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PRACTICE DEVELOPMENT – APPRECIATIVE INQUIRY

Promoting compassionate care with the older people: a relational imperative

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We have been invited to imagine a future where the care for older people goes beyond the current paradigm. This article challenges the fundamental assumptions that underlie current care practices and, instead, promotes systems and processes that elevate nourishing and stimulating relationships with basic dignity, as well as personal agency, in the later days of life. Healthcare professionals still base current care systems on a medical model that emphasises the diagnosis, treatment and cure of disease (Kane RL & West JC, 2005 *It Shouldn't Be This Way: The Failure of Long-Term Care*, Vanderbilt University Press, Nashville, Tennessee). In contrast, we highlight *principles of relating* that support care to older people during the final stages of life, and promote systems, processes, and design elements that constitute compassionate care. To do so, it is necessary to move from a model that responds to the dominant regulatory environment to a model that is designed in the ongoing processes of human relationships. Specifically, we are including all dimensions of relating including relations among the residents and between and among residents' families, and all levels and functions of caretakers and the community.

Key words: appreciative inquiry, compassionate care, culture change, health care, nursing, older people

Introduction/overview

Imagine a community where people of all ages and cultures live together; where health status is evaluated on a continuum; where there are programmes designed to elevate the best of each person thereby enabling their contributions, as they are able; where older people are considered valuable assets to the community offering themselves as mentors to teens and teens to toddlers. These communities are more than imaginable – they are possible. What are the qualities of these communities that highlight the principles of compassionate care and what further resources might we imagine?

Thriving communities that bring together diverse resources seem to be a clear alternative to the stale institutional approach that has marked our history (Vladeck 2003). With successful models like this, how is it that we continue to perpetuate scenarios that pathologize ageing? The current issue has provided a review of the literature on appreciative inquiry as well as a systemic analysis of an action enquiry that seeks to operationalise quality compassionate care. In this article, we begin with a brief description of how we chose to develop our response to the invitation to write a piece that is visionary, challenging and futuristic, to take the reader beyond what is currently known about the topic, and

challenge existing thinking in health care to older people. We decided to build on our own experience in health care and care to older people, and interviewed people who themselves are visionaries; practitioners who are imagining the futures we have been invited to create. Armed with this rich array of professional expertise, we imagine the future of compassionate care with older people.

Health care as a process of social construction

Our approach is based on the view that the way we construct the conversation is consequential to what we create as we go forward. One approach, the more traditional approach, takes the form of problem identification and diagnosis. While diagnosis and problem talk might be generative at times, there is a good deal of recent work that suggests conversations focused on strengths, values and future possibilities might be a more generative form of interaction. Here, we are going beyond strength-based conversations as an intervention in planning care. We are proposing this more generative form of interaction as an ongoing way of being in the caring community relationships.

The focus on possibility is grounded in a social constructionist orientation (McNamee & Gergen, 1999; Gergen, 2009). In brief, social construction argues that what people do together creates the reality within which they live. In other words, meaning is created in relational interchange. Thus, if we talk about problems, we construct and live within a reality of problems. If, on the other hand, we talk and connect with others about values, strengths and possibilities, we create and live within a reality of potential. When we view health care as social construction, we are less interested in pre-determining what sort of conversations will produce transformative care. Rather, we open the conversation to a broader range of issues – issues that are no longer limited to dysfunction and disease. These issues address such questions as: How do we live together? How do we make decisions about the structure of our daily lives? Who do we interact with? How we interact? What do we do? How do we eat? How do we interact with the greater community? Transformative models of care emerge from those conversations.

There are multiple ways in which personal and relational transformation can occur. We are more concerned with adopting what we refer to as a *relationally engaged* stance with clients. Within such a stance, the ethic of professional practice is one of being relationally responsible (McNamee & Gergen, 1999) in the interactive moment. A relational approach is one of knowing *how* to be attentive to the *process* of opening viable possibilities and potentials for those with whom we work. This requires focus on what professionals and clients do together in the healthcare conversation. It shifts the conversation from diagnosis and problem solving, to exploring: what can *we* accomplish (i.e., create) in our conversations together?

We are not suggesting that diagnosis is bad or wrong. Rather, our point is that when we explore health care as social construction, our attention is focused on how health professionals/care givers, client and others in the community, together, might expand the range of resources for action. This *might* require professionals and clients to construct a relationship, wherein the professional becomes the expert or authority, and, in particular, the expert who is capable of providing a diagnosis and treatment plan. Yet, it also might require the professional and client to construct a discursive domain where the interaction departs from the cultural expectations of healthcare conversations (i.e., health professional as diagnostic expert). Here, the professional and client work together to create a conversational space where the healthcare worker's role as expert is not central. The relational approach promotes variety and flexibility in the different roles or stances one might assume in a particular engagement.

Thus, a relational approach suggests that what is most important in human interaction is *what people do together*. Rather than focus on bounded and separate individuals and assume that the rationale for their actions is to be found in the deep recesses of their private interiors, a relational approach places emphasis on social interaction. A relational stance places our attention on the process of relating, itself.

Themes from interviews

To be consistent with our commitment to the relational approach, we interviewed people who are integrally involved in working with older people including people who are involved with direct service, administrators, systems designers and faculty who train the next generation of providers. We have included their comments throughout the remainder of this article. The questions we asked included:

- Would you tell us a bit about how your work with health are organizations is guided by/informed by the principles and concepts of appreciative enquiry?
- Would you share a particular story about a client or situation where you felt the process was particularly inspiring and transformative?
- What was it about the client and your relationship with the people in the organization that influenced that process or made that process come to life?

The themes we heard from our interviews included the following:

- Relationships need to be central to care and care needs to be patient centric.
- Nurses yearn to reclaim the positive core of nursing which is the opportunity to be with patients and be attentive and quality caretakers.
- The systems and processes for elevating the positive core need to centre on the relationship.
- Facilities benefit from being an integral part of the larger community. Older people, who are able, can be valuable mentors to youth, and younger people can play an important role in relating with older people.
- Professional development needs to include creating the opportunity for ongoing conversations that explore high-points in patient care. These conversations help professionals notice and focus on these experiences, amplify these experiences, and, thus, strengthen their skills, capacities and frequencies of such moments.

One consultant we interviewed highlighted one such example:

> Facilitating an inquiry in an appreciative way gave nurses energy for insights they did not have. One homecare worker learned that she was a good problem solver as a result of her reflection. She turned that insight into action as a model speaker for homecare workers. As a result of her stories, this organization has community meetings where they invite staff once a quarter to share stories about how they have changed clients. (Organization Consultant)

What have we learned?

A history of the healthcare industry helps to explain how the institutional medical model was developed. Before the 20th Century, care for older people was primarily the responsibility of local communities, where the regulator, rather than the resident, became the client. Beth Baker, a proponent of culture change in the nursing home industry, in her review of the history of care to older people writes, 'Nursing homes are a predictable outgrowth of a US culture that views old age as a disease to be prevented or conquered, rather than a life stage to be honoured. We have long segregated those who are very old or ill, treating them as expendable to community life. As a society, we set them out on the ice float, wish them luck and get on with the important business of living' (Baker, 2007, p. 20). Regulators in the 1950s used hospital design to guide construction of new homes under Hill Burton funding because they thought that was the state of the art for good care as compared to smaller mom and pop homes.

In our recent history, nursing homes were the place of last resort to care for people in their final stages of life. What insurance companies cover has driven the design and delivery of services. Those who determined policy and practice for their particular jurisdiction determined what care can be provided. Thus, we have seen a vicious cycle of services delivery being both restricted by and determined by what is covered rather than by what is best. In the end, neither the former is not necessarily the best nor the most economic form of practice.

Thus, we have learned that central to enhancing the quality of care to older people is providing environments that honour and empower staff and individual's choices around the rhythms of daily life. Simple things like choosing what one wears, what one eats, when one wishes to shower or bathe and what activities one engages, supports one's sense of being valued. Such support comes from being in a relationship with others rather than serving as the object to which professionals attended.

What do we yearn to foster in compassionate caring relationships?

Despite how the state of care has evolved, the intentions of those who provide care have been consistent: people go into the nursing profession to provide loving care to those who are in need. To do so, caretakers need the time and the flexibility to listen to their patients, to hear what it is that they want and need, and then be able to respond creatively.

> Knowing the person as a whole person would increase patient satisfaction as well as increase nurses' satisfaction. It would enable nurses to have deeper relationships with their patients. Nurses do their best to provide the best care – but they get frustrated because they are talking in different ways [from their patients]; patients are talking about their needs and nurses are looking to pick up on symptoms. (Geriatric Psychologist)

> The roots of nursing are in caring for people. Nurses are the frame-makers. If they understand the person undertaking this challenge – they can become the interpreter from malevolence to helping people cope with what is going on. Aging is a stage of development. The question caretakers need to ask is, what do you need to learn to cope with what is going on? (Program Administrator)

In our work with nursing homes, as well as our conversations with those who have worked with nursing homes, appreciating and developing compassionate care begins with reclaiming the core principles of what the relationships are about. Bill Keane, an author who writes about nursing home transformation suggests that: 'Fundamental change begins in the human heart. If we really don't believe that people are still people because they have dementia, we will not care for them as persons, but as objects of medical maintenance. If we

really don't believe that [older people] can be a great age of enlightenment and societal participation then we will continue to relate to [older people] as retirees on the golf course. Each of us must work deeply on our own journey of aging transforming our traditional fears and uncertainties into a hopeful, joyful embrace of who we are and our new capacities for growth and giving' (Keane, 2005).

One of the core principles of the appreciative enquiry process is that our words and actions become the reality we live. This principle is derived directly from the constructionist understanding that we make meaning in our interactions with others. Simply put, meaning, knowledge, beliefs and values are not private possessions of individuals but are created in the flux and flow of joint action. Thus, the questions we ask and the conversations we invite others into are fateful. In one instance, enquiring into what and who are important to nursing home residents, and what matters to them while they are staying in the hospital opened up conversations that challenged taken-for-granted assumptions. These taken-for-granted assumptions centre on understanding problems and difficulties and attempting to 'manage' a programme of treatment or stability. Because both clients who are older people and healthcare professionals typically do not challenge the appropriateness of problem-saturated conversations, enquiring into what is important and generative can, at first, feel disruptive. Pursuing that which is generative requires letting go of a commitment to those problem-focused assumptions and being responsive to the relationship – to making the relationship central.

> If what we do together creates the possibilities and constraints within which we live, then how might our realities change if we replace deficit-based language, which focuses on what is not working with talk of what is working? (McNamee, 2003, p. 24)

The emphasis is on being in a relationship and recognising that what is being created. Both the nature of the relationship and the reality created are a joint responsibility (see McNamee & Gergen, 1999). It is much less about who is right and much more about what is needed.

> As a clinician and organizational consultant, we were being asked to work with people with Alzheimer's disease. It was clear that the way the person saw themselves and how they were seen by the care environment were different. The conflict was whose version of reality was right. The interventions were about reality orientation – let me tell you why you are wrong, crazy, your memory doesn't work, etc. So the first thing that struck me was that there were different constructions of reality and that they were in conflict. My approach was to get the paid caregivers to see the world through the eyes of the person with Alzheimer's. They were responding to the environment as they saw it: with partial information based on remote memory because that was what they had left. We needed to create successful person–environment fit. We needed to look at what problems they were trying to solve rather than what problems they were creating for us. (Geriatric Psychologist and Clinical Director)

As caretakers are freed up to meet the client within his or her lived reality, they are more likely to consider that:

> Many older people are not afraid to die; they are afraid of the process that they are put through to avoid dying. Nurses have to understand the process for the elder: how do I join with them bearing witness to their narrative; what does this mean to their life. (Geriatric Psychologist/Organization Development Practitioner)

> Whatever you do to help the person develop psychologically at the end of life helps them to prepare for the end of life. (Geriatric Psychiatrist)

A study published in the *British Medical Journal* (Fossey *et al.*, 2006) compares residents of 12 nursing homes in England. In half the homes, staff received training and support in person-centred care, including such skills as behaviour management, awareness of environmental design, individualised interventions, active listening and communication, reminiscence techniques and involvement of family caregivers. In the other six homes – the control group – residents with dementia continued to receive traditional medical care. After 12 months, 23% of residents in the intervention group were taking antipsychotic drugs compared with 42% of those in the control group. Behaviour did not worsen when the drugs were eliminated. This is one of many studies that provide support for the argument that relationships are central to the support of physical health and longevity.

Models of innovation

Imagining the model of nursing for older people in the future, we see villages where people are living in community with nursing care as an integral part of their home environment. We see older people playing an important role in the life of young people and young people being part of their lives as well.

The possibilities of new relationships later in life have been the subject of many films. The popularity and notoriety of the recent film *Up* (2009) highlight the transformation of Carl Frederickson from living a narrative marking the end of his life to forging a whole new volume of his life. In this endearing film, young Carl shares a childhood dream to live the life of an adventurer and to scale the heights of Paradise Falls with his childhood sweetheart, Ellie. But in a matter of

minutes, Carl and Ellie grow from children to the elder years and Carl is about to move to a retirement home. It is here that the next chapter unfolds. In an interesting twist, Carl, in a relationship with a young wilderness scout named Russell, revives his pursuit of his childhood dream. His relationship with Russell does more than provide a sweet story of young meets old and renewal. In the end, Russell gains a relationship with the father figure he has so lacked and Carl is inspired towards a new purpose. Although this chapter is without Ellie, it is enriched by his relationship with Russell. This story highlights the value of relationships, not only with caregivers, but also with the community, in supporting and sustaining compassionate care.

Innovation is becoming a reality; there are positive deviants from which we can learn. Bill and Jude Thomas developed a model called the Eden Alternative (Thomas, 1999). This approach creates a living environment that includes plants, pets and children. One of the principles of the Eden Alternative is that an elder-centred community creates opportunity to give as well as receive care. The Eden Alternative suggests the following guidelines:

- Care partners and care receivers are empowered. The organization is committed to treat the staff the way they want the staff to treat older people.
- Decision making is in the hands of older people and the people surrounding them. They have a voice in their daily routine and their life.

The residence includes plants and animals and children. 'I want the people to be confused when they walk through the door. What kind of place is this? I mean, there's kids running around and playing, and there's dogs and there's cats and there's birds, and there's gardens and plants and … I want them to be confused. This can't be a nursing home. Right. It's an alternative to the nursing home'.

- Spontaneity and variety are a part of daily life.
- Diversity and access to companionship are abundant.
- There are many opportunities to give as well as receive.
- The focus of the care revolves solely around the body and soul. The emphasis is placed on care-giving.

There has to be a commitment to ongoing growth. We believe in the Eden Alternative that even the frailest, most demented, most feeble elder can grow. And that the young person who maybe has a difficult home life or is living on the edge of poverty, they can grow. That the organization commits itself to human growth. And those words, human growth, nursing home, they've never gone together before and with Eden Alternative they can.

Ransom (2000), in her measures of clinical outcomes in Texas (USA) nursing homes, found a 60% reduction in behavioural incidents, 57% decrease in pressure sores and an 18% reduction in the use of restraints along with an 11% increase in census, a 48% decrease in staff absenteeism, all attributed to the Eden model. From the perspective of employees, the benefits of this model are attributed to the variety of social contacts available to the residents. Antonovsky (1997) refers to this as the theory of Salutogenesis. 'Despite severe physical or emotional stress factors, which are known to be a major cause of immunological, cardiovascular and psychosomatic diseases, salutogenesis is the sense of 'coherence' where one has an enduring though dynamic feeling of confidence, that the world one lives in is structured, predictable and explicable, that the resources to meet the demands of this world are available and that these demands are challenges worthy of investment and engagement' (Monkhouse, 2003, p. 350).

Meadowlark is another example of transformative care (http://www.culturechangenow.com/stories/meadowlark.html). Steve Shields, Executive Director says: 'What we think is unique about what we've done environmentally is to go through piece by piece and pull out everything we could that was institutional … stainless steel tray transport racks, med carts, the visibility of lifts in the hallways, peeping wonder guard alarms. I mean, everywhere you look we've made something completely unnatural about aging'. He goes on to say, 'fixing how we treat older people in these environments is a moral imperative that must involve everyone, not just nursing homes' (Cardin, 2009).

The Greenhouse model, developed by Dr William Thomas, builds upon the Eden Alternative in its concept of a small intentional community for a group of older people and staff. Its primary purpose is to serve as a place where older people can receive assistance and support with activities of daily living and clinical care, without the assistance and care becoming the focus of their existence. The primary focus is on relationships. The Green House model leverages relationships through facility size, interior design, staffing patterns and methods of delivering skilled professional services. 'Research shows that the Green House model provides more direct and personalised interaction between caregivers and [older people] than traditional nursing homes. On average, Green House residents receive 25 minutes of direct engagement outside of assistance with activities of daily living compared to 5 minutes for residents in a traditional setting' (Lagnado, 2008).

There are many examples of communities that have been influenced by and have expanded upon the Eden Alternative. Centrecare, in Western Australia, pursued a culture change process built on the concept of preferred view – the notion that people have preferences for the qualities, attributes, preferences, hopes and intentions for which they want to be known by others (Eron & Lund, 1996). 'Organizations are at

their best when they are acting or seen to be acting in line with their preferences and when they see others viewing them in these ways' (Slocombe, 2003, p. 312). Conversely, people and organisations are at their worst when there is a large gap between how they would like to view themselves and how others view them. Centrecare engaged help from a consultancy to address the gap they were experiencing between how management thought of them and how staff and the residents viewed them. Each was invited to share stories of their preferred views along multiple dimensions. Staff's stories included reasons for entering the profession and what they valued about the organisation. Gaps were identified along with processes they believe would narrow the gap. Residents and their families were involved with the culture change process as well having parallel opportunities to explore their preferred and actual views. People were energised by the preferred focus in contrast to the problem-focused conversations (p. 320). The ripple effect manifested in the relationships with and among residents. Aged Care Service Group has evolved to a community model with small dining rooms and lounges in smaller community settings (MacKenzie, 2003). Staff is permanently assigned to one community and is able to develop more intimate connections with the residents. Values of person-centred care and self-determination are central to their model. Australia is spreading awareness about the impact of innovations spurred by the Eden Alternative.

Similarly, in Switzerland, Monkhouse (2003) lead a culture change effort with two homes applying the core concepts of the Eden alternative. Staff is encouraged to create their own approach to applying the concepts of the plagues and their remedies. Central to the model are the remedies proposed by Thomas. The remedy for loneliness is companionship, for helplessness is the opportunity to give care and for boredom is spontaneity (Monkhouse, 2003, p. 346). One administrator summarised her experiences as follows:

> The true added value of the implemenation of the Eden Alternative is that every employee … contributes to remedying loneliness, helplessness and boredom. This is achieved by being a companion, explore what is meaningful in the life of the residents and provide opportunities to give care. Being spontaneous means laughing, joking and the power to alter routines. (Monkhouse, 2003, p. 352)

Principles of Appreciative Organising: inspiring models of innovation

Thus far, we have talked about the relational approach and its role in promoting models of compassionate care. Dewar and Macay (in this issue), claim that in order for care to continue to flourish and grow, the following need to be present:

- Caring for and about each other.
- Being conscious and deliberate about giving positive feedback.
- Valuing, legitimising and articulating compassionate caring acts.
- Feeling confident to speak out about the way we do things around here.
- Being curious and taking another look at what we do.
- Being critical in an appreciative way.

Here, we offer central principles that support appreciative organisations. These principles are the foundation from which we conclude with inspiring images. [These principles have been adapted from The Appreciative Organization (Anderson *et al.*, 2008).] These principles emerge from the relational orientation of social construction, as described earlier. They move our focus individuals who control the nature of a given interaction to a focus on *relational processes* (i.e., what people do together and what their actions co-construct) (Ronch, 2003; Tobin, 2003).

Relationships and their interdependencies are central. Personal meaning, roles and interdependencies are constructed in our encounters with one another. The roles that are construed in services to older people are in service of promoting different levels of care at a developmental stage marked by shifts in capacity, skills, activity and purpose. 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, a recreation therapist, etc.) are all a reality we can create in creative collaboration.

In accordance with this stance, we no longer view healthcare professionals, elderly or family members as inherently good or bad, professional or not, helpful or hindering. Instead, we examine the patterns of coordination that generate a sense of good/bad, right/wrong, professional/not professional, etc.

Forge new links. Creative new links, even improbable connections, offer the potential for new meanings. These links may involve different pairings among current care providers, or expansion to include people not currently in the care network. Innovations between nursing homes and schools (Whitehouse & George, 2009), daycare centres and other community groups are one such example of expanding connections outside the boundaries. Other links could include opening conversations among various functions in the care facility and residents where they have not yet existed.

This expansion of the domain of participation emerges from the constructionist notion that the coordination of diverse interactive patterns and partners has the potential to yield new meaning, new understanding and new forms of practice. To invite the voice of a neighbour into conversation

about the care of an elderly patient might transform the ways in which family members and healthcare professionals understand the elderly person's current situation.

Promote dialogue. 'It is through dialogue that we grow sensitive to multiple realities and learn to negotiate across diverse relationships and realities' (Anderson *et al*., 2008, p. 12). Fostering an ongoing dialogic culture promotes transformative action. A dialogic culture supports attending to what we take for granted, noticing what others notice that would be otherwise invisible to us, and opening pathways exploring new opportunities and possibilities.

If we understand that meaning is made in our interactions with others, then it makes sense to create opportunities for dialogue. As we expand the domain of participants and explore alternatives modes of interpretation, we engage in transformative dialogue.

Creating new forms of 'We'. Engaging with others whose narratives are significantly different from one's own often creates a sense of confusion or dissonance. Critical reflection on these moments, *with others with whom we experience dissonance* opens the possibilities of creating new forms of relating that include our differences more fully (Wasserman & Gallegos, 2007).

However, our encounters with diverse others must be carefully crafted to encourage generous listening, curious questioning and attempts to coordinate multiplicity rather than debate or persuade each other (McNamee, 2002).

Articulating what works and what is valued. Appreciation is the basis of generativity: the essential element of coordination, harmony and the growth of meaning. In appreciating others' words and actions, we enhance the value within and among our relationships, the organization, the community and beyond.

Encouraging the imaginary. When we come together in a relationship with different perspectives, the possibilities of what we might imagine together go beyond what any one of us might create ourselves. Often when we encounter others as professionals, we focus on 'getting the story straight'. Our attention is placed on past events that have led to the present. By focusing instead on the future, we invite those with whom we engage into a moment of construction. Imagining the future is an invitation into potential.

Acting towards the next moment. Change is inevitable. Each successive moment redefines what has already happened and creates new possibilities.

Foster continuous open-ended conversations. Each conversation creates the potential for new discovery and innovation. Because meaning is never fixed, the possibility for continually constructing more livable ways to 'go on together' (Wittgenstein, 1953) is ever-present.

In summary: what are the implications for the role of nurses?

Throughout this article, we have emphasised the value of innovative models that emphasise the space where new forms of conversation and creative relationships can transpire. We cannot enter into the same old space and expect change. Models, such as the Eden Alternative and the Greenhouse Project, promise opportunities but are too often criticised as costly. If we are to imagine innovative new models of care, new measures of health and benefit need to correspond. It has been noted in several places that what supports people being at their best is shared among staff, and residents alike. 'These interventions have been used with recruitment and selection, informing empowering performance management interventions, decision-making practices, team building, conflict resolution, stress management, strategic planning and organizational culture. It is about consistency of approach and motivating staff to connect with their strengths and resources in the midst of a society that seems often transfixed on pathology and dysfunction, regulation and ''sameness''' (Slocombe, 2003, p. 321). The models that inspire are those that elevate, the quality of life and relating with and among residents, caretakers, families and community members, all of whom serve to benefit.

From the interviews we conducted as well as from our own experience, creating the conditions for dialogue, adopting a relational understanding of the construction of meaning, expanding the domain of participation, and exploring the future create generative alternatives to the present tradition of elderly care. Replacing the voice of the expert with multiple voices and creating contexts where these diverse voices can co-mingle offers new possibilities for elderly care, as well as for healthcare practice. The alternative we are proposing does not require new structures, instruments or techniques. Rather, what is required is a relational sensitivity; that is, an understanding that there is nothing more important than what we create together in our interactions.

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