Delivering dignified care

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Delivering Dignified Care : A Realist Synthesis Of Evidence That Promotes Effective Listening To And Learning From Older People's Feedback In Acute Care Settings.

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ABSTRACT

Aims and Objectives:

This review aims to explore effective mechanisms for listening to and learning from feedback from older people in the context of acute care.

Background: Maintaining the dignity of older people in acute care has become an issue of international concern. In the United Kingdom, recommendations for care improvement have led to the formation of an implementation group, the 'Listening and Learning Hospitals Pilot Project'. This literature review forms phase 1 of the project.

Design: Realist synthesis was used to explore and synthesise wide-ranging evidence

Methods: Using 12 databases, literature was scoped to propose four principles that underpin the context, mechanism and outcomes (CMO) of effective relation-based interventions with older people and their care partners in the acute care setting. A search was carried out in order to synthesise data to refute or support each principle. 137 studies and 11 sources of grey literature were appraised and included. A final synthesis of evidence across all principles identified key mechanisms for effective relation-based interventions.

Results: Eight essential mechanisms support effective care interventions

Conclusions: This review adds depth and breadth to current nursing knowledge in this field through the process of realist synthesis. Acute care organisations need to make a commitment to supporting relational care at organisation and unit levels. Additionally, they need to value and support the well-being of the nurses delivering it so that interventions to improve care for older people can succeed.

Relevance to Clinical practice: Essential mechanisms synthesised from the review, together with other suggested interventions for improving dignified care of older people in acute care by

listening to them and learning from their feedback, may contribute towards practice development in acute care.

Keywords: Older people; acute care; dignity; listening ; communication; feedback; relationships; assessment; person-centred care.

'What does this paper contribute to the wider global clinical community?'

- Nurses working in acute settings need to be open to new ways of delivering care to older people which meet their relational needs, and take account of their biographies using narrative approaches to assessment and feedback.

- In order to commit to person-centred care, continuous assessment and feedback should be sought from older people in acute care settings.

- Essential mechanisms for effective listening and learning from older people in acute care, synthesised from this review, can contribute towards model development in implementing change in practice.

DELIVERING DIGNIFIED CARE: A REALIST SYNTHESIS OF EVIDENCE THAT PROMOTES EFFECTIVE LISTENING TO AND LEARNING FROM OLDER PEOPLE'S FEEDBACK IN ACUTE CARE SETTINGS

INTRODUCTION

This literature review synthesises evidence to address the key question "*What aspects of listening to and learning from feedback work, in maintaining dignified care for older people and their care partners in acute care settings, for whom do they work, in what circumstances and why?* " The provision of dignified care to older people continues to vary considerably, particularly in acute care (Tadd *et al.* 2011, Department of Health 2014). This issue is of growing national and international concern, to which the Dignity in Care Commission (set up in 2013) have responded by forming implementation groups to carry out recommendations for care improvement including the 'Listening and Learning Hospitals Pilot Project'. This review is derived from phase 1 of this project. The overarching objective of the project was to test out whether listening, hearing, acting on and learning from feedback when caring for older people would lead to an improvement in the delivery of dignified, person-centred care.

Listening to patients is regarded as essential to the provision of individualised, person-centred care that promotes dignity. Whilst dignity as a concept may elude precise definition, debate about achieving dignified care emphasises the relevance of nurse behaviours and the need for person-centred approaches to care delivery (Tadd *et al.* 2011). The act of listening extends beyond a communication skill. It requires presence, engagement and has therapeutic effect (Fleischer *et al.* 2009) through acknowledging the dignity and personhood of the person speaking. However, although listening is valued as a comforting act in healthcare, there is a dearth of systematic research integrating it into support literature (Jones 2011). Listening is part of person-centred communication and integral to relational care, yet little is written about how to develop effectiveness in listening and responding to older patients in acute settings.

This paper reports the findings of a systematic literature review that used realist synthesis methods. The aims of the study, the methodological principles that guided the literature review

and key findings are presented. These illuminate the contextual factors that impact effective listening, mechanisms that can help nurses to listen and outcomes that may arise from effective listening to and learning from older people in acute care settings. Eight essential mechanisms which could form the elements of a model of listening and learning to guide practice developments are proposed.

AIM

This review aims to explore effective mechanisms for listening to and learning from feedback from older people in the context of acute care.

METHODS

The literature review uses realist synthesis, a theory-driven approach to evaluation (Pawson 2006). Realist synthesis was developed as a method of studying complex interventions in response to the perceived limitations of traditional systematic review methodology that, it is argued, follows a highly specified and intentionally inflexible approach, with the aim of assuring high reliability. As such, it steers away from failed unidimensional ways of responding to problems with specific interventions (Pawson 2006, Rycroft-Malone *et al.* 2012). An intervention in realist synthesis is a strategy used to promote evidence-informed practices. The underlying logic of realist synthesis is that not all healthcare interventions will be effective in all care contexts and the term 'mechanism' is used to explain the relationship between an intervention and outcomes (Rycroft-Malone *et al.* 2012). An underpinning principle is therefore that we should identify and challenge assumptions that direct interventions and how and for whom they work (the 'programme theories') (Pawson 2006).

Thus, realist synthesis explores diversity and change in the development and delivery of complex interventions and seeks to explain these rather than drawing a conclusion about which interventions may be more effective. Therefore in this review, instead of focusing on how

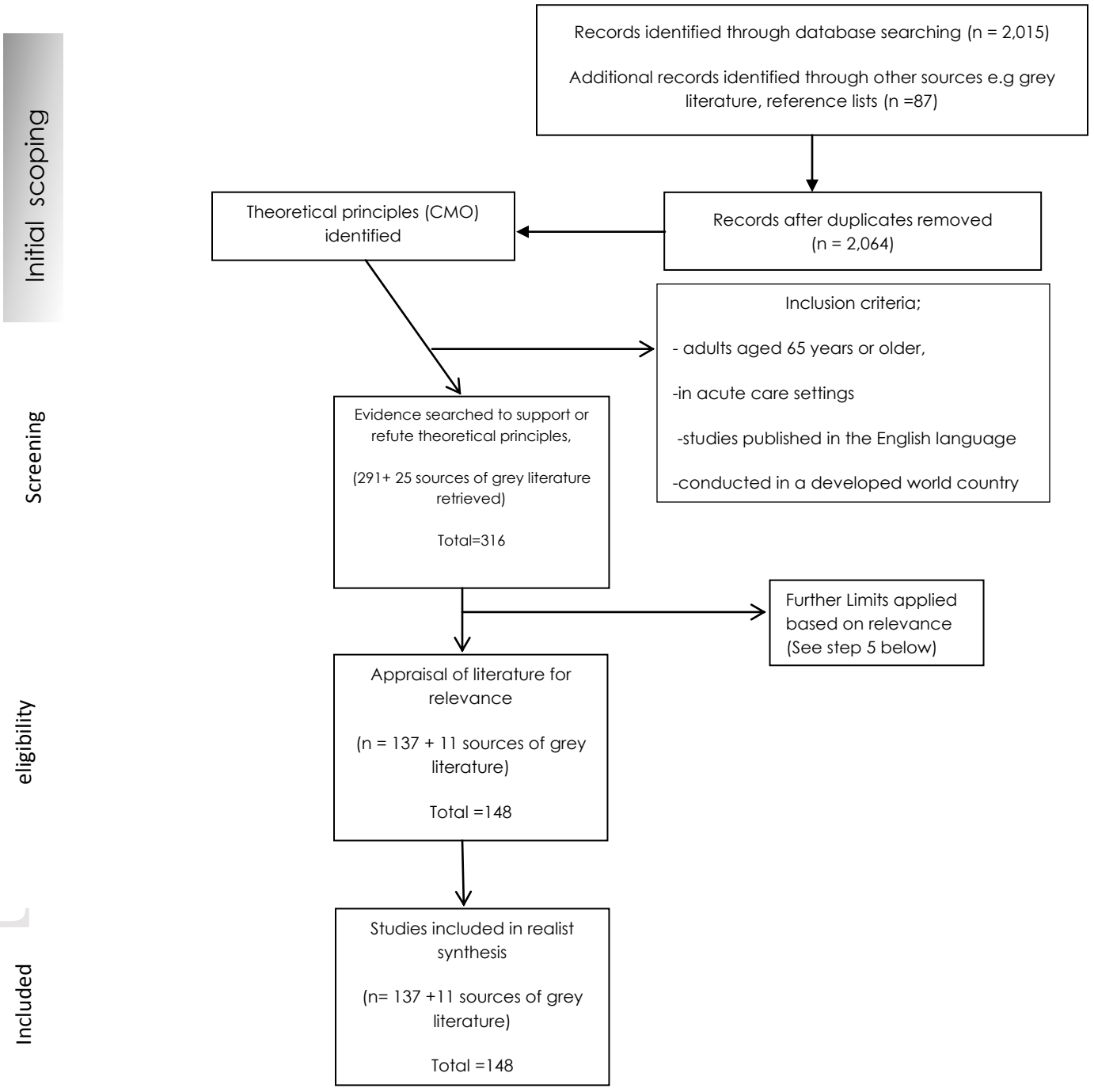
effective specific interventions are, the key question is aimed at understanding *'What aspects of listening and learning from feedback are effective, in maintaining dignified care for older people and their care partners, for whom are they effective, in what circumstances and why?"* This review will examine the programme theories underpinning ways of effectively listening to and learning from older people and their care partners in acute care settings. However, it may be argued that what works in listening and learning from older people in acute care will also be effective in providing dignified care to other adults in other settings.

Search strategy

The search strategy was guided by realist synthesis, which prioritises relevance over rigour, and is iterative and purposive. A broad body of literature, including qualitative research and grey literature was explored. Additionally informed opinion about selection of sources was sought from relevant people, including commissioners, stakeholders and the research team.

The search process is summarised in **Figure 1**, and explained in more detail following this.

Figure 1. Flow chart for the search and study selection process (PRISMA).



The process for search, retrieval and appraisal of the literature in this review is described below according to the steps in realist synthesis advocated by Pawson (2006).

Step 1. Identify the Review Question.

This began with an exploratory scan of the literature using the key question as a guide in order to identify initial impressions, key terms and concepts. The key question was broken down into sub-questions to assist the search. A pragmatic decision was made at this stage to exclude studies that focused exclusively on dementia, due to time limits on the project and recognition that listening to and learning from people living with dementia is a different research focus in itself (Eggenburger *et al.* 2013). 2,064 sources were retrieved for consideration from this scan.

Step 2. Clarify the purpose of the review.

The overall aim and purpose of the review was further clarified with the members of the Dignity in Care Commissioning Group.

Step 3. Find and articulate the programme theories.

These are the assumptions or hypotheses about what mechanisms might impede or promote effective interventions for listening to and learning from older people and their care partners in acute care settings. They were derived from the initial scan of the literature. Following brainstorming and discussion, the team identified and proposed principles that underpin the context, mechanism and outcomes (CMOs) of effective relation-based interventions with older people /care partners in the acute care setting and discussed these with commissioners and stakeholders. Principles, rather than 'programme theories' were referred to, since this term more appropriately reflected the complexities of delivering person-centred care. Common concepts were summarised, and through a process of refinement four key principles were finally derived. These are detailed in **table 1** and discussed in detail in the results section.

Table 1. Principles derived from scan of literature.

Principle 1. Encouraging the establishment of relationships between patients, nurses and their care partners within the acute care setting, results in person-centred care becoming an everyday cultural norm.
Principle 2. Active learning in clinical settings, which focuses on raising awareness of the negative effects of 'Institutional Ageism' and encourages person-centred engagement, can produce attitudinal and behavioural change towards nursing older people.
Principle 3. Continuous feedback from older people and their care partners, which is actively encouraged through a range of mechanisms, supports exploration of what is important to them while in hospital and can inform individualised, person-centred care.
Principle 4. Flexible, creative nursing assessments, which are open to listening and constructing patients' biographies, can ensure that individuals' stories are heard and absorbed into the clinical encounter.

Step 4. Search for the evidence. This involved purposively looking for evidence which supported or refuted the proposed principles in table 1. An extensive and systematic search was conducted to identify the relevant literature. The search criteria included adults aged 65 years or older, in acute care settings. The search was limited to studies published in the English language and conducted in a developed world country. Permutations and combinations of the following search terms were used:

listening, active listening, compassionate listening, communication, interpersonal communication, engagement, dignity, person-centredness, person-centred care, person-centred practice, person-centred nursing, personhood, relational, interpersonal, nurse-patient interaction, nurse-patient communication, nurse-patient, nurse-patient relation, older people, gerontology, gerontological nursing, elderly, older adults, older person, aged care, acute care, carers, feedback.

Additional searches were conducted using the following keywords to identify sub-topics:

'narratives, biography, communication barriers, ageism, therapeutic relationship, patient experience, nurses attitudes.'

All relevant databases were searched. These included:-

Applied Social Sciences Index and Abstracts (ASSIA), ABI/INFORM Complete, The Cochrane Library, Communication and Mass Media Complete (CMMC), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Educational Resources Information Center (ERIC), Kings Fund Database, Linguistics and Language Behaviour Abstracts (LLBA), NHS e-library, ProQuest Central, Pubmed and Scopus.

These databases were supplemented with searches of a number of relevant websites (e.g Kings Fund, NHS). In addition, reference lists of identified studies were scanned and free text searches

were carried out to identify evidence. The initial search yielded 291 studies, and 25 sources of grey literature. In order to manage the data, all these retrieved studies were entered into the bibliographic software package 'RefWorks.'

Step 5. Appraise the evidence

Selection of studies in realist synthesis is not carried out based on research methodology but on relevance (Pawson 2006). Two team members screened and analysed each paper for relevance to the proposed principles. Some limits were put on this. Studies that did not investigate or discuss the effectiveness of different approaches to listening and learning from older people / care partners or factors which may affect this engagement were excluded at this stage. 137 studies and 11 sources of grey literature were selected for review.

Using customised data extraction templates, data from empirical studies and grey literature were abstracted to populate them. Appraisal was based on the quality of authors' inferences and data abstraction reflected a narrative synthesis of these to illuminate the CMOs influencing the four principles. This process was iterative, and expert colleagues were invited to contribute their own experience of CMOs in populating the templates. A further synthesis from across the data templates for all four principles identified eight essential mechanisms that support effective listening and learning work, listed in **table 2.**

Table 2. Eight essential mechanisms for promoting effective listening and learning from feedback from older people in acute care settings.

- Desire and motivation
- Self-awareness
- Emotional engagement
- Presence and availability
- Curiosity and risk taking
- Continuous feedback
- Flexible, creative assessments
- Establishment of relationships

RESULTS

The findings were broad-based and complex, exploring numerous features of nursing relationships with older people. Context in this synthesis addresses the macro, meso and micro context of acute care settings, including structural and organisational factors. Outcomes are viewed as aspirational or actual. The overarching outcome is person-centred care, regarded as aspirational in this account and which comprises relational qualities, such as 'authenticity' or 'connection'. Actual outcomes also emerge, for instance the positive and negative effects of nursing behaviours on person-centred care for older people. Listening to and learning from feedback with older people may be seen as an intervention to facilitate person-centred care. Through exploring mechanisms, the relationship between the proposed interventions and possible or actual outcomes may be explained. This relationship may be direct or indirect, positive or negative, and may reflect, for example, nursing values, or those of the older person .Each proposed principle, with its associated synthesis of evidence is presented in turn.

Principle 1: Encouraging the establishment of relationships between patients, nurses and their care partners within the acute care setting results in person-centred care becoming an everyday cultural norm.

Within acute care, there is a generally reported lack of relational engagement that reduces the likelihood of older patients sharing information that nurses can act and learn from to provide person-centred care. Existing evidence is consistent in showing that person-centred care embraces the formation of a therapeutic relationship between nurses, older patients and their care partners (McCormack & McCance 2010). However, acute care delivery is often dominated by routine practices with minimal attention given to the older person's beliefs, values

and priorities for care, which underpin investment in person-centred relationships (Mitchell & McCance 2012). Reasons for this are explored in more detail in the next synthesis. Featuring high on the list of complaints from older patients about their care is how they are treated by people, with lack of respect and dignity cited as key issues. (Clwyd & Hart 2013, Moore *et al.* 2014). Moore *et al.* (2014) emphasise that interpersonal relationships are of paramount importance to the older patient, however relational 'work' requires nursing presence and engagement. Engagement initiates 'connectedness' which is the starting point for person-centred care (McCormack 2001). Through connectedness, autonomy is mediated, informed by knowing the person, their values and beliefs, viewpoint and immersion in their 'life world' (Mitchell & McCance 2012). However, interpersonal engagement in nursing practice has in the past been equated with the acquisition and employment of behavioural communication skills emphasising goal-directed actions through which forming and being in relationship can be achieved (McCabe 2004). Hartrick (1997) argued that this behavioural approach provides a profoundly limited, mechanistic view of human relating by failing to reflect the significance of relationship as a foundation for human caring. Human relating requires an appreciation of people's connectedness, the development of relational awareness and an interest in the growth of relationship.

In their synthesis of qualitative studies that explored older people's and their relatives' views and experiences of acute health care, Bridges *et al*. (2010) concluded that older people want nursing staff to 'see who I am', 'connect with me' and 'involve me'. These themes reflect the older person's need for the nurse to establish warm and human connection, understanding and involvement (Bridges *et al*. 2013). Similarly, in Patterson *et als*'.(2011) exploration of the quality of acute hospital care for older patients and their care partners, participants were able to identify often seemingly 'little things' that enhanced the development of therapeutic relationships with certain nurses. Nursing staff were seen to value relational aspects of care if they engaged in real conversations or small encounters with patients. These encounters

provided the older person with a sense of worth and value, promoted personhood and subsequently affected their overall experience of acute care. Baillie (2009, p.24) identifies these emotional aspects of care as being intimately linked to dignity, and feeling 'comfortable, in control and valued'. Simple conversations then can create a relationship or connection with the patient that encompasses entering their world and developing an appreciation of the circumstances and relationships that shape their lives (Atherton & Kyle 2015).

Evidence suggests that relationships between nurses and older people are limited by a lack of information, failure to communicate and a lack of a visible nursing presence (Patterson *et al*. 2011). Lack of nursing availability causes anxiety to both patients and relatives (Bridges *et al.* 2010). A study by Mitchell & McCance (2012) found that in hospital, a culture of 'not wanting to bother the busy nurse' had developed which also hindered the opportunity for relationship-building. The likelihood of engagement between patient and nurse is therefore diminished by organisational context and cultural mechanisms affecting nursing availability. Dewar & Mackay (2010) suggest that nurses' lack of visibility, (unless providing care to address physical need), may be a distancing or avoidance strategy that reduces the risk of emotional exposure or over-involvement. The consequence of such distancing is that care can become depersonalised, with a focus on physical tasks rather than affective engagement (Bridges *et al* 2013).

Developing relational approaches to care in acute care settings could focus on interventions that facilitate the nurse to meaningfully engage with the older person and their care partners. Dewar & Nolan (2013) found that through the use of appreciative inquiry, two key forms of 'person and relational knowledge' emerged from the data; 'knowing who I am and what matters to me' and 'understanding how I feel'. The results of their study suggest that through skilled facilitation, effective engagement in caring conversations can become the norm and the relational process of nurses and patient working together can shape how care is provided. This challenges the misconception that developing relationships and getting to know

something about the person being cared for is not always possible (Bridges *et al.* 2010, Dewar *et al.* 2014).

In summary, older people desire positive and beneficial relationships with nurses who care for them and the quality of relationships older people have with nurses in acute care lies at the heart of person-centred care. Communicative interventions such as appreciative enquiry, and a focus on relational care help nurses to recognise the social nature and interdependency of older persons. Genuine conversations, albeit brief, determine whether nurse-patient relationships will flourish. The less tangible aspects of nursing such as presence, availability and awareness are positive mechanisms that can create the sense of security needed for older patients to engage and share what matters to them. More limiting mechanisms are nurse disengagement and distancing, which arise from the cultural context of acute care delivery. These issues are examined in exploring the next principle.

Principle 2: Active learning in clinical settings which focuses on raising awareness of the negative effects of 'Institutional Ageism' and encourages person-centred engagement can produce attitudinal and behavioural change towards nursing older people.

The relationship between the contextual factors that shape the acute care of older people, the quality of communication with them and the outcomes of care can be explored at a number of overlapping levels. These include societal, institutional, professional, organisational and individual (Patterson *et al.* 2011). Societal attitudes towards ageing, which are generally held to be negative, have permeated policy-making in the past, and older people have been perceived as problems requiring considerable attention and resources (Ward 2000). Such negative, age-based attitudes underpin ageism and often manifest themselves through stigmatisation and exclusion processes such as age discrimination (Lagacé *et al.* 2012). At an institutional level, the NHS is argued to harbour ageism that remains hidden and unchallenged

despite anti-discriminatory policies and guidelines being in place (Carruthers & Ormondroyd 2009, Department of Health 2012, Calnan *et al* 2013.). Policy narratives in turn have influenced acute care priorities, through an emphasis on risk management, performance targets and audit. This has created a culture whereby professional ideals of person-centred care are challenged by the necessity to meet the demands of quality assurance and speedy 'throughput' of patients, giving rise to routinised and task-orientated nursing care (Patterson *et al.* 2011). Nurses in acute care have reported that organisational constraints and inadequate resources often prevented them from being able to provide the time, support and level of care required to effectively nurse older people. A focus on routine aspects of care resulted in standards of care being allowed to 'slip', consequently older patients only received essential care and attention (Tadd *et al.* 2011, Higgins *et al.* 2007). Nurses also feel that they lack the core skills to care for older people in this setting (Calnan *et al*.2013).

Additionally, the focus on specialism and single conditions in acute care contexts fails to take full account of the complex array of social, psychological and cultural factors that shape health (Patterson *et al.*2011) or which meet the needs of older people with multiple co-morbidities. Older people have multiple needs that cut across disease categories and require creative, reflective approaches to care, for which protocols are insufficient (Tadd *et al*. 2011). Higgins *et al.*(2007) found in their study that older people were often differentiated from the 'mainstream' patient who required highly valued, advanced acute care. The complex contextual factors identified, which mediate the provision of acute care for older people have negative outcomes. The theme of 'marginalisation and oppression' of older people was identified in the qualitative study by Higgins *et al.* (2007), and this process often resulted in older people's needs being ignored or diminished to a lower priority in terms of care. It is also echoed in the virtually unanimous view expressed by all participating staff within Tadd *et als*'.(2011, p.116) report that the acute setting is 'just not the right place' for older people together with the assumption that there must be a better place for 'them' to be.

Parke &Hunter (2014) conclude that in acute care, ageist attitudes underpin an intricate relationship between the older person, the environment and assumptions about care, that contribute towards nursing care decisions that disadvantage older people. Other negative outcomes of ageist behaviours are well described in research. For instance, the way nurses communicate and engage with older people is significant as underlying attitudes are shaped by our use of language, as well as by our culture. Negative stereotyping of older people can manifest itself in careless or inappropriate terminology and over-accommodative communication, which older people often find patronising (Brown & Draper 2003). Associated with paternalistic nursing behaviours, negative consequences for the older person include passivity, loss of independence and erosion of their sense of self-worth, dignity and personal identity (Brown &Draper 2003, Phelan 2011, Vize 2012). This in turn may lead to a 'negative feedback loop' (Draper *et al*. 2013) whereby the older person accommodates the caregiver's ageist expectations of them rather than challenging them, thus ironically reinforcing patterns of ageist behaviour. Consequently, participation in care and decision-making by the older patient may be diminished or absent.

The majority of studies discussed above focus on negative aspects of care and do not capture the actions that exemplify good standards of care and practice. Maben *et al.* (2012), in their examination of the links between staff experiences of work and patient experiences of care, observe that despite reported deficiencies in standards of care the majority of NHS staff strive to offer dignified and high quality care. Importantly, Higgins *et al*. (2007) emphasised that for the nurses in their study, delivering less than adequate care was clearly a source of stress. Tadd *et al*s'. (2011) report also found that the majority of nurses expressed feeling motivated to represent patients' interests but argued that this was frequently compromised by systemic and organisational constraints. However, despite voicing their desire to provide person-centred care, these intentions were rarely reflected in practice (Tadd *et al*.2011).

Interventions to improve engagement with the older adult in acute care may include an awareness of the effect of unconscious beliefs and attitudes underlying health care processes and outcomes. Clarifying values and beliefs and knowing self are at the heart of person-centred care and place a responsibility on the nurse not just to get to know his/her patient, but also to recognise what they bring of themselves into the caring interaction (McCormack & McCance 2010). 'Knowing self' is based on the assumption that in order to help others, nurses need to have insight into how they function as a person (McCormack & McCance 2006). Active Learning can facilitate nurses in 'Knowing-self' by raising awareness of the negative effects of ageism, the impact that it has on patient care and exploring ways of providing person-centred care (Dewing 2010). Dewing discusses that through activities of self-discovery, self-reflection and education, negative attitudes towards older people can be challenged and changed.

In summary, the influence of wider and deep-rooted negative social attitudes to ageing, and negative social processes associated with organisational culture may compromise dignified interpersonal engagement. They manifest in behaviours which act as negative mechanisms in achieving person-centred care, since they have negative outcomes for the older person which include inhibition of effective communication. This will discourage listening to and learning from patients, working with patients' beliefs and values and engaging in shared decision-making. Active learning offers an important intervention through which the many mechanisms that may influence effective listening and learning from older patients and their care partners such as language and discourse, values and beliefs and routines and rituals within the workplace can be explored (Dewing 2010).

Principle 3: Continuous feedback from older people and their care partners, which is actively encouraged through a range of mechanisms, supports exploration of what is important to them while in hospital and can inform individualised, person-centred care.

Internationally, government strategy is moving towards ensuring that health care providers are more responsive to data derived from patient experience and real-time feedback. Within the UK National Health Service, senior managers consider complaints, comments and compliments, patient surveys, and information from the Patient Advice and Liaison Services (PALS) to be the most useful sources of patient experience information (YouGov 2005).

However, patient satisfaction surveys assume that service providers know what is important to ask about and how to ask it. Coulter *et al.* (2009) point out that there is a difference between patient satisfaction and patients' experience of care, and that in order to develop a successful strategy to improve patients' experience we need to measure the things that matter most to them. Patients' experience is partly dependent on their expectations of care, which in turn reflects their humanity and individuality. There is an inherent inability within 'quality' measures to adequately account for these wider aspects of patient experience (Tadd *et al*. 2011). Surveys and quantitative methods do not capture aspects of care that are exceedingly important to patients and these are subsequently neglected. Moreover, health systems have a culture of denial and defensiveness regarding the handling of complaints from patients that has shaped nurses' reluctance to listen to them (Clwyd & Hart 2013).

Although It is important that nurses in acute care do not assume how people want to be cared for but actually seek feedback directly from patients, it is generally observed that older people are reluctant to assert their views or provide negative feedback with regard to their care, and this may lead to unmet needs in the acute care setting (Tadd *et al.* 2011). This may be because of the perceived negative effect of such feedback on the social relationships with those providing care or through fear of judgement and retribution (Coulter *et al.* 2009). Such barriers to active and purposeful dialogue suggest that older people must be encouraged by nurses to provide feedback, negative or positive, in order to clarify what is important to them and take part in decisions regarding their care.

No existing policies provide advice on how nursing staff can effectively collect real-time feedback. In order to be significant to nurses, feedback from older people, or their carers should be immediate, specific and actionable, leading to learning and appropriate outcomes, in order to prompt real-time changes in practice. (Larsen *et al.* 2011). This does not need to be a formal process. Feedback can be integrated into everyday care activities and conversation but this requires a commitment to full immersion in the social context of the older person (McCormack & McCance 2010, Dewar & Sharp 2013). Appreciative Inquiry, being a relational process has the capacity to uncover what people value in the care they receive and aims to translate their accounts into statements of aims and practices that can be applied to promote person-centred care (Reed 2007). Through simple questioning and probing, the nurse creates a space open to feedback that challenges assumptions about care (Dewar & Sharp 2013). Both nurse and patient must be prepared to learn and have a genuine curiosity about the other person's perspective. This involves willingness to take risks (Dewar & Nolan 2013) and address patients' and relatives' concerns directly instead of avoiding what may be seen as unpleasant confrontation. Therefore, nurses must value each encounter as an opportunity to both listen and learn from the older person. Bridges and Nicholson (2008) explored the use of narratives to inform service improvement. Nurses were trained to undertake Discovery Interviews, however the success of these depended on the interviewing skills of the participant. Narrative inquiry (Hsu & McCormack 2011) may also offer a means for gaining feedback from older people.

In summary, new behaviours and approaches to gathering feedback from older people should be explored at organisational as well as ward level and reflect the immediacy of patient and carer experiences. The context in which feedback from patients is collected has an organisational emphasis on measurement. The outcomes of this are that older people's voices are likely to go unheard and what may be important to them is not elicited or responded to. Reluctant to complain and quick to praise their nursing care, the influence of their perceptions of the power of health professionals needs further exploration, and acts as a negative

mechanism to listening and learning from their real-time feedback. Interventions that may capture this process involve intentionally using nursing encounters with older people as opportunities for appreciative enquiry or narrative enquiry.

Principle 4: Flexible, creative nursing assessments, which are open to listening and constructing patients' biographies, can ensure that individuals' stories are heard and absorbed into the clinical encounter.

Assessment can be seen as providing the foundations of care in which therapeutic working and care needs are identified, clarified and agreed by nurses, older patients and their care partners. Assessment which may be regarded as an ongoing process, provides an opportunity for nurses to understand how the older person views their past, present and future experiences. However, assessment strategies in nursing have been influenced by the problem-solving framework of nursing models and the nursing process and debate exists about the effectiveness of such strategies for assessment in practice (Dougherty & Lister 2011). Parke & Hunter (2014) further suggest that nursing assessments concerned with deficits and biased towards diagnosing pathological conditions can lead to a view of older people as weak and dependent. Rigid, inflexible assessment frameworks fail to capture the older person's priorities and do not encourage relationship-building. The older patient, as a person, may remain invisible. Clinical assessment information in acute care often supersedes older people's own view of their chronic health needs and important information relating to social or cognitive function may be overlooked leaving them at risk of adverse health outcomes (Parke & Hunter 2014). Within acute care, it is essential that there is a shift from a problem-orientated form of assessment, in which the professional determines goals and priorities of care, to a goal-based paradigm in which wishes and needs of patients become of central value in the response to complex co-morbidities. For this to be achieved the nurse must be creative and flexible in their assessments, integrating questions that invite patients' narratives.

Genuine curiosity as to what is significant to each patient in each moment is vital to discovering, understanding and accepting individuals' stories (Hsu & McCormack 2011). Nurses therefore need to be open to listening and hearing patients' stories and value this activity as an important part of continuous assessment. McCance & McCormack (2010) argue that 'knowing the person' in this way, through historical narrative and discovery of identity, is essential to person-centred nursing. 'People have a past, a present and a future and to detach oneself from the past serves to deform the present and plans for the future' (McCormack and McCance 2010, p.15).

To summarise; the context of assessment in acute care for older people may be a single event on admission, with a focus on bio-medical disorder and little opportunity for engagement or exploration. To achieve the outcome of holistic, person-centred assessment, narrative approaches and interventions which construct older people's biographies could be adapted and used in acute care. A continuous assessment process should allow older patients and nurses to build shared expectations and priorities for care that reflect what is meaningful to the older person and genuine participation in care. Negative mechanisms considered in principle 2, may impact nurses' desire and curiosity to understand the origin of patients' thoughts and feelings or to 'hear' their questions and concerns (Hsu & McCormack 2011). Positive mechanisms would include a strong ward-level philosophy of care, which values the 'life -world' biography and personhood of the older person.

Essential mechanisms to support effective listening and learning

Eight essential mechanisms that could support the successful achievement of listening to and learning from feedback from older people in the acute care setting were further synthesised from across all four of the principles

'*Desire and motivation* 'is indicative of commitment to providing person-centred care. *Self-awareness* reflects the awareness of professional and personal attitudes, beliefs and values and

their influence on practice. These act as pre-requisites for developing relationships and engaging with patients at a social and emotional level. *'Emotional engagement'* involves valuing patient's stories and experiences, openness to the reality of the situation, the courage to 'drop roles' and deliver human responses. '*Presence and availability'* emphasises the importance of communicating accessibility, warmth and a readiness to listen. '*Curiosity and risk taking*' necessitates questioning, discussing and clarifying how older people experience their existence and openness to the unknown. Ultimately, the purpose of curious questioning is to gain contextual knowledge of both the patient and family and to strive for understanding as to how this shapes their priorities for care. *'Continuous feedback'* focuses on the validation of what is salient or meaningful to the patient, through the exploration of patient's narratives in everyday conversations. This is closely linked to '*flexible, creative assessments'* that integrate shared decision making through negotiation. Finally effective listening and learning from older patients and their care partners includes the '*establishment of relationships'* in which a sense of security is developed and dignity is maintained. These will facilitate interventions that enhance person-centred care.

DISCUSSION

This review has proposed and explored four principles that encompass the care context, mechanisms for improvement and desired outcomes of care for older people in acute care settings, in relation to aspects of listening and learning from feedback . It is acknowledged that each of these principles whilst discussed in turn cannot be appreciated contextually without the others and so therefore, there is some overlap of themes. A possible limitation to this review is the referral to, rather than exploration of the concept of partnership in care with older people, which may underemphasise the active role they can, and may wish to take in participating in decision-making, for example. It is suggested that the essential mechanisms synthesised from this review would facilitate enablement and support in establishing best care in partnership with the older person and their carers. The review findings emphasise that the provision of dignified,

person-centred care for older people in acute settings is strongly dependent upon the relational aspects of nurse-patient interaction. Interpersonal engagement allows caring relationships to form, these may have social or therapeutic depth, but they confirm the identity and self-worth of older people and uphold their dignity. The core attributes of dignity including respect for identity, autonomy and control lie at the heart of person-centred care, and within trusting relationships will facilitate effective partnership in care for older people (Penney & Wellard 2007). The extent to which older people are denied participation in care in hospital may be inferred from the context of their relationships with nurses, which reveals an inherent asymmetry. This may render them vulnerable to assaults on their dignity. Maben *et al.* (2012) suggest that they may seek to manage their relationships with nurses by trying to minimise the perceived burden they add to a 'high demand' setting, through apologetic or passive responses. This adds to their emotional labour, which is greater in the face of poor or unpredictable care. Such 'managing' strategies emphasise the powerful position of staff in hospital settings. Older people also seek to develop and maintain positive relationships with staff in order to promote their own dignity (Baillie 2009). They can judge the amount of respect with which another person treats them and make attempts to restore the imbalance of their relationships with nurses. This can be seen in Jacelon's (2003) study, where older people deliberately tried to establish reciprocity in the nurse-patient relationship by engaging staff members and showing an interest in their personal lives. This had the effect of enhancing their dignity and reducing depersonalisation, through minimising the differences between them and their care providers.

Asymmetry in the relationship of older people with nurses is manifested in nurses' use of negative communication styles, which serve to objectify and control, and which promote passivity and dependency. Nurses may not work as equal partners with older people, and tend to be paternalistic in information-sharing and decision-making processes (Mitchell & McCance 2010). Power differentials in relationships affect how communication will proceed (Lagacé *et al* 2012) and can be discerned in the reluctance of older people to complain or provide negative

feedback about care, possibly for fear of retribution. However whilst it might be tempting simply to interpret the unequal relationships older people have with nurses in this context as a function of ageist social discourses (Phelan 2011), a more complex picture emerges, relating to organisational climate and culture.

The tension between espoused professional values and managerial demands, and how nurses respond to this in terms of relating with older people in their care, involves mechanisms which may disrupt or promote 'relational practices'. Patterson *et al*. (2011) conclude that initiatives aimed at enhancing the quality of acute hospital care for older people are unlikely to be effective without close attention being paid to these. A pre-requisite for relational practice is the desire and motivation of nurses to engage in this process. However, as noted, nurses are sometimes neither visible nor present, which limits opportunity for social or therapeutic interaction (Bridges *et al* 2010, Mitchell & McCance 2010). Bridges *et al.* (2013) also found that although nurses aspired to form supportive relationships with patients, they felt that they lacked capacity to do this due to lack of time and the influence of organisational pressure that resulted in inflexible routines. Nurses admit to implicit care rationing in hard-pressed, poorly resourced working circumstances. Further, nurses may be unaware, or unable to explain how their interactions affect dignity towards older people (Baillie 2009, Tadd et al.2011) which suggests that there is a lack of awareness about what older people view as important.

Two consequences of this seem evident --nurses form relationships and give excellent care only to selected patients (identified as 'poppets')(Maben *et al.*(2012), in order to carry out their nursing role the way they believe it should be, or nurses disengage from older people in their care as a coping strategy, because they are morally distressed or have reduced caring capacity. Disengagement from the nurse-patient relationship is therefore a coping strategy (Bridges *et al.* 2013, Higgins *et al*. 2007).

Organisational priorities, influenced as they are by managerial narratives of accountability, efficiency and quality improvement, also affect local culture at ward level, through prioritising pace and promoting routinised care over person–centred care (Calnan *et al.* 2013). Patterson *et al.* (2011) noted that if the predominant culture on an acute ward involves a 'pace model', new staff, students and patients very quickly become attuned to the message that staff-centred nursing tasks are a priority and small but dignity-promoting actions are not valued.

A number of mechanisms may contribute towards a more positive working culture. Older people themselves value small, but compassionate interactions with nurses, and clearly there are nurses in acute care who capitalise on small opportunities to engage in these. Research needs to examine in closer detail how some nurses are able to withstand the forces of organisational demand and culture, and remain true to their professional values consistently, which implies resilience. Mitchell & McCance (2010) suggest that nurses themselves need to feel empowered and autonomous, in order to challenge some of the constraints that prevent them from nurturing autonomy and independence in older people in acute care. The well-being of staff and support of the organisation can also be regarded as important elements in the development of practices that enhance therapeutic relationships. Importantly strong ward leadership emerges as a consistent suggestion for improving the culture of care in acute settings (Tadd *et al.* 2011, Maben et al. 2012, Bridges & Fuller 2015).

This review has identified the potential of active learning and appreciative Inquiry as a means of developing practice. Through such processes practitioners can be supported to develop skills in actively listening and engaging with older people. Person-centred approaches to understanding the older person, which are biographically orientated and use narrative methods, can be deployed in clinical encounters, such as assessment and admission. Participation in decision-making can be enhanced through continually assessing with the older person whether their needs are being met through these approaches.

Realist synthesis, which integrates a range of sources in addition to empirical evidence, was deemed an appropriate method of presenting an overview of the key messages emerging from evidence on 'what works 'in listening to and learning from feedback with older people receiving acute care. The synthesised data presented in this review suggests a complex interplay of contextual influences with sociocultural and organisational mechanisms that influence listening and learning from feedback. Mechanisms that impede the provision of person-centred care to older people are often indirect and difficult to disentangle from the context in which they emerge, and originate in psychological and social processes -whereas realist synthesis is more often applied to explaining policy. The interventions discussed here therefore can only provide a partial answer to the key question, 'what works' by suggesting 'what might work?'. However, the extensive inclusion of wide- ranging sources has permitted a rich exploration of the 'nursing world' in acute care as well as giving voice to older people in this context, through qualitative research and reports exploring the quality of their care.

Future research exploring relational care of older people in acute settings could take two possible directions:-firstly it would be enlightening to examine the extent to which the quality of nurse patient engagement is affected by the complexity of care required by the older person; secondly the influence of the cultural background of either nurse or older person on their relationship in this setting could be explored further.

CONCLUSION

Through the process of realist synthesis, four principles have been proposed that underpin listening to and learning from the feedback of older people in the delivery of dignified care in acute settings. The synthesised evidence has shown that listening extends beyond a

communication skill for nurses. It requires desire, motivation, presence, engagement and connection, and has both social and therapeutic value, through acknowledging the dignity and personhood of the person speaking. These are relational activities that inform person centred care. The context of acute care delivery has been explored. It is generally accepted as often being detrimental for older people in meeting their relational needs or endorsing their sense of dignity. This has identified positive and negative mechanisms that affect how nurses can care for older people in a manner that acknowledges and supports the significance of their health and social world. Mechanisms may also act directly or indirectly on nursing interventions since they are subtly intertwined with societal and organisational influences that affect nurses' delivery of person-centred care to older people. Eight essential mechanisms were synthesised from the four principles, to support successful listening and learning from the feedback of older people to improve person-centred care. These may act as the basis for a model in developing practice. However for interventions to work in promoting what is essentially cultural change, acute care organisations need to make a commitment to supporting relational care at strategic and ward level and also value and support the well-being of the nurses delivering it.

Relevance to clinical practice

Four principles which were explored in this review suggest specific areas where improvement in the engagement of nurses with older people in acute care can be focused, and person-centred care can become a reality. Eight essential mechanisms for listening to and learning from feedback of older people may form the elements of a model which could be used in future practice development.

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