded in the concerns of everyday people?	Hope and Waterman (2003)
5. Transformational change	Is the study emerging towards a new and enduring infrastructure? Is there specific tangible change with improvisation? Are participants orientating towards desired futures / passions?	Bradbury and Reason (2001) Bushe and Kassam (2005) McNamee and Hosking (2012)

Table 38: Points to consider for evaluating the quality of AI/AR studies

Each of the points to consider outlined in Table 38 will be used to frame the following discussion on the strengths and limitations of my research.

8.7.1 Relational processes

During the study there were varying levels of engagement from the participants. There was limited engagement from patients and relatives, with them contributing

the most to the initial phases of the study. The differences in engagement are a limitation of the study and it reflects the reality of the high patient turnover on both stroke units. Patients and relatives were offered to continue to be involved in the study after discharge from the stroke unit, but all chose not to, resulting in it not possible for prolonged engagement. Exceptions were a couple of patients and their relatives who remained on the stroke units for several months.

Staff participants engaged the most with the whole of the AAR project, especially during the action and evaluation phases. Prolonged engagement with staff participants over 20 months enabled many opportunities during the AAR cycles for collaborative sense-making and co-participation. The length of engagement (notable in the first site) increased trust and, therefore, potentially richer data (Moore 2008). A limitation in the second site was the reduced amount of time (four months) that impacted on the level of relationship and co-participation that was able to be achieved in a short space of time. It is accepted in the literature that AI is not a 'quick fix' process and usually takes months to years (Clouder and King 2015). However, this is useful learning to inform future studies intending to use a relational approach.

Previously, most studies on experience of care on stroke units tended to research different roles (patient, relative or staff member) separately and, more often than not, excluded patients with communication difficulties. In this study, the entire research process was conducted with all three participant groups together, which reflected real-world stroke units, including non-clinical staff within the stroke MDTs and patients who had difficulty communicating. This enabled a focus on the participants' web of relationships with each other, attended to the 'hidden voices' of non-professional staff and patients with low levels of consciousness or communication difficulty, and supported different perspectives and commonalities synonymously, which are strengths of this study.

The explicit focus on relational processes was another particular strength of this study. It has been extensively discussed in the previous sections of this chapter; however, it is significant to the quality of the study and worth re-iterating. The study not only had a RC approach to its method, its research outcomes were also to develop humanising relational practices. My study nurtured multiple relational perspectives and relational knowing-of-self that supported the quality of the research through promoting relational participation alongside also reflexivity and mutuality. When sufficient time was given to developing relationships with the co-participants, there was a feeling of authentic co-participation. This was more apparent in the first site than the second.

8.7.2 Reflexivity

Reflexivity from the lens of RC goes beyond assessing the quality of knowledge produced by the AAR process. It also pays attention to the negotiation of shared meanings and the construction of relational-self (Savin-Baden 2004; McNamee and Hosking 2012). This thesis has already addressed reflexivity with regards to the research method and data analysis, in particular referring to collaborative sense-making. Here I would like to discuss, in light of the results, the lack of clear AAR cycles in my study which could be considered a methodological limitation. A clear AAR cyclical process was the initial intention, however, I have justified in the discussion above that these changes occurred from being reflexive to the influence of the AAR cycles on the quality of the inquiry into humanising relationships. The co-participants and I experienced a hindering towards humanising relational knowing, and in particular embodied relational knowing, when the process of AAR cycles were the focus rather than the relational processes. A relational focus required a more emergent process that was able to nurture and respond to the constantly changing and sharing in-the-moment of relational knowing. Therefore, the potential limitation of the lack of clear AAR cycles could also be a strength as it demonstrates reflexive concerns for the cyclical process and aligns with the RC and humanising/lifeworld-led philosophical orientations of the study.

8.7.3 *Multiplicity of knowing*

Multiplicity of knowing was supported in this study through embracing experiential and embodied ways of knowing alongside cognitive, propositional and practical ways of knowing. This has already been discussed extensively in previous sections of this chapter. Another aspect of multiplicity of knowing was supported through the study's co-participatory nature through using animation and facilitation. Animation and facilitation brought in many stakeholders that would not usually have a voice within research and practice developments, for example non-professional staff and patients with limited communication ability. Through using patients' and relatives' stories alongside staff stories, all participants had the opportunity to connect with multiple perspectives to inform their relationships. A limitation of animation and facilitation is its dependency on the skills and competencies of the individuals adopting this role (Newhard 2010; Dewar and Sharp 2013). Because of the emergent and complex process, and different staff participants alongside myself at times adopting these roles, it is difficult to articulate fully the impact of the different individuals on the study and therefore provide a full description of this part of the research process.

8.7.4 *Real-world relevance*

The real-world relevance of this study has been outlined through discussion of the literature and the current concerns of the culture of care on stroke units and the wider NHS. The co-participatory and collaborative nature of this study with analysis and action conducted together ensured that the study continued to be grounded in the concerns of the participants involved – human connections. As mentioned previously, more prolonged engagement of patients and relatives could have contributed further to the ensuring relevance to service users.

To enable readers to transfer this knowing to other sites, I have provided rich contextual information in the methods chapter about the stroke units so that readers can assess the relevance of findings to other settings. A limitation of this study is that both sites were combined stroke units in smaller district general hospitals, and therefore does not reflect the context of care for all stroke units in the UK. Further research within different stroke units (including hyper-acute and rehabilitation stroke units) may increase its transferability and relevance for more stroke services.

8.7.5 *Transformational change*

Transformational change is the desired outcome for all AI, but demonstrating transformational change in AI healthcare studies is limited (Bushe and Kassam 2005; Cooperrider et al. 2005; Watkins et al. 2016). This study demonstrated both personal (staff) and organisational (team) transformation on the first site. Staff participants described experiencing a change in their self and, therefore, their relationships. Relational practices were being adopted within staff participants' own work and practice developments to support relational knowing continued. For example, there were occasions when 'it clicked' for certain staff which were notable moments within the study when their perspectives changed. This different perspective was energising and motivating, and subsequently led to them naturally placing themselves as co-facilitators, which was generativity occurring within the AAR process. In another example, staff participants continued with new practice developments and shared their work through presentations to other hospital departments and healthcare conferences. This confirms what Dewar (2011) found in her appreciative inquiry into compassionate care on hospital wards where staff became co-facilitators as part of the transformational change.

The contribution of humanising/lifeworld-led theory to relationality supported personal transformation and meaningfulness of the inquiry process that was particularly important in achieving transformation within a healthcare context.

Although paradoxically, a focus on experiential and embodied knowing through humanising/lifeworld-led theories can be a limitation in demonstrating transformational change. The complexity of disseminating the knowing and evaluating impact to others outside of the study's local context is difficult. Staff participants stressed the importance of not over-simplifying their new relational knowing through developing a framework or set of principles that could facilitate translation and evaluation. Therefore, further research is required on how to demonstrate the translation and transformation of this type of study within other stroke services while honouring the deeply personal, nuanced and embodied nature within relational knowing.

In conclusion, when evaluating this study alongside the key points of quality described in the AAR literature outlined in Table 38, there is evidence that these were met. A summary of the main strengths and limitations of my study are tabled below.

Strengths	Limitations
A co-participatory and relational perspective including all three participants groups enabled a focus on the web of relationships with each other.	Engagement of patients and relatives throughout the complete inquiry, including access to data, was not fully realised.
The study sought to include the often excluded voices of people with communication difficulty, including low levels of consciousness, and non-professional staff within the stroke MDT.	The individual contribution of the co-facilitators to the AAR process was difficult to describe.
Reflexivity throughout the research process enabled the direction of the inquiry to support experiential aspects of relationships.	A lack of clear AAR cycles due to the difficulty to align experiential aspects of relational practice within the AAR cycles.
Using humanising/lifeworld-led theory to inform the focus of relational practice led to inquiry into deeply meaningful relational experiences including embodied knowing.	Transformational change was not achieved on both sites, raising questions whether development of relational practice using AAR can be achieved in a short period of time.
Personal and cultural transformational change was achieved on one stroke unit.	Transferability of the orientations supporting humanising relational practice need to be further researched in other stroke unit contexts.
Collaborative sense-making and embodied interpretation enabled the more nuanced aspects of relationality to be explored within an AAR inquiry.	

Table 39: Summary of the Strengths and Limitations of the Study

Having discussed the quality of this research, the next section will summarise the implications of this study for research, education, policy and clinical practice.

8.8 Study implications

This study, with its pragmatic focus on ‘real-world’ research, has already highlighted within the discussion of the results its wider implications for practice, education and research. Therefore, I will summarise the main points for those concerned with enhancing the experience of meaningful relationships on stroke units.

8.8.1 *Implications for research*

This study has described how AAR can contribute to the clinical application of humanising/lifeworld-led approach to relationships on stroke units. Inevitably it has raised several issues that require further research:

- Further exploration is needed of the potential of AAR as a methodology to contribute towards the translation of humanising/lifeworld-led theories into clinical practice.
- The bringing together of embodied relational understanding within RCC needs to be explored further.
- Further research is needed to ascertain the translation of humanising relational practice other stroke service settings, for example high dependency stroke units or community stroke rehabilitation teams.
- If one takes a relational constructionist stance of transformational change to practice, then the focus needs to be directed towards processes rather than outcomes. New ways to relationally evaluate practice that focus on the relationships within the evaluation process need to be developed to align with the underpinning philosophy of the approach.

8.8.2 *Implications for education*

- This study has highlighted how developing relational knowing can support meaningful healthcare experiences and well-being for all. For clinicians, to be sensitive to and value relational knowing throughout their healthcare careers, there needs to be continuing opportunities to nurture personal and cultural relational sensitivity. There needs to be equal value place on experiential ways of knowing alongside cognitive, propositional and practical ways of knowing. Further resources and investment in staff development in

this area are needed, including facilitation of humanly sensitive approaches in clinical practice.

- Facilitation and animation, alongside being able to respond to the lifeworld of staff, are important processes to support relational practice. It cannot be assumed that human resources/line managers/leaders/practice educators within stroke units have these skills to support relational knowing. It is important that organisations recognise and value staff that have these skills, and provide them with the resources to utilise these skills as an educational and quality development approach.
- This research has shown that humanising relational knowing can support team-working relationships and lead to a more relationally sensitive MDT. In stroke services MDT working is considered a cornerstone of quality stroke services. Further investment in MDT opportunities to support relational practice among MDT members may contribute to effective MDT working alongside enhancing relationships with patients and relatives. It may lead to opportunities to develop more individualised and relationally sensitive approaches to stroke care and rehabilitation.
- Using embodied listening to inform relational practice can provide stroke unit staff with a new perspective to interacting with patients who have post-stroke communication impairments or low levels of consciousness. Incorporating this knowing alongside traditional skills and competency-based education can give staff the confidence and freedom to draw on their embodied knowing to support connecting with those who have limited communication.

8.8.3 *Implications for policy*

To date, the focus on compassion and person-centred care in NHS policy in a context of increasing pressures for efficiency savings, measurement of productivity and outcomes, have had limited impact on day-to-day practice. Over the last decade, stroke services in the UK have focussed on developing medical

interventions (e.g. mechanical thrombectomy) and organisation of care (e.g. four hour target to access a specialist stroke unit), and less focus on supporting the experience of healthcare for patients, relatives and staff. As a result of this research, the following can be considered by policy-makers:

- This research has outlined the counter-cultural stance of humanising relational knowing within the current NHS, including stroke units. There is a need for policy to stop undermining the complexity and nuanced nature of experiential knowing by reducing it to a set of characteristics, skills or even slogans. Policy needs to be developed that can reflect and value the local, contextual and multiple perspectives of healthcare experience with increased emphasis on experiential knowing.
- Increased recognition that transformational change of meaningful relationships at a personal and organisational level cannot be achieved through 'quick fixes', and invest in long-term and sustainable change.
- This research has shown how relational knowing can contribute to feelings of existential well-being for staff on stroke units. In the current climate of compassion fatigue, high staff vacancy rates and recruitment problems for all healthcare professions, relational knowing can contribute towards more meaningful and supportive working environments for healthcare staff.
- Humanising relational knowing through an AAR process can contribute towards patient safety by developing a culture that is collaborative (not hierarchical); open and curious (not blaming); and sensitised towards human aspects of care (not dehumanised).

8.8.4 *Implications for clinical practice*

- The appreciative and relational stance to AAR had a real contribution to developing humanising relational knowing through a focus on existing practice occurring everyday on stroke units. This was a powerful method to support relational practice when clinicians have high workloads. This study

demonstrated that this approach can be incorporated into daily clinical practice through opportunistic conversations and 'reflection-on-the-hoof'.

- This research showed that there were regular times of high emotional and workload pressures for all members of the stroke team. These times have the potential to lessen focus on relational aspects of healthcare. It is recommended that there are networks and organisational structures on stroke units to support continued attention towards humanising relational practice on a day-to-day basis.
- Organisational and evidence-based (scientific) drivers have been the main influencers in stroke service developments. If stroke services are going to meet the holistic needs of service users and staff that include all aspects of their lifeworld, there is a need to re-balance the focus towards experiential aspects of stroke care.
- This study has shown how a humanising relational approach can support feelings of well-being for patients and relatives. This has a wide potential to support recovery and adjustment after stroke. This approach provides a new alternative to the psycho-social interventions usually adopted to support recovery and well-being after stroke.
- A humanising relational focus to MDT relationships provides new knowledge and an alternative emphasis to stroke MDT working. Previously stroke MDT working has focussed on sharing of knowledge and skills. Good team relationships have been described as supporting MDT working. This study has shown how stroke MDTs can develop positive relationships that not only support team working but also develop their openness to connect at a human level with others.
- The main outcome from this study was the description of processes that support human connections. These human connections were not specific to stroke services and there is the possibility of wider implications this research in other in-patient settings.

8.9 Conclusion

This study is submitted at a time when there continues to be rapid developments in the medical treatments for people after stroke, reinforcing a focus on the technical and scientific aspects of care. This is alongside the Stroke Association lobbying policy makers for increased focus on rehabilitation and life after stroke, culminating in the recent NHS Long Term Plan (2019), and a continued drive for person-centred approaches in the NHS, including personalised care (NHS England and Local Government Association 2017). All of these initiatives are committed to measurement of outcomes, including developing new quality measures. This study provides key practical knowing on how meaningful relationships can continue to be valued and nurtured within the NHS Stroke Services during this time of change. There is the risk that, if we cannot be more explicit on humanising relationships, the meaningfulness in healthcare, for patients, relatives and healthcare staff, will be lost. This study has demonstrated possibilities for practitioners to become more sensitive to, value, respond and nurture human connectedness within their practice, and provide key orientations for stroke MDT cultures to develop and sustain meaningful relationships now and in the future.

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Legislation

Data Protection Act 1998.

Mental Capacity Act 2005.

Appendices

Appendix 1: Table of studies evaluating RCC Senses Framework

Authors / Year / Country	Topic /Focus/ Purpose	Conceptual/ Theoretical Framework	Paradigm and Methods	Context/ Setting/ Sample	Findings
Andrew et al. (2011) UK	Review of education project in first year of nursing education.	Senses Framework	Framework development	Data on nursing students taken from two previous projects.	Senses Framework has resonance with undergraduate nurses. It has the potential to underpin learning, promote collaboration and draw together the emotional, academic and professional aspects of training.
Anstey (2003) UK	The nurse's role within the multidisciplinary team in facilitating the involvement of patients and informal carers in the assessment of continuing health care needs.	Senses Framework for analysis	Observations of patient care and key decision making activities throughout hospital and stay and after discharge. Interviews with staff on their perceptions of their own roles with regard to assessments.	One London DGH. n=20 older patients and informal carers. n= 32 MDT staff.	Nurses' continual presence on the ward was almost universally seen by the MDT as offering them unrivalled opportunities to build a rapport with patients and thereby develop better understandings of their needs. Patient and informal carer involvement in this process may be affected by strategic and practice issues. Application of the Senses Framework to data suggest gaps in Framework with regard to 'sense of expertise'.
Aveyard & Davies (2006) UK	To explore ways of collaborative working to create positive environment for dementia residents and carers.	RCC and Senses Framework. Person-centred practice development.	Constructivist framework. Observation (with informal conversations) Questionnaire Semi-structured interviews. Action research	Nursing Home for older people with dementia in the North of England.	Creating a shared understanding through spending time with each other. Learning to value one another (appreciation). Becoming a powerful voice for change created by the action group. Senses Framework useful to support partnership working in older people settings.

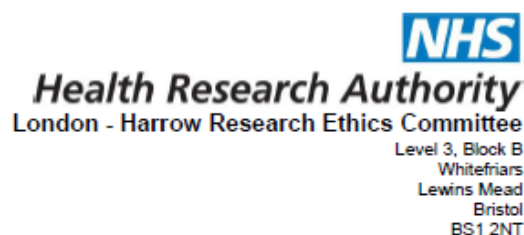
Authors / Year / Country	Topic /Focus/ Purpose	Conceptual/ Theoretical Framework	Paradigm and Methods	Context/ Setting/ Sample	Findings
Brown Wilson et al. (2013) UK	Evaluate training programme in care homes to enhance quality of care.	RCC and Senses framework.	Mixed methods: Facilitated workshops exploring Senses Framework; Focus groups; Questionnaires; Likert scale. Descriptive analysis and Thematic content analysis	1 Care Home Staff, residents and families.	Senses Framework alongside facilitation through Practice Development Framework enabled staff to gain greater insight into how residents experience their lives in a care home, and the need to locate their interaction in the person's frame of reference. Storytelling found to encourage staff to see beyond the immediate physical needs of residents.
Cooper, Meyer & Holman (2013) UK	To explore facilitating factors that enabled staff on rehab ward to engage in change activities.	Action research	Thematic analysis	N=13 interviews staff & managers. Mixed sex 29 bed old person rehabilitation ward.	Findings discussed in relation to Senses Framework. Elements to help staff engage with change: Continued presence and neutrality of the researcher who worked together with staff on their issues of concern Enabling staff opportunity to explore working on the ward. Facilitator help to revise learned helplessness and contain anxiety, and for staff to experience the senses for themselves that then impacted on their practice.
Davies-Quarrell et al (2010), UK	To evaluate the ACE club – a younger person with dementia service	RCC and Senses Framework	Case study	One service in North Wales.	Sense of significance most important in helping people with dementia to structure their evaluation of ACE club.
Dewar & Nolan (2013) UK	To promote compassionate RCC in acute hospital settings	Appreciative inquiry. Participative	Participant observation; interviews; story- telling and group discussions.	Part of 3 year programme. One inpatient older persons ward.	Appreciative inquiry approach can support 'deep conversations' necessary for compassionate relationship-centred care.

Authors / Year / Country	Topic /Focus/ Purpose	Conceptual/ Theoretical Framework	Paradigm and Methods	Context/ Setting/ Sample	Findings
	for older people.	analysis with immersion crystallisation.		N=35 staff N=10 patients N=12 relatives	Data described the inter-relationships between staff, patients and families. Developed a model of caring conversations highlighting the subtle & complex interactions necessary to develop compassionate RCC.
Faulkner, Davies, Nolan & Brown-Wilson (2006) UK	Development and initial testing of a set of reliable questionnaires to evaluate positive events in care homes.	Senses Framework.	Questionnaire design and testing in four care homes.	Older persons and dementia care homes. N= 28 care home residents, N=25 staff (nursing team), N=38 relatives . Final testing from 4 care homes.	Questionnaire based on Senses Framework. Internal consistency with CARE profiles.
Leadership in Compassionate Care (2012) UK	To embed compassionate care as an integral part of nursing practice and education in one NHS region.	Action Research Appreciative Inquiry and RCC	Four aspects to project: 1.Establishing Beacon Wards to showcase excellence 2.Developing leadership skills of key individuals 3.Embed RCC practice in undergraduate curricula 4.Support newly qualified nurses.	One NHS Regional Authority in Scotland. 27 different inpatient settings over 3 years.	Dedicated opportunities for caring conversations. Reflective forums enhanced ability to learn. Using stories from clinical practice for learning.
Orr, L et al (2014) UK	Potential of Senses Framework in family drug services.	Social Constructionism.	Qualitative.	8 Focus groups and interviews of carers, service providers and policy makers 28 carers 43 service providers 19 policy makers	Participants are relational and contradictory rather than autonomous and rational Can senses framework be applied to non institutional settings? There are some weaknesses with lack of contact with service providers

Authors / Year / Country	Topic /Focus/ Purpose	Conceptual/ Theoretical Framework	Paradigm and Methods	Context/ Setting/ Sample	Findings
Ross, Head et al. (2014) UK	To explore the perspectives of student and lecturer on the personal development tutor role.	Data analysis with Senses Framework.	Face to face interviews.	N=6 undergraduate nursing students N=5 nurse lecturers On one nursing programme.	Senses Framework was a valuable tool for data analysis concerning relationships. Students referred to a sense of security and significance most common, and for lecturers a sense of significance and continuity. The remaining senses were less apparent.
Ryan et al. (2008) UK	To evaluate the use of Senses Framework in achieving relationship-centred dementia services.	Senses Framework	Case study	Development of new dementia service in one UK city.	Senses framework used as an analytic framework to help understand how good relationships are created and maintained. Senses Framework highlights the structures and interactions that maintain positive relationships.
Watson, J (2016) UK	Examine the role of embodied and inter-embodied self-hood within care relationships in dementia care home.	Ethnographic approach with appreciative intent. Analysed with Senses Framework.	Qualitative Framework Analysis. Observation; Interviews; Discussion Groups.	One specialist Dementia Care home in UK for 40 people with dementia. N=20 residents N= 33 staff 207 hours observation.	3 themes shaping face to face relationships: Hands on care Taking appreciative stance and positioning of patient in the interaction Attention to the embodied ways of communication Recognising and supporting self-hood Sense of shared identity Knowing things 'handles to hold onto' Witnessing and responding to distress The Senses Framework used to frame how to support relationship-centred care.

Table A - 1: Summary of Studies Evaluating the Senses Framework

Appendix 2: REC Approval Letter



11 March 2016

Mrs Clare Gordon
NIHR Clinical Academic Fellow
Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
Stroke Offices, Education Centre
Castle Lane East
Bournemouth
BH7 7DW

Dear Mrs Gordon

Study title: Enriching relational knowing in stroke care: using appreciative action research to co-create a relationship-centred care approach to patient and family relationships and multidisciplinary working on stroke units.

REC reference: 16/LO/0085
IRAS project ID: 187509

Thank you for your letter of 29 February 2016, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Georgina Castledine, nrescommittee.london-harrow@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Mental Capacity Act 2005

I confirm that the committee has approved this research project for the purposes of the Mental Capacity Act 2005. The committee is satisfied that the requirements of section 31 of

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the Act will be met in relation to research carried out as part of this project on, or in relation to, a person who lacks capacity to consent to taking part in the project.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

1. Regulatory authorities access to research data point is missing from the patient consent form. Please revise. Please exclude the wording relating to medical records.
2. In the Consultee PIS, the last sentence of the second paragraph should say- 'Take time to decide whether or not to advise that your relative or friend should take part in this study.' Please revise.
3. Under the heading 'Why have I been asked to give advice on my relative's wishes?' please add a final sentence as follows- 'You do not have to undertake the role of consultee if you do not wish to do so.'

You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publicly accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Copies of advertisement materials for research participants [Ward poster]	1	28 October 2015
Covering letter on headed paper [160229 Response]		29 February 2016
Interview schedules or topic guides for participants [Topic guide]	1	28 October 2015
IRAS Checklist XML [Checklist_29022016]		29 February 2016
Letter from funder [Letter from funder]		30 July 2015
Letter from sponsor [Site agreement]		10 April 2014
Letters of invitation to participant [Patient/Relative Invitation]	1	28 October 2015
Letters of invitation to participant [Supported communication invitation]	1	28 October 2015
Other [Supervisor 2]	1	27 November 2015
Other [Supervisor 3]		25 November 2015
Participant consent form [Supported communication consent form]	1	28 October 2015
Participant consent form [Consultee declaration form]	2	22 February 2016
Participant consent form [Patient/Relative/Staff Consent Form]	2	22 February 2016
Participant information sheet (PIS) [PIS Supported Communication]	1	28 October 2015
Participant information sheet (PIS) [Post Enrolment PIS]	1	22 February 2016
Participant information sheet (PIS) [Patient PIS]	1	22 February 2016
Participant information sheet (PIS) [Relative PIS]	1	22 February 2016
Participant information sheet (PIS) [Staff PIS]	2	22 February 2016
Participant information sheet (PIS) [Consultee PIS]	3	22 February 2016
REC Application Form [REC_Form_15122015]		15 December 2015
Referee's report or other scientific critique report [RDS Stroke Network review]		28 November 2013

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Referee's report or other scientific critique report [RDS Lay Review]		28 November 2013
Referee's report or other scientific critique report [RDS 1]		28 November 2013
Referee's report or other scientific critique report [RDS 2]		28 November 2013
Referee's report or other scientific critique report [RDS Re-review]		11 March 2014
Referee's report or other scientific critique report [Bournemouth University Review]		01 December 2013
Research protocol or project proposal [Research protocol]	1	07 December 2015
Summary CV for Chief Investigator (CI) [Clare Gordon CV]		25 November 2015
Summary CV for supervisor (student research) [Supervisor 1]		26 November 2015
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Protocol Flowchart]	1	26 November 2015

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

16/LO/0085

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

A Research Ethics Committee established by the Health Research Authority

pp. *Lebets.*

Dr Jan Downer
Chair

Email: nrescommittee.london-harrow@nhs.net

Copy to: *Mrs Caroline Jamieson-Leadbitter, Royal Bournemouth Hospital R&D
Office*

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Appendix 3: Site Approval Letters

3.1 Site 1 Approval Letter

	Salisbury NHS NHS Foundation Trust
	Salisbury Research Support Service Block 24 SDH South Salisbury District Hospital Salisbury Wiltshire SP2 8BJ Telephone: (01722) 425026 Email: stef.scott@salisbury.nhs.uk
 24 March 2016	
 Mrs Clare Gordon Royal Bournemouth Hospital Castle Lane East Bournemouth BH7 7DW	
Dear Mrs Gordon	
CSP number:	187509
RDMC number	80/2015/2016
Title:	Enriching relational knowing in stroke care
 Thank you for submitting the above project to the Salisbury Research Support Service (RSS) for NHS permission for research at Salisbury NHS Foundation Trust.	
 I am pleased to inform you that Enriching relational knowing in stroke care was granted NHS permission to proceed within Salisbury NHS Foundation Trust on 24 March 2016 on the basis described in the application form, protocol and supporting documentation. The documentation received and the governance reviews are detailed in the attached Research Governance Report. NHS permission for the above research is subject to the following conditions:	
<ul style="list-style-type: none">• The Trust will act as a research site, conducting the research activities described in the Trust Site Specific Information (SSI) form;• A letter of access is in place before beginning research activities	
 The study should be conducted in accordance with the Research Governance Framework for Health and Social Care (2 nd edition 2005), and Trust policies and procedures. Additionally, it is a legal requirement that Clinical Trials of Investigational Medicinal Products (CTIMPs) are conducted in accordance with the Medicines for Human Use (Clinical Trials) Regulations 2004 and Amendment Regulations 2006 incorporating Good Clinical Practice as well as any other relevant regulations.	
 You should notify the R&D Office, within the same timeframe of notifying the REC and any other regulatory bodies, of the following:	
<ul style="list-style-type: none">• any urgent safety measures implemented by the research sponsor/the chief investigator in order to protect research participants against any immediate hazard to their health or safety• Serious adverse events/SUSARs at Salisbury NHS Foundation Trust• Amendments (including changes to the local research team) in accordance with guidance on IRAS• Progress reports• Changes to the status of the study• End of study reports• Planned monitoring and audits visits by the Sponsor or other body	
 The research involves NHS patients under the care of Salisbury NHS Foundation Trust. Indemnity for harm to study participants resulting from clinical negligence of the Salisbury NHS Foundation Trust research team is provided by NHS indemnity.	
 <hr/> <small>The Salisbury Research Support Service provides research management and governance services to Wessex CCGs (as part of Wessex shared service), Salisbury NHS Foundation Trust and Dorset Healthcare University NHS Foundation Trust.</small>	

Please note that Salisbury NHS Foundation Trust is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. The above research may be selected for audit.

Please do not hesitate to contact the RSS Office on 01722 425026 if you require any additional information or support.

I wish you every success with your research project

Yours sincerely



Dr Stef Scott
Head of Research

CC:

Local Contact:

CTP

CTA

RSA

Division contact

Dr Toby Black

Alpha Antony

Ruth Fennelly

Melba Knighton

3.2 Site 2 Approval letter

Mrs Clare Gordon
NIHR Clinical Academic Fellow
Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
Stroke Offices, Education Centre
Castle Lane East
Bournemouth
BH7 7DW

5th September 2017

Dear Clare,

Written Agreement to Proceed - Confirmation of Capacity and Capability at Dorset County Hospital NHS Foundation Trust

Study Title:	Enriching relational knowing in stroke care: using appreciative action research to co-create a relationship-centred care approach to patient and family relationships and multidisciplinary working on stroke units.
REC reference:	16/LO/0085
IRAS project ID:	187509
Date of Confirmation by Site:	5 th September 2017

Based on an HRA approval date of 19th June 2017, this letter confirms that Dorset County Hospital NHS Foundation Trust has the capacity and capability to deliver the above named study, in agreement with the study actions listed in the 'Statement of Activities' and 'Schedule of Events'.

Please find attached our agreed *Statement of Activities* as confirmation.

The study may commence at this site when the Sponsor gives the green light to begin.

Should you have any queries or feel I can be of any help, please do not hesitate to contact me.

Yours sincerely



Dr Zoë Sheppard
Head of Research and Innovation
Research and Innovation
Dorset County Hospital Foundation Trust
Williams Avenue
Dorchester
Dorset, DT1 2JY
Tel 01305 2555298
Email – Zoe.Sheppard@dchft.nhs.uk

Cc: Louise Clark, Head of Occupational Therapy and Principal Investigator

S:\Research & Development\GCP Inspection Dossier\18 Trial Master File\10 Stroke Trials\OPEN\Enriching Relational Knowing in Stroke Care - Clare Gordon project\R&D set-up\Clare Gordon project_Written Agreement to Proceed DCHFT.doc

Version 1.0, 13 April 2016.

Appendix 4: Participant Information Sheet

22/02/2016

1

Patient Participant Study Information Sheet

Developing relationship-centred care on a stroke unit

This study is about caring relationships on a stroke unit and how positive, valued relationships between you, your family and the stroke team can happen more often.

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Who is organising/funding the research?

This research study is being organised by Clare Gordon. She is a post-graduate student at Bournemouth University and a Registered Nurse. The study is sponsored by the Royal Bournemouth Hospital NHS Foundation Trust. Clare Gordon is funded by a Clinical Academic Fellowship from the National Institute for Health Research.

Clare Gordon is supervised by Dr Caroline Ellis-Hill, a Senior Lecturer in Qualitative Research at Bournemouth University; Caroline Watkins a Professor of Stroke and Older People's Care at the University of Central Lancashire ; and Belinda Dewar a Professor of Practice Improvement at the University of the West of Scotland.

What is the purpose of the project?

The purpose of this study is to understand what positive caring relationships are for patients, relatives and the stroke unit team. It will explore the experiences of being cared for by the stroke team, and caring for a patient with a stroke and their family. This information may then be used to potentially develop and enhance future care experiences that support the needs of the patient with a stroke and their family.

Why have I been invited?

You have been admitted to the stroke unit after having a stroke and are being cared for by the stroke unit team.

Do I have to take part?

It is up to you whether or not to take part in this study. If you do decide to take part, you will be given this information sheet to keep (and be asked to sign a participant agreement form). You will be free to change your mind at any time and without giving a reason. This will not in any way alter your care, now or in the future. If you later decide not to continue you can either request for all the information collected so far to remain in the study, or if you prefer, we can destroy all information collected up to the point where your information has been anonymised and processed.

What would taking part involve?

You will be involved in the study for as long as you are an inpatient on the stroke unit and for up to 4 weeks after being discharged from the stroke unit. The study involves observations, an interview and discussion groups. It is up to you whether you chose to be involved in all of these, or just one.

Observation: You can choose to have your care observed while you are on the stroke unit. The observations will be looking at positive caring experiences among you, your relatives and staff. You will be invited to be involved in a maximum of 5 observations for between 5 to 30 minutes for each observation. For example, we may ask to observe you having your blood pressure taken by a nurse or doctor.

Individual interview: The purpose of the interview is to find out about your experiences on the stroke unit. This will involve asking you some questions about how you felt about your care and support on the stroke unit, to understand what worked well and how you feel your care could have been improved. The interview will last for approximately 1 hour. We can arrange a time and location suitable for you, for example at your home or at the hospital.

Discussion Group: There will be meetings with a group of 5 to 8 people that will be a combination of stroke unit care staff, patients and relatives to meet and discuss what has been found out in the study so far. This information will include anonymous information gathered from prior interviews and observations. The aim of the discussion groups will be to work together to develop caring relationships on the stroke unit. The discussion groups will happen at the hospital and will last a maximum of 1 hour. You will be invited to participate in either 1 or 2 discussion groups.

Will I be recorded, and how will the recorded media be used?

If you choose to take part in an interview or discussion group, the conversation will be audio recorded and only used for analysis during this study. No other use will be made of them, and no one outside the project will be allowed access to the original recordings.

The audio recordings will be stored anonymously for the duration of the study on a NHS password protected secure server in accordance with the Data Protection Act 1998. The recordings will be deleted at the end of the study.

What are possible benefits of taking part?

The main potential benefit of this study will be to understand what is important for a person with a stroke, their family and the staff caring for them on a stroke unit. Whilst there is no intended benefit for you individually from taking part in this study, as a participant you may help to develop possible future caring experiences received by others experiencing a stroke.

What are the possible disadvantages or risks of taking part?

It is not anticipated that there will be any disadvantages to you by joining the study, but there is a possibility that you may find the interview or discussion groups upsetting. You can end the discussion at any time if you feel uncomfortable. The researcher will check if you are alright and if you want to continue. If you do not want to continue, the researcher will check with you if you are

willing for the information that you have already contributed can be included in the research. If you have any ongoing issues the researcher will direct you to where you can get support.

Will my taking part in this project be kept confidential?

With your permission, all the information that we collect about you during the course of the research will be kept strictly confidential. No personal data will be kept, and all data will be fully anonymised. Occasionally specific information could be linked to you. If this happens, you will be asked if you are willing to share that particular information with other participants in the study. You will not be able to be identified in any reports or publications. All data relating to this study will be kept for a minimum of 5 years at a NHS password protected secure network in accordance with the Data Protection Act 1998.

If any unsafe practices that put patients at risk are observed on the ward or mentioned in the discussion groups or interviews, the researcher is obliged under the Nursing and Midwifery Code (2015) to report these immediately.

What will happen to the results of the study? What happens when the study is finished?

The results are likely to be published in 2018. The results of the study may be used to inform further development of healthcare. They will be presented as a PhD thesis and also for healthcare journal publications. Verbal quotes may be used within the PhD thesis and journal publication, however they will be fully anonymised.

You will be asked if you would like a copy of the results once they are published.

Contact for further information

If you have any questions about the study please contact Clare Gordon

Telephone 01202 726406
Mobile 07473 533375
Email clare.gordon@rbch.nhs.uk



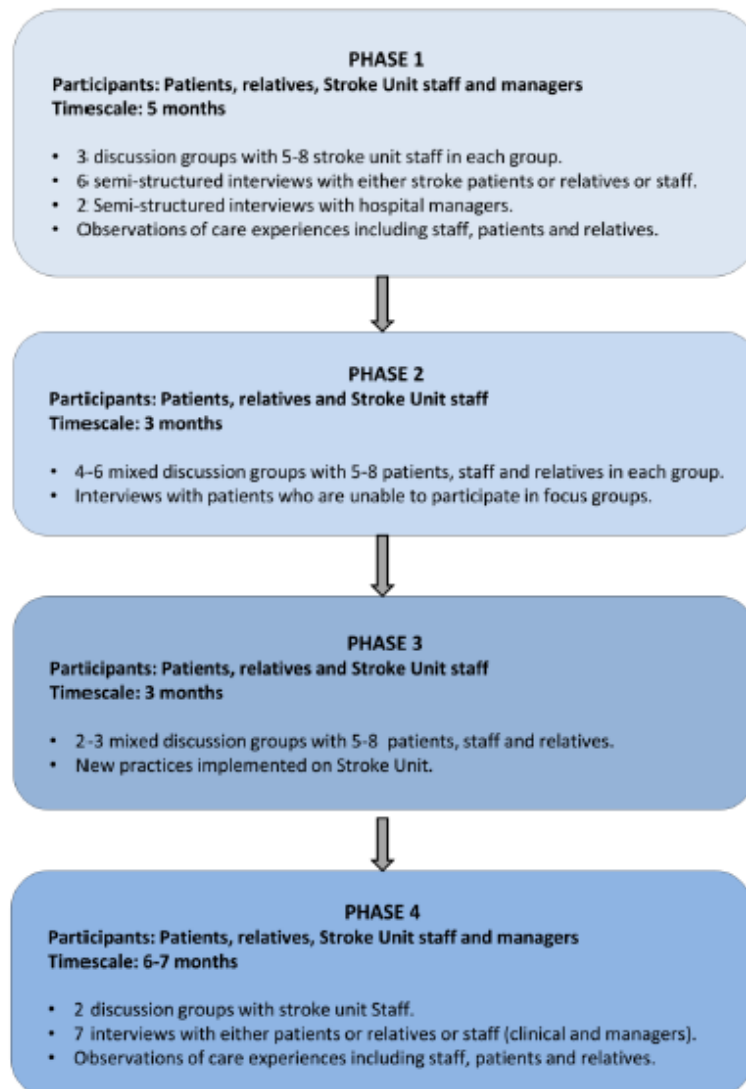
If you have any further questions about the study please contact Caroline Ellis-Hill.

Telephone 01202 962173
Email cehill@bournemouth.ac.uk
Address Dr Caroline Ellis-Hill
Royal London House R110
Christchurch Road
Bournemouth
BH1 3LT

If you wish to make a complaint about this study, you can contact Professor Vanora Hundley, Deputy Dean of Research and Professional Practice:

Telephone 01202 965206
Email vhundley@bournemouth.ac.uk
Address Professor Vanora Hundley
Royal London House R118
Christchurch Road
Bournemouth
BH1 3LT

**A flow-chart of the stages of a research study
to develop relationship-centred care on a stroke unit**



**Please note: Participants will not be involved in all stages.
The recruiter will circle which stages you could be involved in.**

Thank you for taking the time to read this information sheet.

You will be given a copy of the information sheet and, if appropriate, a separate signed participant agreement form to keep.

Appendix 5: Participant Consent Form

14/03/2016

Participant Agreement Form

Short title of the project: Developing relationship-centred care on a stroke unit.

Full Project Title: Enriching relational knowing in stroke care through appreciative action research.

Name, position and contact details of researcher:

Clare Gordon, NIHR Clinical Academic Fellow
Email: Clare.Gordon@rbch.nhs.uk Telephone: 01202 726406

Name, position and contact details of supervisor:

Dr Caroline Ellis-Hill, Senior Lecturer Bournemouth University
Email: cehill@bournemouth.ac.uk Telephone: 01202 962173

Please initial
or
tick here

I have read and understood the participant information sheet for the above research project.	
I confirm that I have had the opportunity to ask questions.	
I understand that my participation is voluntary.	
I understand that I am free to withdraw up to the point where the data are processed and become anonymous, so my identity cannot be determined.	
During the research study, I am free to withdraw without giving reason and without there being any negative consequences.	
Should I not wish to answer any particular question(s), or be observed on the stroke unit, I am free to decline.	
I understand that the researcher will report any information that I disclose about unsafe practices that could put patients at risk.	
I give permission for the responsible individuals from Bournemouth University, the Royal Bournemouth Hospitals NHS Foundation Trust or from regulatory authorities to access my anonymised responses. I understand that my name will not be linked with the research materials. If there is any possibility that I can be identified from the research, I understand that my permission will be sought to use the data.	
I agree to take part in the above research project.	

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

This form should be signed and dated by all parties after the participant receives a copy of the participant information sheet and any other written information provided to the participants. A copy of the signed and dated participant agreement form should be given to the participant, and a copy kept with the project's main documents which must be kept in a secure location.

Participant Agreement Form version 3









National Institute for
Health Research

Appendix 6: Supported Communication Participant Information Sheet

28/10/2015

Research Study Participant Information

This study is about what **you think** about your care on the **stroke unit**.

	<p>In this research you will be asked about your care on the stroke unit.</p>
 	<p>You will need to:</p> <ul style="list-style-type: none"> • Be observed having your normal care on the stroke unit. • Talk to researchers about your care experiences.
  	<p>You can choose how much you want to do:</p> <ul style="list-style-type: none"> • Have your care observed while in the hospital. <p>and</p> <ul style="list-style-type: none"> • An interview at your home after you have left hospital. <p>or</p> <ul style="list-style-type: none"> • take part in a group discussion while you are in hospital.
<p>The main researcher is Clare Gordon</p>   01202 726406  clare.gordon@rbch.nhs.uk	<p>Any questions.....please contact Caroline Ellis-Hill</p>  01202 962173 <p>Dr Caroline Ellis-Hill Royal London House R110 Christchurch Road Bournemouth BH1 3LT</p>   cehill@bournemouth.ac.uk

Appendix 7: Supported Communication Consent Form

28/10/2015

Participant Agreement Form

Taking part in research about

what **you think** about your care on the stroke unit.

Please mark  ☐ **yes**  ☐ **no** 



I have **read** the
information about the
research

 ☐ **yes**  ☐ **no**



I have had the **chance** to
ask questions about the
research

 ☐ **yes**  ☐ **no**



I am **happy** with the
answers to my questions

 ☐ **yes**  ☐ **no**



I understand that the
researcher may make **sound**
recordings

 ☐ **yes**  ☐ **no**



I understand that **information**
about me will be **kept safe**

 ☐ **yes**  ☐ **no**



It will **not** be **shared** with
anyone outside the
research

 ☐ **yes**  ☐ **no**

28/10/2015



I know that when **results**
are shared the researcher
will **not use my name**

☐ ☐
yes no



I understand that I **can stop**
being in the research at any
time

☐ ☐
yes no



If I stop I do not have to
give a reason

☐ ☐
yes no

...and I will still get my
normal care



I agree to take part in the
research

☐ ☐
yes no

Name _____



Signature _____ Date _____

I give my consent to

Name _____



Signature _____ Date _____

The Main Researcher is
Clare Gordon



01202 726406

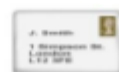


clare.gordon@rbch.nhs.uk

Any questions.....please contact Caroline Ellis-Hill



01202 962173




Royal London House R110,
Christchurch Road,
Bournemouth. BH1 3LT.



Email: cehill@bournemouth.ac.uk

Appendix 8: Consultee Information Sheet

14/03/2016	1
<u>Consultee Study Information Sheet</u>	
Developing relationship-centred care on a stroke unit	
<p>This study is about caring relationships on a stroke unit and how positive, valued relationships between your relative, you and the stroke team can happen more often.</p>	
<p>You are being consulted about your relative taking part in a research study. This will be to observe care given by the stroke unit staff. It will record information on how staff interact with your relative. Before you advise on your relative's participation, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not to advise that your relative or friend should take part in this study.</p>	
Who is organising/funding the research?	
<p>This research study is being organised by Clare Gordon. She is a doctoral student at Bournemouth University and a Registered Nurse. The study is sponsored by the Royal Bournemouth Hospital NHS Foundation Trust. Clare Gordon is funded by a Clinical Academic Fellowship from the National Institute for Health Research.</p>	
<p>Clare Gordon is supervised by Dr Caroline Ellis-Hill, a Senior Lecturer in Qualitative Research at Bournemouth University; Caroline Watkins a Professor of Stroke and Older People's Care at the University of Central Lancashire; and Belinda Dewar a Professor of Practice Improvement at the University of the West of Scotland.</p>	
What is the purpose of the project?	
<p>The purpose of this study is to understand what are positive caring relationships for patients, relatives and the stroke unit team. It will explore the experiences of being cared for by the stroke team, and caring for a patient with a stroke and their family. This information may then be used to potentially develop and enhance care experiences that support the needs of the patient with a stroke and their family.</p>	
Why have I been asked to give advice on my relative's wishes?	
<p>Your relative has been admitted to the stroke unit after having a stroke, and is being cared for by the stroke unit team. Your relative is not able to communicate or understand information about this study and give consent, therefore I am asking for your advice on your relative's wishes or feelings on observing care that they receive on the stroke unit. You have been asked as you are their next of kin or hold power of attorney. The Mental Capacity Act (2005) Section 32 requires you to be consulted on your relative's wishes and whether he or she should join the research. You do not have to undertake the role of consultee if you do not wish to do so.</p>	
Consultee Information Sheet v4	 National Institute for Health Research

14/03/2016

Do I have to give permission for my relative's care to be observed?

It is up to you to decide whether or not your relative would be content to take part or whether doing so might upset them. You should consider your relative's past and present wishes and feelings about taking part in this study. If you do decide that your relative would be willing to take part, you will be given this information sheet to keep (and be asked to sign a consultee declaration form). You will be free to change your mind at any time and without giving a reason. This will not in any way alter your relative's care, now or in the future. If you later decide for your relative not to continue you can either request for all the information collected so far to remain in the study, or if you prefer, we can destroy all information collected up to the point where your relative's information has been anonymised and processed.

What would taking part involve?

Your relative will be involved in the study for as long as they are an inpatient on the stroke unit and will involve a researcher observing the care that your relative receives. The observations will be looking at positive caring experiences among patients, relatives and staff. Your relative will be involved in a maximum of 5 observations for between 5 to 30 minutes for each observation. For example, we may observe your relative having their blood pressure taken by a nurse or doctor.

If you agree for your relative to take part, we will tell you on which dates the observations are due to happen. If you would not like your relative to be observed on a particular date, please contact Clare Gordon on 01202 726406 or clare.gordon@rbch.nhs.uk.

What are possible benefits of taking part?

The main potential benefit of this study will be to understand what is important for a person with a stroke, their family and the staff caring for them on a stroke unit. Whilst there is no intended direct benefit for you or your relative from taking part in this study, the study may help to develop future caring experiences received by others experiencing a stroke.

What are the possible disadvantages or risks of taking part?

Although it is not anticipated that there will be any disadvantage to your relative, there is a possibility that they may become distressed during an observation. If this occurs, the observation will stop immediately.

Will my relative's taking part in this project be kept confidential?

All the information that we collect about your relative during the course of the research will be kept strictly confidential. No personal data will be kept, and all data will be fully anonymised. Occasionally specific information could be linked to your relative. If this happens, you will be asked if you are willing for the particular information to be shared. Your relative will not be identified in any reports or publications. All data relating to this study will be kept for a minimum of 5 years at a Bournemouth University password protected secure network in accordance with the Data Protection Act 1998.

14/03/2016

If any unsafe practices that put patients at risk are observed, the researcher is obliged under the Nursing and Midwifery Code (2015) to report these immediately.

What will happen to the results of the study? What happens when the study is finished?

The results are likely to be published in 2018. The results of the study may be used to inform further development of healthcare. They will be presented as a PhD thesis and also in healthcare journal publications. Verbal quotes may be used within the PhD thesis and journal publication, however they will be fully anonymised.

You will be asked if you would like a copy of the results once they are published.

Contact for further information

If you have any questions about the study please contact Clare Gordon

Telephone 01202 726406
Mobile 07473 533375
Email clare.gordon@rbch.nhs.uk



If you have any further questions about the study please contact Caroline Ellis-Hill.

Telephone 01202 962173
Email cehill@bournemouth.ac.uk
Address Dr Caroline Ellis-Hill
Royal London House R110
Christchurch Road
Bournemouth
BH1 3LT

If you wish to make a complaint about this study, you can contact Professor Vanora Hundley, Deputy Dean of Research and Professional Practice:

Telephone 01202 965206
Email vhundley@bournemouth.ac.uk
Address Professor Vanora Hundley
Royal London House R118
Christchurch Road
Bournemouth
BH1 3LT

Thank you for taking the time to read this information sheet.

You will be given a copy of this information sheet and, if appropriate, a separate signed consultee declaration form to keep.

Appendix 9: Consultee Declaration Form

22/02/2016

Consultee Declaration Form

Short Title: Developing relationship-centred care on a stroke unit

Full Project Title: Enriching relational knowing in stroke care through appreciative action research

Name, position and contact details of researcher:

Clare Gordon, NIHR Clinical Academic Fellow

Email: Clare.Gordon@rbch.nhs.uk Telephone: 01202 726406

Name, position and contact details of supervisor:

Dr Caroline Ellis-Hill, Senior Lecturer Bournemouth University

Email: cehill@bournemouth.ac.uk Telephone: 01202 962173

Please initial
or
tick here

I have been consulted about 's participation in this research project. I have had the opportunity to ask questions about the study and understand what is involved.

In my opinion he/she would have no objection to taking part in the above study.

I understand that I can request he/she is withdrawn from the study at any time, without giving any reason and without his/her care or legal rights being affected.

I understand that if specific information that I provide in the study could identify me, I will be asked permission to use this information. I understand that the researcher will report any information that I disclose about unsafe practices that could put patients at risk.

I understand that data collected during the study may be looked at by responsible individuals from Bournemouth University or Royal Bournemouth Hospitals NHS Foundation Trust or from regulatory authorities, where it is relevant to my relative or friend's participation in this research.

Name of Consultee

Date

Signature

Relationship to Participant : _____

Person undertaking consultation
(if different to the researcher)

Date

Signature

Name of Researcher

Date

Signature

This form should be signed and dated after the consultee receives a copy of the consultee information sheet. The original should be stored in the patient's medical notes, a copy given to the consultee, and a copy kept with the project's main documents which must be kept in a secure location.

Consultee Declaration Form version 2


National Institute for
Health Research

Appendix 10: Post-enrolment Participant Information Sheet

22/02/2016

1

Post-enrolment Participant Study Information Sheet

Developing relationship-centred care on a stroke unit

This study is about caring relationships on a stroke unit and how positive, valued relationships between you, your family and the stroke team can happen more often.

You are being invited to continue or decline further involvement in a research project. Before you decide it is important for you to understand why the research is being done and what it involves. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to continue to take part.

Who is organising/funding the research?

This research study is being organised by Clare Gordon. She is a post-graduate student at Bournemouth University and a Registered Nurse. The study is sponsored by the Royal Bournemouth Hospital NHS Foundation Trust. Clare Gordon is funded by a Clinical Academic Fellowship from the National Institute for Health Research.

Clare Gordon is supervised by Dr Caroline Ellis-Hill, a Senior Lecturer in Qualitative Research at Bournemouth University; Caroline Watkins a Professor of Stroke and Older People's Care at the University of Central Lancashire; and Belinda Dewar a Professor of Practice Improvement at the University of the West of Scotland.

What is the purpose of the project?

The purpose of this study is to understand what are positive caring relationships for patients, relatives and the stroke unit team. It will explore the experiences of being cared for by the stroke team, and caring for a patient with a stroke and their family. This information may then be used to potentially develop and enhance future care experiences that support the needs of the patient with a stroke and their family.

Why have I been invited?

You are already in the study due to your recent stroke. The Mental Capacity Act (2005) Section 32 requires your relative to be consulted on if they thought you would be interested in helping with the study, and they gave permission for you to take part.

Now that you are feeling better, we would like to ask for your consent for you remain in the study or decline further involvement. You can also choose to withdraw the data already collected if it has not been anonymised and processed.

Do I have to continue to take part?

It is up to you whether or not to continue to take part in this study. If you do decide to continue in the study, you will be given this information sheet to keep (and be asked to sign a participant agreement

form). You will be free to change your mind at any time and without giving a reason. This will not in any way alter your care, now or in the future.

If you decide not to continue you can either request for all the information collected so far to remain in the study, or if you prefer, we can destroy all information that has not been anonymised and processed.

What will happen if I continue to take part?

You will be involved in the study for as long as you are an inpatient on the stroke unit and for up to 4 weeks after being discharged from the stroke unit. The study involves observations, an interview and discussion groups. It is up to you whether you chose to be involved in all of these, or just one.

Observation: The study so far has involved observing the care that you have received whilst you are on the stroke unit. The observations looked at positive caring experiences among you, your relatives and staff. Now that you are feeling better you may be invited to be involved in a maximum of 5 further observations for between 5 to 30 minutes for each observation. For example, we may ask to observe you having your blood pressure taken by a nurse or doctor.

Individual interview: The purpose of the interview is to find out about your experiences on the stroke unit. This will involve asking you some questions about how you felt about your care and support on the stroke unit, to understand what worked well and how you feel your care could have been improved. The interview will last for approximately 1 hour. We can arrange a time and location suitable for you, for example at your home or at the hospital.

Discussion Group: There will be meetings with a group of 5 to 8 people that will be a combination of stroke unit care staff, patients and relatives to meet and discuss what has been found out in the study so far. This information will include anonymous information gathered from prior interviews and observations. The aim of the discussion groups will be to work together to develop caring relationships on the stroke unit. The discussion group will happen at the hospital and will last a maximum of 1 hour. You will be invited to participate in either 1 or 2 discussion groups.

Will I be recorded, and how will the recorded media be used?

If you choose to take part in an interview or discussion group, the conversation will be audio recorded and only used for analysis during this study. No other use will be made of them, and no one outside the project will be allowed access to the original recordings.

The audio recordings will be stored anonymously for the duration of the study on a NHS password protected secure server in accordance with the Data Protection Act 1998. The recordings will be deleted at the end of the study.

What are possible benefits of taking part?

The main potential benefit of this study will be to understand what is important for a person with a stroke, their family and the staff caring for them on a stroke unit. Whilst there is no intended benefit for you individually from taking part in this study, as a participant you may help to develop possible future caring experiences received by others experiencing a stroke.

What are the possible disadvantages or risks of taking part?

It is not anticipated that there will be any disadvantages to you by joining the study, but there is a possibility that you may find the interview or discussion groups upsetting. You can end the discussion at any time if you feel uncomfortable. The researcher will check if you are alright and if you want to continue. If you do not want to continue, the researcher will check with you if you are willing for the information that you have already contributed can be included in the research. If you have any ongoing issues the researcher will direct you to where you can get support.

Will my taking part in this project be kept confidential?

With your permission, all the information that we collect about you during the course of the research will be kept strictly confidential. No personal data will be kept, and all data will be fully anonymised. Occasionally specific information could be linked to you. If this happens, you will be asked if you are willing to share that particular information with other participants in the study. You will not be able to be identified in any reports or publications. All data relating to this study will be kept for a minimum of 5 years at a NHS password protected secure network in accordance with the Data Protection Act 1998.

If any unsafe practices that put patients at risk are observed on the ward or mentioned in the discussion groups or interviews, the researcher is obliged under the Nursing and Midwifery Code (NMC 2015) to report these immediately.

What will happen to the results of the study? What happens when the study is finished?

The results are likely to be published in 2018. The results of the study will be used to inform further development of healthcare. They will be presented as a PhD thesis and also for healthcare journal publications. Verbal quotes may be used within the PhD thesis and journal publication; however they will be fully anonymised. You will be asked if you would like a copy of the results once they are published.

Contacts for further information

If you have any questions about the study please contact Clare Gordon

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If you have any further questions about the study please contact Caroline Ellis-Hill.

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If you wish to make a complaint about this study, you can contact Professor Vanora Hundley, Deputy Dean of Research and Professional Practice:

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Appendix 11: Relative Participant Information Sheet

22/02/2016

1

Relative Participant Study Information Sheet

Developing relationship-centred care on a stroke unit

This study is about caring relationships on a stroke unit and how positive, valued relationships between you, your family and the stroke team can happen more often.

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Who is organising/funding the research?

This research study is being organised by Clare Gordon. She is a post-graduate student at Bournemouth University and a Registered Nurse. The study is sponsored by the Royal Bournemouth Hospital NHS Foundation Trust. Clare Gordon is funded by a Clinical Academic Fellowship from the National Institute for Health Research.

Clare Gordon is supervised by Dr Caroline Ellis-Hill, a Senior Lecturer in Qualitative Research at Bournemouth University; Caroline Watkins a Professor of Stroke and Older People's Care at the University of Central Lancashire ; and Belinda Dewar a Professor of Practice Improvement at the University of the West of Scotland.

What is the purpose of the project?

The purpose of this study is to understand what positive caring relationships are for patients, relatives and the stroke unit team. It will explore the experiences of being cared for by the stroke team, and caring for a patient with a stroke and their family. This information may then be used to develop and enhance future care experiences that support the needs of the patient with a stroke and their family.

Why have I been invited?

Your relative has been admitted to the stroke unit after having a stroke, and are being cared for by the stroke unit team.

Do I have to take part?

It is up to you whether or not to take part in this study. If you do decide to take part, you will be given this information sheet to keep (and be asked to sign a participant agreement form). You will be free to change your mind at any time and without giving a reason. This will not in any way alter your relative's care, now or in the future. If you later decide not to continue you can either request for all the information collected so far to remain in the study, or if you prefer, we can destroy all information collected up to the point where your information has been anonymised and processed.

What would taking part involve?

You will be involved in the study for as long as your relative is an inpatient on the stroke unit and for up to 4 weeks after your relative is discharged. The study involves observations, an interview and discussion groups. It is up to you whether you chose to be involved in all of these, or just one.

Observation: The study will involve observing your interactions and relationships with the stroke unit staff whilst your relative is on the stroke unit. The observations will be looking at positive caring experiences among you, your relative and staff. You will be invited to be involved in a maximum of 5 observations for between 5 to 30 minutes for each observation. For example, we may ask to observe you having a conversation with a therapist about your relative's discharge plans.

Individual interview: The purpose of the interview is to find out about your experiences on the stroke unit. This will involve asking you some questions about how you felt about your relative's care, to understand what worked well and how you feel care could have been improved. The interview will last for approximately 1 hour. We can arrange a time and location suitable for you, for example at your home or at the hospital.

Discussion Group: There will be meetings with a group of 5 to 8 people that will be a combination of stroke unit care staff, patients and relatives to meet and discuss what has been found out in the study so far. This information will include anonymous information gathered from prior interviews and observations. The aim of the discussion groups will be to work together to develop caring relationships on the stroke unit. The discussion group will happen at the hospital and will last a maximum of 1 hour. You will be invited to participate in either 1 or 2 discussion groups.

Will I be recorded, and how will the recorded media be used?

If you choose to take part in an interview or discussion group, the conversation will be audio recorded and only used for analysis during this study. No other use will be made of them, and no one outside the project will be allowed access to the original recordings.

The recordings will be stored anonymously for the duration of the study on a NHS password protected secure server in accordance with the Data Protection Act 1998. The recordings will be deleted at the end of the study.

What are possible benefits of taking part?

The main potential benefit of this study will be to understand what is important for a person with a stroke, their family and the staff caring for them on a stroke unit. Whilst there is no intended benefit for you or relative from taking part in this study, as a participant you may help to develop possible future caring experiences received by others experiencing a stroke.

What are the possible disadvantages or risks of taking part?

It is not anticipated that there will be any disadvantage to you by joining the study, but there is a possibility that you may find the interview or discussion groups upsetting. The discussion can stop anytime if you feel uncomfortable or upset, and the researcher will give you information on where to get support if this occurs.

Will my taking part in this project be kept confidential?

With your permission, all the information that we collect about you during the course of the research will be kept strictly confidential. No personal data will be kept, and all data will be fully anonymised. Occasionally specific information could be linked to you. If this happens, you will be asked if you are willing to share that particular information with other participants in the study. You will not be able to be identified in any reports or publications. All data relating to this study will be kept for a minimum of five years at a NHS password protected secure network in accordance with the Data Protection Act 1998.

If any unsafe practices that put patients at risk are observed on the ward or mentioned in the discussion groups or interviews, the researcher is obliged under the Nursing and Midwifery Code (2015) to report these immediately.

What will happen to the results of the study? What happens when the study is finished?

The results are likely to be published in 2018. The results of the study will be used to inform further development of healthcare. They will be presented as a PhD thesis and also for healthcare journal publications. Verbal quotes may be used within the PhD thesis and journal publication; however they will be fully anonymised.

You will be asked if you would like a copy of the results once they are published.

Contact for further information

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Thank you for taking the time to read this information sheet.

You will be given a copy of the information sheet and, if appropriate, a separate signed participant agreement form to keep.

Appendix 12: Staff Participant Information Sheet

22/02/2016

1

Participant Study Information Sheet (Staff)

Developing relationship-centred stroke care using appreciative inquiry.

This study is about caring relationships on stroke units and how positive, valued relationships between the stroke multidisciplinary team, patients and their families can happen more often.

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Who is organising/funding the research?

This research study is being organised by Clare Gordon. She is a post graduate student at Bournemouth University and a Registered Nurse. The study is sponsored by the Royal Bournemouth Hospital NHS Foundation Trust. Clare Gordon is funded by a Clinical Academic Fellowship from the National Institute for Health Research.

Clare Gordon is supervised by Dr Caroline Ellis-Hill, a Senior Lecturer in Qualitative Research at Bournemouth University; Caroline Watkins a Professor of Stroke and Older People's Care at the University of Central Lancashire ; and Belinda Dewar a Professor of Practice Improvement at the University of the West of Scotland.

What is the purpose of the project?

The purpose of this study is to understand being cared for and caring for a patient with a stroke and their family, in particular understanding what are valued relationships for the patient, relative and stroke unit team. This may then be used to potentially develop and enhance future care experiences that support the needs of the patient with a stroke and their family.

Why have I been invited?

You are part of the stroke multidisciplinary team (MDT) that cares for stroke patients and their relatives on Farley Ward at Salisbury District Hospital.

Do I have to take part?

It is up to you whether to take part in the study or not. If you do decide to take part, you will be given this information sheet to keep (and be asked to sign a participant agreement form). You will be free to change your mind at any time and without giving a reason and this will not have any negative consequences in your workplace. If you later decide not to continue you can either request for all the information collected so far to remain in the study, or if you prefer, we can destroy all information collected up to the point where your information has been anonymised and processed.

What would taking part involve?

The study will be for approximately 10 months. It involves observations, interviews and discussion groups. It is up to you whether you chose to be involved in all of these, or just one.

Observation: The study will involve observing the usual care that you and the stroke MDT provide on the stroke unit. The observations will be looking for the positive care interactions with your team, your patients and their family on Farley Ward. Observations will not be happening all of the time. They will occur at specific intervals throughout the project. Each observation will last for between 5 to 30 minutes, for example, observing interactions during a consultant ward round or a therapy session. The timing of these observations will be agreed by all involved before they happen.

Individual interview: The purpose of the interview is to find out about your experiences of valued relationships on Farley Ward and will involve asking you questions about how you feel caring for your patients, their family and team members. The aim is to understand what works well and how valued care experiences can happen more often. The interview will last for approximately 1 hour. It will take place at work, or we can arrange a time suitable for you after work at a convenient location, for example your home.

Discussion Group: There will be discussion groups with the stroke unit MDT, patients and relatives to meet and discuss what has been found out in the study so far, including anonymous information gathered from prior interviews and observations. There will be between 5 to 8 people in each group. Some of these groups will be mixed, and others will be staff only. The aim of the discussion groups will be to work together to further develop caring relationships on the stroke unit. The discussion groups will happen at work and will last a maximum of 1 hour.

Will I be recorded, and how will the recorded media be used?

If you choose to take part in an interview or discussion group, the conversation will be audio recorded and only used for analysis during this study. No other use will be made of them, and only the researcher and her supervisory team will be allowed access to the original recordings.

The recordings will be stored anonymously for the duration of the study on a NHS password protected secure server in accordance with the Data Protection Act 1998. The recordings will be deleted at the end of the study.

What are possible benefits of taking part?

The main potential benefit of this study will be to understand what caring relationships are important for a person with a stroke, their family and the staff caring for them on a stroke unit. Whilst there is no intended benefit for you individually from taking part in this study, as a participant you may help to develop with other participants possible strategies to further develop caring experiences received by others experiencing a stroke, their families and also between staff.

What are the possible disadvantages or risks of taking part?

It is not anticipated that there will be any disadvantages to you by joining the study, but there is a possibility that you may find the interview or discussion groups upsetting. You can end the discussion at any time if you feel uncomfortable. The researcher will check if you are alright and if you want to continue. If you do not want to continue, the researcher will check with you if you are willing for the information that you have already contributed can be included in the research. If you have any ongoing issues the researcher will direct you to where you can get support.

Will my taking part in this project be kept confidential?

With your permission, all the information that we collect about you during the course of the research will be kept strictly confidential. No personal data will be kept, and all data will be fully anonymised. Occasionally specific information could be linked to you. If this happens, you will be asked if you are willing to share that particular information with other participants in the study. You will not be able to be identified in any reports or publications. All data relating to this study will be kept for a minimum of five years at a NHS password protected secure network in accordance with the Data Protection Act 1998.

If any unsafe practices that put patients at risk are observed on the ward or mentioned in the discussion groups or interviews, the researcher is obliged under the Nursing and Midwifery Code (2015) to report these immediately.

What will happen to the results of the study? What happens when the study is finished?

The results are likely to be published in 2018. The results of the study will be used to inform further development of healthcare. They will be presented as a PhD thesis and also for healthcare journal publications. Verbal quotes may be used within the PhD thesis and journal publication; however they will be fully anonymised. You will be asked if you would like a copy of the results once they are published.

Contact for further information

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National Institute for
Health Research

Appendix 13: Interview Schedule for Discovery Phase

28/10/2015

v1

Interview Topic Guide

1. Start with a brief overview of the project background and description.
2. Check consent with the participant, and remind them that they are free to stop the interview at any time, and can withdraw consent at any time. Tell the participant that the information that they provide will be kept anonymous.
3. Confirm that the participant is willing to be audio recorded.
4. Looking back over your care experiences on the stroke unit:
 - Can you tell me of one really positive experience of your care while you were on the stroke unit? What were your feelings when you experienced this?
 - Why do you think that experience was so positive? What is it about the hospital / staff/ culture/ procedures etc. that enables this to happen?
 - Can you tell me about a time when you felt that you as a person were listened to and valued (rather than focussing on your diagnosis) while you were on the stroke unit?
 - What is it about the hospital / staff/ culture/ procedures etc. that enabled this to happen? How do you think that experience can happen more often?
 - From your experience on the stroke unit, what were the most effective things that made a difference to the care received?
 - Imagine you were back on the stroke unit in 2020, and you were receiving the best possible care that you can imagine. What would that look like? What are the staff doing? What are the patients doing? How is the care different?
 - If you had three wishes for the stroke unit, what would these be?
5. Check with participant a convenient time to meet to discuss the key themes from the data
6. Describe the 'next steps' in the research process.
7. Thank the interviewee.

Appendix 14: Approaches used to elicit and connect with meaningful stories

14.1 Posters of stories displayed on the ward corridors

Edited summaries of participant stories were displayed on the main corridors in the stroke units. The stories were changed weekly throughout the project. The benefit of this method is that anyone passing could engage with the stories on the ward, even if they were not participating in the study. They were a prompt to staff about the project, especially when the researcher was not present on the ward. Apart from interviews, this was the main method for relatives to engage with the project.

A limitation of this method is that they limit the co-construction of stories between the story-teller and the listener/reader. However this was partly counter-acted when reading a story started a conversation with another.



Figure A- 1: Examples of Data Displayed on the Stroke Units

14.2 Emotional touchpoints

Emotional touchpoints focus on how people felt about a particular experience (touchpoint) in a healthcare setting. They are suggested to be an effective resource for enabling the sharing of care experiences (NHS National Institute for Innovation and Improvement 2009; Dewar et al. 2010). Emotional touchpoints include elements of talking mats that is used in patients with communication difficulties, and therefore was a particularly useful resource for participants with limited communication after stroke to engage with the project (Murphy et al. 2016). The emotional touchpoints used were from on a NHS Education for Scotland (2012) online resource of 35 touchpoints and emotions with some examples shown in Figure A-2 below.

Examples of touchpoint cards:



Examples of emotion cards:



Figure A- 2: Examples of Emotional Touchpoint Cards (NHS Education for Scotland (2012)

An example of emotional touchpoints used in an interview with a relative:

Cards chosen	Description of experience
	<p>Frustrated, angry, um, I leave the ward sometimes in tears, but then I know I am very tired at the moment because it's continuous.</p> <p>Yes I get frustrated, I get a little bit angry that no-one seems to care, oh, (no-one), some people don't care. Frustrated that he's waiting for a bottle and when they came to put him to bed his trousers were wet and I can't position him to get the bottle organised.</p> <p>Urrr I was, yes, I was pleased to see him dressed and shaved, in a trousers and shirt.</p> <p>(R01 Relative, Interview, Site 1)R</p>

Table A - 2: Example of Emotional Touchpoints used in a Discovery Interview

14.3 Photo elicitation

Participants found it difficult to describe what it was about an encounter that meant it was meaningful for them. For example, they would describe 'being respectful' or 'I treated them with dignity'. To try and facilitate further elaboration of their meaningful encounters, photographs were used within interviews and occasionally in discussion groups. Within qualitative research, photo elicitation is recognised to enhance data collection through helping to describe tacit aspects of

care or evoke different perspectives on an experience (Harper 2002; Oliffe and Bottorff 2007; Dewar 2012)(Dewar 2012; Harper 2002; Oliffe 2007).

The photographs used were from on a NHS Education for Scotland (2012) online resource of 35 photographs, some examples are below:

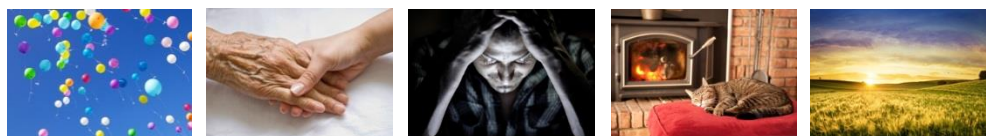


Figure A- 3: Examples of Photo Elicitation Resources (NHS Education for Scotland 2012)

An example of photo elicitation used in an interview:


Photograph chosen	Description of meaningful experience
	<p>So that's like something you did in childhood isn't it? Jumping in puddles. Splashing. Having a great time. And it happened this morning actually [laughs]. It seems a bit <i>silly</i>, but we were - went into the bay and there were about 4 nurses in there and they were all talking about, um, a keep fit session that they had done. But they were involving all the patients in this conversation as well, and we ended up doing like a little yoga like sitting down [laughs] yoga session! [laughs] And the patients were just having a great time and I thought, 'this is what rehabilitation should be about!' It was lovely. And I have to say it was the nurse in there (name), who started it off and she was great. And we thought, this is what we need, we need a bit of a, jump back to childhood and just do silly things sometimes.</p> <p>(S14 Therapy assistant, Interview, Site 1)</p>

Table A - 3: Example of Photo Elicitation used in a Discovery Interview

14.4 Vignettes

Vignettes of data generated through observations and informal discussions were used for feedback of data, and to create a space to generate further sharing of stories, to reflect and learn from these as a group, and to create openings to value different perspectives. Below are two examples of the vignettes produced.

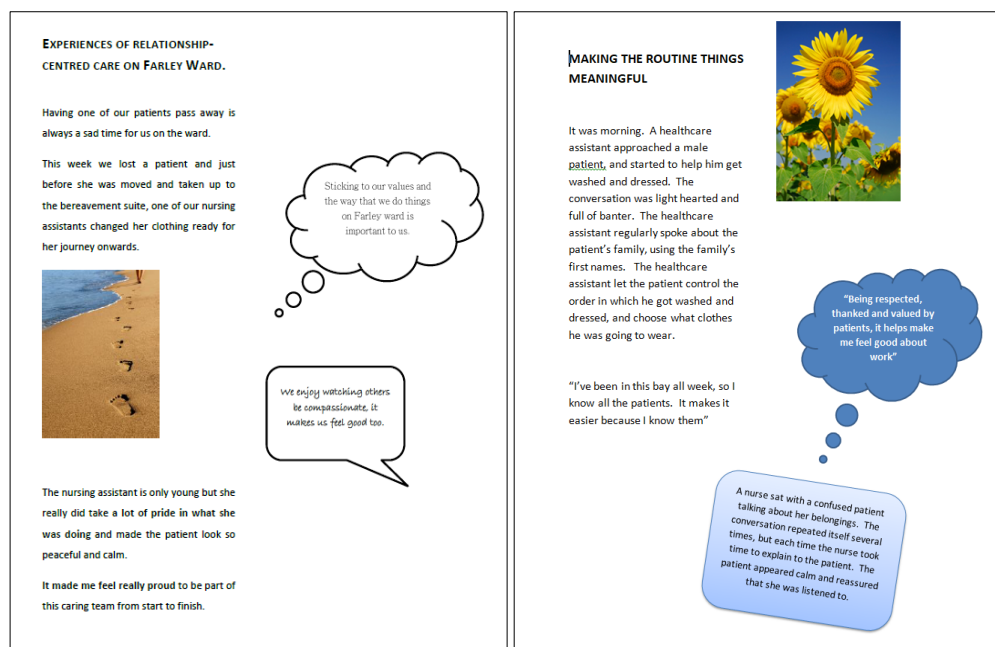


Figure A- 4: Examples of Vignettes of Data used for Feedback

Appendix 15: Example of Transcription of Interview Data

Line	Timespan	Content	Speaker
1	0:00.0 - 0:13.4	So what I'm doing is just asking people, um, to pick a picture, for how.. you.. to help you describe how you feel working on this stroke unit.	CG
2	0:13.4 - 0:25.7	Oh my God! You haven't got chaos have you? Ha Ha Ha! That's quite, that's quite interesting! Ha Ha. Right can I can I - do I have to pick one?	S18
3	0:25.7 - 0:26.3	You can pick a few.	CG
4	0:26.3 - 0:40.8	Ok, I'm going to pick that one, and I'm going to pick that one, because that what's I do a lot, um, ha ha, no I'm not going to pick that one because I'm I'm.. OK. (Pause while she chooses a card) I'll pick that one.	S18
5	0:40.8 - 0:46.7	Ok. (Pause while she chooses more cards)	CG
6	0:46.7 - 0:50.8	I'm going to pick that one. That makes me very happy.	S18
7	0:50.8 - 0:56.7	So, can you go through each one for me. Describe them to me and why you chose them.	CG
8	0:56.7 - 1:01.2	Oh I'm getting really upset!	S18
9	1:01.2 - 1:08.6	Ohh. I'm sorry. Do you want me to stop (recording)? Yeh?	CG
		<i>Recording stopped for 5 minutes while participant composed herself</i>	
10	0:00.0 - 0:08.3	Is when you've got so much to do, you've gotta, for me my face always tells what's happening, so I've had to really re-train my face (ha ha).	S18
11	0:08.3 - 0:10.0	Oh that's interesting.	CG
12	0:10.0 - 0:57.1	Into, you know, I am really listening to you because I'm not, I probably should be listening more effectively, but I've got so much going on in my head. I'm processing what I'm doing next, and they teach you not to do that don't they, but I'm still finding that quite hard. Um. Yeh, yeh. Especially with family because they don't always understand the pressures of the ward, but to them their loved one is the most important, and it would be the same if that was me, so you have to make time to listen to people and listen a-actively, so that was one of the main things that I do. Um, and I, I do enjoy what I do massively (ha ha) which ha, yeh.	S18

Table A - 4: Example of Transcription of Interview Data

Appendix 16: Schedule for Discussion Group

Whilst keeping the discussion group informal and emergent, the following questions were used as a framework to guide the discussions:

1. Observe:

- What interests or excites you?
- What are you noticing?

2. Reflect:

- What surprises you?
- What values and assumptions do you notice (your own and others) and how are they being challenged or affirmed?
- What does it show about what matters to you and others?

3. Plan:

- What does it show you about what you need to keep doing and what helps you to do that?
- What does it show you about what gets in the way of how you'd like things to be?
- What possibilities for continued or new action do you see (however small)?

4. Act:

- Is there anything you could do or do more of (tomorrow)?
- What do others need to keep doing or do differently?
- What support do you/they need to implement this?
- What governance structures will you/they report this to?
- What will convince you that it's been worthwhile or successful?

Developed by Cathy Sharp and Belinda Dewar (2014)

Appendix 17: Site 1 Possibility Statements

Draft / proposed statements	Co-constructed final possibility statements
We sometimes worry that we are not going to understand a patient. Patients really value us just trying, even if we are not always successful	We want to support a person with communication problems by getting to know them. Patients value us just trying to communicate, even if we are not always successful. It can take time to make a connection. We will commit to spending time with them. We will not interrupt other colleagues while they are communicating with them.
Communicating well as a team can help us to support our patients	
We will try to notice patients' cues on what makes them feel comfortable	
Taking time to share information with the team about individual patients – this helps us care for them	Getting to know who the patient really is, not why they are here is important to us. We will explore what matters to individual patients and their family. We will take time to share information with the team about individual patients as this helps us all care for them.
Getting to know who the patient really is, not why they are here is important to us	
We want patients and relatives to trust us	
Focussing on the patient first, not the task we are there to do, makes the experience more memorable	We value and enjoy having relatives here. Relatives are key to helping us getting to know and caring for our patients. It is important that relatives know that we care for them too. We want to make relatives feel that they can leave their loved one and know that they will be cared for. We will gladly speak with family members so that they feel part of the team.
Being playful, having fun, is important to all of us (patients, relatives and staff)	
Pausing from our tasks, even momentarily can mean so much to others	Pausing from our tasks, even just for a moment, can mean so much to others. We will make a personal promise to spend time and not rush with patients. We will try to notice patients' cues on what makes them feel comfortable. At times we need to speak about the practical things, but we will always remember the individual by choosing language that reflects this.
We will make a personal promise to spend time and not rush with patients	
At times we need to speak about the practical things, but we will always remember the individual	
Colleagues with less experience may need support and guidance to achieve a balance between the tasks to do and patients' needs	Our team will reflect and learn from positive experiences as this helps us to develop care. We will be open and honest, especially when things aren't working. We will share memorable experiences that uncover caring relationships between each other in the team, patients and / or relatives. We recognise that communicating well as a team helps us to work together to support our patients and their family.
Being open when things aren't working can help us work together	
We will promote among the therapy team memorable experiences that uncover the benefits of caring relationships	
We enjoy watching others be compassionate, it makes us feel good too	Sharing experiences brings us as a team closer together. We will get to know and understand others' values, appreciating that they may be different to our own. We value and enjoy watching others in our team be compassionate. We will take the time to give positive feedback to our colleagues when we see compassionate care.
Sharing the same experiences brings the team closer together	
Learning and reflecting on positive experiences helps us to look after our patients and develop care	

Table A - 5: Table Illustrating Possibility Statement Development for Site 1

Appendix 18: Interview Schedule for Evaluation Phase

If you were to tell a new member of staff about your involvement in this project; how would you describe:

1. What have you valued the most about this project?
2. What if felt like to be involved?
3. What have you learnt through being involved?
4. Have you learnt anything about yourself through this project?
5. Is there anything that you are thinking or doing differently?
6. Can you tell me about the different things that we tried – what did you think worked well, and ones that we had to change?
7. What do you think we should do differently when we do the project again on another stroke unit? And what should be definitely take with us?

Appendix 19: Guidance questions for appreciative noticing by staff co-participants

The staff co-participants on the second site were invited to participate in noticing and recording their experiences and stories on meaningful relationships on their stroke unit. Each staff participant who expressed an interest was given a pocket-sized notebook that contained some guidance notes to help frame their noticing with an appreciative lens. This was in addition to regular contact with me to support their noticing. The following are the guidance notes contained in their notebooks.

Gathering Stories

Here are some questions that may help you gather your stories:

- Who were involved?
- What was the context e.g. was it during a ward round, while you were helping a patient eat?
- What was it that was meaningful or surprising about this interaction?

For example did they phrase something in a particular way, was it the way the patient or relative reacted, was everyone having fun?

- Why do you think it worked?

For example did the person have a certain approach / values, did the environment/setting help? Did something happen before this interaction that helped them be more open?

- How did it make you feel?
- Did you ask the others involved how it made them feel?

Sharing Stories

Once you've gathered a story, share it with those around you.

Be brave! If what you observed touched you in some way, then share it.

Be curious - the interaction will mean different things to different people.

Here are some questions you may want to try:

- How do you feel after hearing this story?
- Which bits stand out or struck you?
- Why was this?
- What does this story tell you about what matters to you and others?

- What do you think was going on here?
- What are the positive elements of this story?
- What happened in these positive elements?
- What helps this to happen?
- How could this happen more of the time?
- What do we need to do to help it happen more of the time?

Try not to ignore the negatives:

- What do you think was going on here?
- What would a positive slant on this experience look like?

Glossary of terms

Action Research (AR): A group of related co-participatory approaches that integrate theory and social action with the aim to address important organisational, social and community problems (Coghlan and Brydon-Miller 2014).

Aphasia: “An impairment, due to acquired and recent damage of the central nervous system, of the ability to comprehend and formulate language. It is a multimodality disorder represented by a variety of impairments in auditory comprehension, reading, oral-expressive language, and writing” (Rosenbek et al. 1989, p.53).

Appreciative Action Research (AAR): A research method that integrates the generativity, imagination and attention to language of appreciative inquiry, with the focus on collaborative action, experimentation and practical orientation of action research (Dewar et al. 2017).

Appreciative Inquiry (AI): A form of action research developed by Cooperrider and Srivastva (1987) that focusses on the generative capacity of change through a positive approach that creates a sense of possibility and creativity (Coghlan and Brydon-Miller 2014).

Attending towards: A practice of being present with another, opening up a space for possibilities of human connectedness and not necessarily understanding each other (Todres et al. 2014).

Centredness: An umbrella term encompassing patient-centred, person-centred, client-centred, family-centred and relationship-centred care concepts. Healthcare professionals centred on those they look after in a variety of ways. It reflects a movement in favour of increasing the social, psychological, cultural and ethical sensitivity of our human encounters (Hughes et al. 2008; Thompson et al. 2018).

Communication impairment / disability: Disruption in communication from impairments in speech, language, cognition, vision or hearing. The presentation of communication impairment after stroke depends on the area of the brain affected and on any pre-existing communication deficits, such as age-related hearing loss. Whether language function is affected (aphasia), how well cognitive processes support the use of language and to what extent the different modes of communication are affected will determine the overall ability of the patient to communicate successfully (Borthwick 2012).

Constructionism: Originating from social sciences, it is an intellectual movement concerned with social reality and the processes by which social reality is created

and assigned meaning. Its focus is on the lived world not 'there' but rather it is actively constructed by participants. There are many forms of constructionism (Holstein and Gubrium 2008).

Embodied / embodiment: Embodiment is a unity that we live, not perceiving the world in pieces or meaningless sensations but as a whole pre-given, pre-reflective world. It requires the bringing of the whole perceiving body. Intuition is an aspect of embodiment (Benner 2000; Todres 2008).

Humanising healthcare: A value base for caring systems and healthcare interactions that is philosophically informed from the dimensions of humanisation and dehumanisation (Todres et al. 2009).

Lifeworld: A particular view of the person as humanly living in the seamlessness of everyday life that includes temporality, spatiality, embodiment, sociality, or being in relation to others. The lifeworld is something both shared and uniquely individual as we live in a shared world that we experience from our own unique perspective (van Manen 2014; Galvin et al. 2016).

Lived space: Refers to 'more than' the physical space. It is an existential theme that refers to the felt, experiential space in and through which we live our lives (Norlyk et al. 2013).

Mutuality: A view of self and being-in-relation with others. A sharing of, or an emotion, desire or aim; a feeling of community; interdependence and equal sharing (Brown 2016).

Relationality: An aspect of inter-dependent relationships. It is a phenomena in which relationships are not bounded (hard self-other) entities but rather an ontologically inseparable web of relations (Kazimierczak 2018).

Relational knowing: Sensing each other's lifeworld and way of being-in-relation. A form of experiential knowing (Galvin and Todres 2013; Coghlan and Brydon-Miller 2014).

Relational practice: Activities necessary to develop and sustain interpersonal relationships based on an understanding of individuals' circumstances and their contexts (Parker 2002).

Relationship-centred care (RCC): An alternative framework to patient or person centred-care. It is based on the principles that: 1) Personhood matters; 2) Affect and emotion are important; 3) Relationships do not occur in isolation and 4) Maintaining genuine relationships is necessary for health and recovery, and is morally valuable (Soklaridis et al. 2016).

Stroke: “Rapidly developing clinical signs of focal (or global) disturbance of cerebral function, lasting more than 24 hours or leading to death, with no apparent cause other than that of vascular origin” (World Health Organisation 1978)

Stroke unit: A multidisciplinary team including specialist nursing staff based in a discrete ward which has been designated for stroke patients (Hoffman 2007).

Transformational change: Evidence of a qualitative shift in the state of being or identity of a system. Involved changes to self, alongside cultural and organisational change (Bushe and Kassam 2005).