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NET2015

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Group 1 of theme sessions

Tuesday 8 September 2015

Humanising healthcare education

Core paper and theme paper abstracts

Group 1 of the theme sessions
Tuesday 8 September 2015

Humanising healthcare education (HHE)

Core paper and theme paper abstracts

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References are as supplied by authors
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Core paper

Biographical details of core presenters

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Linda Kenward is currently Principal Lecturer at the University of Cumbria having previously worked for The Open University. Her academic experience includes working with NHS Education Scotland, as a consultant to the BBC and in a variety of academic and practice education posts in England. Linda is a Registered General Nurse as well as a Specialist Community Public Health Nurse (School Nursing), and has worked in supporting children and families in crisis.

Linda has a special interest and expertise in supporting traumatised patients and is an Integrative Counsellor registered with the British Associating of Counselling and Psychotherapy, working with CRUSE Bereavement Care Scotland as well as having a small private caseload.

Traumatised patients: Helping nursing students acknowledge and understand the long-term effects of healthcare acquired trauma

Linda Kenward, Principal Lecturer in Nursing and Midwifery, University of Cumbria, UK

With a review of UK nurse education expected following the *Shape of Caring Review* (2015), this paper will contribute to the debate around the need for adult nurses to be able to respond to a broad array of presenting issues in their patients, specifically awareness of mental health issues. The focus will be on trauma experienced as a result of interaction with the healthcare system in the form of unintentional neglect, misdiagnoses, surgical errors and mismanagement of care. For the purposes of this paper trauma can be defined as any severe and debilitating psychological distress that occurs as a result of incidents in a healthcare setting. This could include trauma symptoms of post-traumatic stress disorder (PTSD) as defined by the Diagnostic and Statistical Manual of Mental Disorder (DSM 5) (American Psychiatric Association, 2013), but might include undiagnosed distress presenting as symptoms of anxiety or depression.

Harm happens in healthcare systems. The World Health Organisation (WHO, 2015) estimates that complications after surgery occur in up to 25% of patients and that in industrialised countries, nearly half of all in-patient adverse events are related to surgical care with at least half of cases leading to harm being preventable. Even in the most carefully managed environment mistakes are made. In the UK, the rhetoric around cultures of care and patient safety changed with the realisation that abuse, negligence and errors happen more regularly than is desirable and a greater emphasis on compassion and patient safety has come from both a recognition of past mistakes and the increasing fear of litigation (Illingworth, 2014). With the duty of candour, there is an increased awareness of the role of honesty in the relationship between patients and clinicians (Care Quality Commission, 2014). The fact that avoidable deaths occur as a result of the poor quality of care has been a recent feature of investigative reports such as the recent Kirkup Report (2015). However, the recognition that non-fatal incidents might lead to significant trauma is hardly every acknowledged, other than in specific settings or situations.

In nursing setting the recognition of the impact of traumatic births is well researched as is the psychological impact of treatment in intensive therapy unit (ITU) resulting in PTSD or serious psychological long term implications (Oldea *et al.*, 2006; Ratzer *et al.*, 2014). Patients who experience other types of what might be termed healthcare acquired trauma (HAT) rarely have their trauma acknowledged or the long term consequences recognised. Traumatic hospital experiences may not result in a formal diagnosis of PTSD or trauma symptoms, but for those who develop serious symptoms of distress it is an experience that changes and shapes the way in which an individual views themselves, their future or the world resulting in long term psychological distress, an inability to manage daily life and a fear of the future, especially the possibility of further interaction with the healthcare system (Beck, 1979).

Levenson (2007) acknowledged that a traumatic hospital experience could precipitate incidences of PTSD or psychological distress but healthcare acquired trauma can often go unacknowledged or be minimised by clinicians following formal apologies or compensation offers giving the perception that the matter has been addressed. Indeed, some patients may be required to sign a non-disclosure order that does not enable them to talk freely about their experience, share the distress that occurred to enable them to progress towards recovery or to share learning from that experience with the wider healthcare community. Patients frequently hear that 'lessons have been learnt' following serious incidents but rarely see the long-term benefits of those lessons in the reshaping of services to allow acknowledgement of that trauma. The idea that patients are traumatised, not only by illness but by the manner that care is delivered or managed is an uncomfortable one, not only for patients themselves, but also for clinicians whose focus it is to care and minimise harm. Alongside a lack of recognition that the healthcare system can itself harm and cause trauma goes an understandable reluctance to talk about this. The literature around healthcare acquired trauma that does not include ITU or traumatic birth episodes is therefore sparse in the UK and Europe, but mental health settings in the USA and Australia have made significant strides in recognising that harm that can be caused purely by interaction with the system and are currently moving toward trauma informed care (Bremness and Polzin, 2014; Watson *et al.*, 2014). Randall and Haskell (2013) define becoming trauma informed as:

'…becoming more astutely aware of the ways in which people who are traumatized have their life trajectories shaped by the experience and its effects, and developing policies and practices which reflect this understanding' (pp. 501)

This has yet to happen within general healthcare in the UK and Europe, but it seems as though this might be a timely and appropriate discussion.

In order to change what happens when people experience trauma in a healthcare setting there needs to be a greater understanding and acknowledgement by clinicians of the contributing factors to the experience. Nurse educators can help develop and share this understanding with their students. However, no major study has as yet researched the long-term impact of healthcare acquired trauma. Research on PTSD by Elhers and Clark (2000) informed a psychosocial model of trauma that has been important in moving forward treatments for those experiencing trauma generally. Studies of those with PTSD show that trauma caused by the actions or omissions of people rather than, for example natural disasters, has the

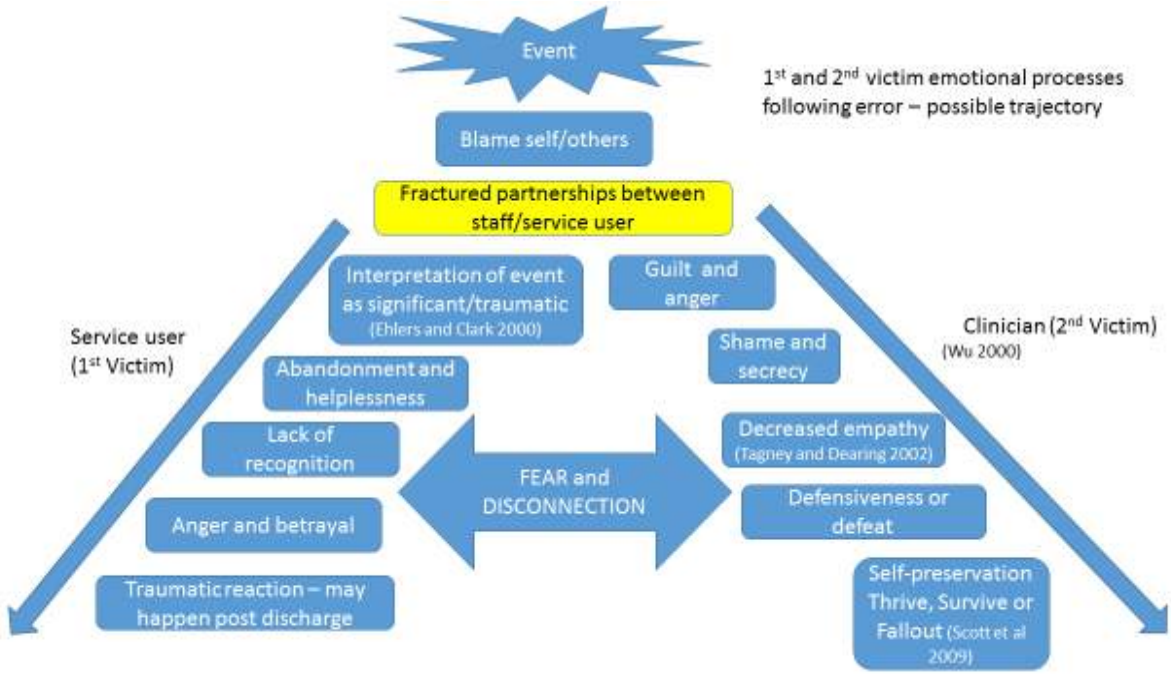
potential to cause significantly greater harm psychologically. Interpersonal factors seems to compound the trauma (Brewin, 2003). This is particularly significant in trauma that is experienced in the healthcare setting, as patients generally enter the system with an expectation of care, even if the system is acknowledged as not being perfect. Brewin's work considers the fact that not all those who experience a trauma go on to develop a traumatic reaction but that a range of factors including previous life experience, attachment style, personal beliefs about oneself and others, all impact on whether a long-term traumatic stress reaction occurs (Brewin, 2009).

The work of Vincent on patient safety emphasises that 'unsafe acts' happen all the time but that many are picked up sufficiently early to allow outcomes to not be damaging (Vincent, 2010).

It seems then that a 'perfect storm' of a vulnerable individual, in terms of the factors mentioned by Brewin, and an adverse event connect to make a specific set of circumstances that may bring about a traumatic reaction. The work of Wu (2000) and Scott *et al.* (2009) on the 'second victims' of errors in healthcare considers the healthcare practitioner. Wu and Scott's work, and that of others in their field examines the emotional reaction of the practitioner to making errors in practice. It is acknowledged that healthcare workers can also develop a traumatic reaction similar to that of the patient. This recognition in the USA has brought about advanced second victim programs for clinicians alongside trauma informed care programmes for patients (Krzan *et al.*, 2015).

It is significant to note two things in the body of research work already undertaken. First, it is noticeable that in reports of the management or aftermath of errors it is the description of what occurred in factual terms that is the focus of the research work. Human emotion and feelings are rarely seen as significant when the primary focus is in finding ways of managing harm. Secondly, there is no recognition of what helps the situation for patients and therefore what might protect them from developing a traumatic reaction in the future. The work of Vincent (2010) acknowledges the need for candour, that since 2014, is now firmly in place following the Mid Staffordshire Review (2013). While simply being honest, open and transparent with patients and with staff is a major step forward, an acknowledgement of the barriers that make this difficult when experiencing an traumatic patient event is also a key aspect of the patient clinician relationship. One of the significant factors in enabling those who have experienced trauma is access to initial and post trauma support (Andrews *et al.*, 2003). However, Robinaugh *et al.* (2011) established through their work that the support would need to be positive in relation to allowing the victim to reframe and to reappraise the trauma rather than just a traditional debriefing. This fits well with the current cognitive behavioural therapy (CBT) practice in terms of cognitive restructuring, exposure therapy and eye movement desensitisation and reprocessing as recommended by National Institute for Health and Care Excellence.

What then can a nurse do in relation to supporting and potentially preventing a traumatic reaction to a significant event? A possible trajectory of emotions for both first and second victims is offered for discussion and has been developed through informal work with patients and an appraisal of the relevant literature on second victims.



This trajectory requires further work including a pilot project to ensure a robust evaluation and reworking but a key feature in patient reports is the fracturing of the patient/clinician relationships at an early stage following the incident. This feature has also been identified by Vincent (2001) as being a 'second trauma' to those involved and cuts across the need for support

that traumatised patients' need to aid recovery. Systems and processes are set up to avoid errors and ensure that they are anomalies or 'never events', yet they still happen (Jones *et al.*, 2012). Expectations are shattered and the patient – clinician relationship breaks down. This can be compounded by a lack of honesty and an unwillingness to admit mistakes which may lead to avoiding engagement with the patient. At that point the mutual respect and support that each has for the other may be replaced for the patient by a reappraisal of what has occurred as being harmful and threatening. The clinical setting feels like a dangerous place. The trajectory of emotions felt by clinicians has been researched by Wu (2000), Scott *et al.* (2009) and Jones *et al.* (2012) with the acknowledged impact of these emotions upon the clinician being considerable. Disappointment in performance, shame, guilt and fear are key emotions for clinical staff following a difficult patient event. Shame researchers Tagney and Dearning (2002) found a clear link between the emotions of guilt, shame, and anger with a decrease in the ability to be empathic which clearly has implications for the continued care of traumatised patients. Davidoff (2012) in his discussion of the relationship between shame and perfectionism notes that healthcare professionals are self-selected for perfectionism when entering the profession – they want to be good at what they do. What matters then, is the response in the clinician to these feelings that ensures that difficult feelings do not distance them from the patient at a time when the relationship is crucial. Maintaining the relationship gives the clinician a significant opportunity to allow for further planning, support and care that may help to minimise, validate and acknowledge the trauma felt by the patient. Repairing of the relationship can only take place whilst dialogue continues and this requires clinicians who are aware of their emotions, who understands the trajectory of emotions when things go wrong and are astute enough to be able to respond to the emotional distress of their patients appropriately.

Educators are charged with developing highly competent and confident students, a responsibility which they rightly take extremely seriously. Given the challenging nature of practice settings nurse education must include helping students to understand the nature of trauma, trauma responses and recognition as well as the ability to respond appropriately to the difficult circumstances and feelings around a significant event (as defined by the patient). Students require a greater awareness of their own difficult feelings, including feelings of inadequacy, failure and shame in a profession that fears vulnerability and inadequacy and sometimes maintains 'professionalism' as a barrier. Educators are well placed to make explicit the importance of maintaining a strong therapeutic relationship after significant events even when feelings of vulnerability, shame and distress run counter intuitively in the clinician. Ensuring clinicians are aware of their own usual cognitive processes, systems of support, strengths and weaknesses as well as their professional responsibilities is an initial step forward in providing trauma informed nurses that can support patients should adverse events occur.

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Theme papers

An inclusive approach and reasonable adjustment

Mary Crawford, Lecturer, King's College London, UK

Recruitment of pre-registration nursing students remains a challenge in terms of recruiting high calibre applicants and meeting NHS commissioned numbers. Universities strive to meet competing demands and one of these is to develop inclusive policies in terms of equality. The focus for this paper is supporting students with disabilities to be successful on their programmes in order to enter the professional register.

Under the Equality Act 2010 protected characteristics are identified; one of these characteristics is disability. Whilst the Nursing and Midwifery Council offers guidance about entry to nursing education programmes the ultimate decision about making adjustments for students with disabilities is up to the universities and the clinical placements to decide.

This paper will describe some of the issues to be considered in conjunction with occupational health assessments, clinical practice and reasonable adjustment.

The purpose of reasonable adjustment is to develop an inclusive approach. Discussion about reasonable adjustment starts pre application and may be discussed at open days, selection days and put in place prior to a student enrolling on a programme. Liaison between university staff and occupational health departments is vital but occupational health assessments seem to make recommendations and leave it to the university to make a final decision.

Kane and Gooding (2009) found that both trust staff and university staff would welcome national guidance from the NMC. There are many aids and adjustments available for use with students but a successful experience for students depends on the university and placement partners working together to make individual adjustment.

Functional capacity assessments may be carried out in order to identify adjustment and there may be discussion regarding professional 'hunches' about what is necessary and what places a student at risk. Griffiths *et al*. (2010) give examples of a tripartite model which may be used in supporting students. It is hoped this paper will promote discussion about dealing with difficult decisions where it is felt that adjustment cannot be made and how students may be supported through what may be perceived as a dehumanising experience.

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Key words:

- disability
- reasonable adjustment
- competence.

How this contributes to knowledge development within this theme:

- to identify what reasonable adjustments should be made
- to discuss how partnership working can support a student with a disability
- to identify what is important in the student experience.

Self-assessment and exploration of the relationship between self-compassion, compassion towards others and caring efficacy in nursing students

Patricia Thomson, Senior Lecturer, University of Stirling (Stirling Campus); Annetta Smith, Senior Lecturer, University of Stirling (Highland Campus), Inverness; Julia Scott, Senior Teaching Fellow, University of Stirling, Stirling, UK

Background

Nursing students' self-assessment of themselves and their ability to be compassionate (self-compassion) is crucial; without this ability they may not be prepared to be compassionate to patients (Heffernan *et al*., 2010). Self-compassion appears to have academic benefits as well; it is linked to intrinsic interest in learning and healthier coping strategies (Neff *et al*., 2007). Several papers have reported on compassion and its importance as an ethos of care in the nursing curriculum, or caring dimensions in practice (Watson *et al*., 2001). The six-factors for compassion adopted in the study are: kindness versus indifference, common humanity versus separation, and mindfulness versus disengagement. Caring efficacy is explained as an indicator of nurses' beliefs in their abilities to express caring orientations, attitudes and behaviours, and beliefs in their ability to establish caring relationships with patients or clients. No studies were found that examined the relationship between nursing students' self-compassion, compassion towards others and perceived efficacy in establishing caring relationships as a basis for developments in education and practice.

Aim

This paper reports the results of a questionnaire survey that assessed undergraduate nursing students' self-compassion, compassion towards others and caring efficacy, and the interrelationship between the concepts.

Methods

This was a quantitative cross-sectional survey of 317 nursing students recruited from a School of Health Sciences in Scotland between 2013 and 2014. Data were gathered from second and third year students using the 12-item self-compassion scale (Raes *et al*., 2011), the 24-item compassion towards others scale (Pommier, 2011), and the 30-item caring efficacy scale (Coates, 1997).

Results

Key findings indicate a statistically significant positive correlation between self-compassion and caring efficacy, and between caring for others and caring efficacy. There was a statistically significant negative relationship between mindfulness (sub-domain of self-compassion) and separation and disengagement (sub-domains of caring for others), and between self-judgement (self-compassion) and indifference and disengagement (caring for others). Mean caring efficacy scores for these students were 4.89 (SD 0.45) which is comparable with those reported by Coates (1997) for novice nurses.

Conclusion

These findings lend support to the need to explore undergraduate nursing students' understanding of the components of compassionate care and related concepts, and perceived relevance to inform curriculum design. It is crucial that the nursing curriculum positively impacts the students' attitudes and behaviours, and ability to develop caring relationships with their patients in the promotion of best quality person-centred care.

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Key words:
- self-compassion
- compassion
- caring
- efficacy
- nurses.

How this contributes to knowledge development within this theme:
- despite efforts to humanise the nursing curriculum still more can be done to enhance student learning and the delivery of compassionate care
- there is limited knowledge of the students' perceptions of the concept and their views about the preparation of students in the delivery of compassionate care
- explores the relationship between self-compassion, compassion towards others and caring efficacy, as a basis for core curricula and the delivery of best quality person-centred care.

G1HHE-T3

Ethical considerations in digital storytelling: Implications for healthcare education and research

Amanda Kenny, Research Program Lead, La Trobe Rural Health School, Australia; Anne Elizabeth Topping, Assistant Executive Director – Nurse Education, Hamad Medical Corporation, Doha, Qatar; Virginia Dickson Swift, Research Fellow; Merrin Grenfell, Research Assistant; Michelle Clarke, Research Assistant, La Trobe Rural Health School, Australia

Digital stories are increasingly used as a potent and influential resource to promote change and humanise healthcare. A digital story brings together the elements of creative writing, photos, keepsakes, music and digital technology to create a short but powerful digital clip. Digital storytelling is promoted as a vehicle for the promotion of empathetic community action (Lambert, 2010). In healthcare, the use of digital stories as a qualitative data collection method, or as a tool in healthcare educational programs is increasing. A growing body of literature supports the use of digital storytelling, with numerous projects reporting success in humanising healthcare, promoting reflective practice and achieving outcomes such as reductions in stigma (Anderson *et al.*, 2010; Canadian Mental Health Association, 2012; Christiansen, 2011; Iredale *et al.*, 2011). The potential emancipatory and transformative effects are commonly documented (Christiansen, 2011).

Our interest in digital storytelling was prompted by our experience in storytelling projects. Whilst the experiences were largely positive, as researchers we were interested in the ethical dimensions of the digital storytelling process and the dissemination and usage of completed stories. A Google search yielded little on ethical considerations in digital storytelling. This prompted the design of a study to identify what was known in the published literature. As there appeared to be little known about ethics and digital storytelling, we utilised Arksey and O'Malley's (2005) scoping review method to guide our search. Scoping reviews are useful to map existing evidence on a topic, to establish research gaps, and to set future research priorities. Whilst the approach is described as a 'rapid review' (Arksey and O'Malley, 2005), the five steps (identifying the research question, identifying relevant studies, study selection, charting the data and collating) provide a systematic approach that is rigorous and replicable.

Our research question, what is known about ethics in digital storytelling, guided our search strategy. Search terms were developed and refined, and inclusion and exclusion criteria agreed by the research team. Searches were conducted across five databases. Through a process of title, abstract and full text review, 60 articles were identified that related to digital storytelling in healthcare. The major inclusion criterion for the study was discussion of ethics or ethical considerations. Through the process of full text review we identified few articles that contained any discussion of ethics. There was some consideration given to whether marginalised voices in digital storytelling are heard by policy makers (Matthews and Sunderland, 2013), and ethical issues including ownership, power, consent and facilitator shaping, confidentiality and release of materials (Dush, 2012; Gubrium *et al*., 2013; Terry, 2013). Given the volume of articles, and the proliferation of digital storytelling in healthcare, the dearth of literature that explored ethics was surprising.

In this presentation, we will draw on our scoping review and case studies of digital storytelling and will explore some of the expected and unforeseen consequences of disclosure. We will explore issues surrounding voice and silence, greater good and personal autonomy, and potential impacts will be examined. The overall premise is not to encourage caution or censorship, but to examine the process and format of digital storytelling within the context of real world lives and relationships. Our purpose is to examine the ethical dimensions of sharing the personal and private and the implications for healthcare education and research.

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Key words:
- Ethics
- digital storytelling
- health education
- research.

How this contributes to knowledge development within this theme:
- digital storytelling is promoted as a means of humanising healthcare
- drawing on a scoping review and case studies, ethical issues associated with digital storytelling will be explored
- whilst digital storytelling has potential for the humanising of healthcare, the ethical dimensions of sharing personal and private stories in healthcare education and research are often not considered.

G1HHE-T4

Exploration of nursing students' meaning and understanding of compassionate care

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Background
A culture which supports delivery of compassionate care is regarded as a fundamental component of healthcare delivery (NHS Scotland, 2010; Willis, 2012). Several authors have investigated the concept of compassionate care and its value and use in the nursing curriculum (Li-Min Wu *et al*., 2009; Brown, 2011). The importance of a nursing curriculum that both reflects and actively integrates compassionate care is strongly advocated. The integration of caring into the nursing curriculum has been described through interrelated components that encompass ethical, ontological and epistemological components (Brown, 2001). While compassionate care as a core component in nursing education is well described, there is limited knowledge of nursing students' perceptions of the concept of compassion and their views about the preparation of nursing students in the delivery of compassionate care.

Aim
This paper reports the results of interviews with undergraduate nursing students that explored their meaning and understanding of compassionate care, the delivery of compassionate care in clinical practice, and how the provision and delivery of the theoretical basis of compassionate care could be enhanced within their curriculum.

Methods
Data were gathered by focus group interview (n = 3), using a cohort of second and third year students (n = 17) recruited from a School of Health Sciences in Scotland between 2013 and 2014. Data from each focus group were analysed separately using Krueger's (1994) framework and themes were compared within and across the groups.

Results
Thematic analysis of the students' reports of class and practice observations revealed three main thematic categories, which reflected, from the students' perspective: insight about their professional identity and responsibilities; the barriers and facilitators for compassionate care; and what happens in the absence of compassionate care. Each of these themes was predominately rooted in students' experience of practice and the personal and professional relationships students both observed and experienced. Thus, nursing students perceived that social relations influenced their experience and perception of compassionate care lending credence to the notion that an ontological component of caring is an important consideration for the nursing curriculum. In the nursing curriculum, the epistemological and ethical components supported the development of students' knowledge and understanding of compassionate care. While these components provided a foundation for compassionate care delivery, they cannot be viewed in isolation from students' experience in practice.

Conclusion
The findings lend support for a caring-focused curriculum and learning that helps students develop caring behaviours and equips them to challenge negative behaviours that might militate against the delivery of compassionate care.

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Key words:
- compassion
- care
- student nurses
- curriculum.

How this contributes to knowledge development within this theme:
- contributes to knowledge about the components of compassionate care that students perceive as important
- considers the importance of students' experience of practice and its influence on compassionate care
- considers what can be done to prepare students for their practice placements when faced with situations that mitigate against compassionate care.

G1HHE-T5

The effect of education on the caring values of nursing students

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Background
It is well recognised that there is a global rise in the elderly population and of associated complex long term conditions with evidence of concerns in the quality of care, particularly of neglect and abuse (Katz, 2011). Within the UK this has been reinforced by a number of high profile examples of poor care and attention has been focused on recruitment, education and training of nursing students as a way to improve the culture in healthcare. The publication of a vision and strategy for nursing and care staff in England (NHS Commissioning Board, 2012) has now been embraced by educationalists and practitioners in England to enhance the organisational culture of the NHS. This longitudinal study evidences the impact of

the education programme based on a 'humanised' philosophy in shaping the students' value base as they progress over time.

Aim

This paper reports phases 1-3 of a 5 phase study exploring the impact of an undergraduate nursing curriculum based on a philosophy of humanisation on the values of individual students.

Methodology

The study uses a qualitative longitudinal approach (Neal, 2013) to understand the beliefs and values of student nurses from the day of entry through their education programme to completion. Two cohorts of students, one year apart and commencing February 2013, were recruited, the first on an outgoing programme and the second, the new curriculum based on a humanisation philosophy (Todres *et al*., 2009). This presentation reports a comparison between the two groups at the end of their first placement and end of first year. Data were collected by individual interviews at commencement of the programme and by focus groups thereafter. Ethics approval was gained for the entire project. At each stage of the process, students were formally invited to participate and given a participant information sheet. Ongoing individual consent was granted.

Findings

At the time of writing, data had been collected from both groups at the programme commencement (phase 1), end of first placement (phase 2) and for the first cohort, the end of their first year (phase 3). Data will be collected at the end of the first year for those in the new curriculum, February 2015. Following the first placement not surprisingly there were few differences between the groups at this stage. Both groups lacked confidence in their ability to put theory into practice, with some negative comments from both groups as to their position as students and learning to avoid poor practice. There were many commonalities expressed by both groups about the importance of knowledge, of how much they are learning about themselves and the negative effects of poor staffing on the quality of care. To date, students in the new curriculum more clearly articulated the difference they felt from being a healthcare assistant, the authority and trust they gained as a student (as opposed to being an HCA) and they focused more readily on the patient at the centre of care rather their own personal development. Details of the comparison at the end of the first year will be more clearly identified once completion of the focus groups for those on the new curriculum in February 2015.

Conclusion

By the end of their first placement, both groups were very similar in the expression of their values and to some extent presented a rather negative view of their experiences. Students from both groups were noticeably more articulate in expressing their values particularly in relation to their placement experience, as they moved through their programme.

Comparisons will also be presented for phase 3 at the conference after the February 2015 focus groups have been completed for the second cohort.

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Key words:

- humanising curriculum
- caring values
- nurse education.

How this contributes to knowledge development within this theme:

- perception of student nurses on the effect of different education programmes on the development of their caring values
- the development of students' understanding as to whether caring and other values underpinning a humanised approach to care can be taught
- the development of students' ability to articulate more positively the nature of humanisation as they move through the education programme.

Wonder-based entrepreneurship education in schools of nursing: Socratic and philosophical dialogue as a way to enhance innovation in healthcare from a humanizing position

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Innovation and entrepreneurship education has its origin in the business world, but has, within the last decade, spread into many different kinds of settings and educations – including healthcare (Steyart and Katz, 2004). This development can take its explanation in a changing economic situation throughout the western world (Boore and Porter, 2011).

Contemporary research on creativity, innovation and entrepreneurship mainly focuses on social constructive, pragmatic, socio-cultural and socio-material dimensions of creative and innovative processes and entrepreneurship (Bager *et al*., 2010; Brinkmann and Tangaard, 2012; Sarasvathy, 2005). In this line the educational focus has been on how to develop product, user and design-driven innovation and on processes of ideation.

Lately though, a more existential and philosophical hermeneutic approach to innovation and entrepreneurship has been suggested. Verganti and Öberg talk about a change from user to meaning-driven innovation, Scharmer and Kaüfer (2014) talk about 'pre-sensing' as a place for 'hearing the call' from an emerging future and Hansen (2014) suggests an existential and wonder-driven approach to innovation and entrepreneurship processes.

In line with this new framework, we want to describe and reflect some of the possible educational consequences of such an approach.

Our empirical departure is our three-year phenomenological action research project called 'Wonder-based Entrepreneurship Teaching in Professional Bachelor Education'. Ten senior lecturers in nursing and pedagogy participated. The purpose was to investigate whether and how Socratic and philosophical dialogues and different forms of phenomenological and existential reflections upon one's own professional assumptions in so-called 'Wonder Labs' could contribute to existing innovation and entrepreneurship education in at least two ways:

- to deeply and existentially root students and educators in their profession and values
- to bring students and educators on the edge of their knowledge into the field of 'not knowing but being'.

This paper will describe how and why a wonder-based approach can enhance students' understandings of what it means to be human and, at the same time, what it means to innovate from a sense of meaningfulness, server beauty or 'longing for the good' in concrete care-situations.

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Key words:

- innovation
- entrepreneurship
- nurse education
- Socratic dialogue.

How this contributes to knowledge development within this theme:

- a philosophical-hermeneutic approach to innovation and entrepreneurship in healthcare education seems to enhance a humanizing position
- working in so called 'wonder-labs' seems to make it possible to innovate from a sense of meaningfulness and 'longing for the good' in nurse education.

G1HHE-T7

Using narrative pedagogy to humanise healthcare education

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Humanism places a high value on human beings, human culture and the human experience. Today, humanism in healthcare reminds us that illness and recovery, living and dying, are an integral part of the whole human experience. Every person throughout the health system – professional and patient alike – is first and foremost a human being. Humanistic health professionals care about their patients as much as they care for them. They understand that compassion can be a powerful catalyst for healing. With the current emphasis placed on individualised care, anti-discriminatory practice and the patient's experience (Francis, 2013; Keogh, 2013; NHS Constitution, 2013), it is clear that humanistic care cannot be achieved through ignorance or the neglect of an individual's needs. This is supported by the Nursing and Midwifery Council (NMC, 2010) who state that all nurses are required to listen to the people in their care and respond to their concerns and preferences.

Narrative pedagogy has been developed over the last decade in nursing as a means of complementing a conventional content and competency driven pedagogy (Walsh, 2010). It focuses attention on the human experience of healthcare by deriving shared meanings from interpretation of stories. A key writer in this field is Dieklemann (2001), whose research has led her to propose that teaching should focus on interpreting the experiences of people and exploring their shared meanings and understandings. It is suggested that patient experience can provide a rich source of knowledge and evidence for practice (Rose and Gidman, 2010).

Narrative pedagogy requires teachers and students to work together to arrive at a shared understanding of the meaning of a patient story. This approach can lead to stories acting as catalysts for the exploration of topics that are very difficult to discuss. Exponents of narrative pedagogy have used a wide range of source materials for their narrative. Brown *et al*. (2008) and McAllister *et al*. (2009) have used film, literature and art as vehicles for facilitating student exploration of a variety of concepts. In their view, depictions of illness and caring have a much greater impact when presented in this way than when presented in a conventional approach.

Narrative pedagogy offers a way of expanding the conventional pedagogical approaches of content and competency to accommodate the complexity of context and the patient as a human being. It promotes critical thinking and there is some research to suggest it leads to new ways of knowing and thinking. Research says that 'stories' – even read to young children – can develop the ability to see alternative perspectives and it is this that develops empathy (Howe, 2012).

At the University of Cumbria we have used a variety of milieu to explore the patient experience of healthcare. We have found that the most widely accessible format for our students is through literature. To this end we developed a module where students were required to choose a book (non-fiction) that addressed the patient and/or family member's experience of disease, disability and illness. The aim of the module was to provide students with opportunities for the analysis and formulation of contextual knowledge through problem-based learning and reflection using biographical and autobiographical narratives of users and carers. Our experience has found that students develop a much greater understanding of the human experience of disease, disability and illness by immersing themselves in the literature and in doing so develop a greater level of empathy and compassion.

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Key words:

- narrative pedagogy
- storytelling
- human experience
- compassion
- nurse education.

How this contributes to knowledge development within this theme:

- narrative pedagogy is not a replacement for conventional pedagogies, but a valuable tool that should be used in conjunction with a content and competency driven curriculum
- storytelling has the unique power to inform and present an unforgettable insight into patient reality
- educators need to recognise and value learning from patient stories and should provide time and opportunities to facilitate reflection on these experiences.

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