

Chapter 9

‘Care in Crisis’: Health Action Training (HAT) for Person-centred Care, Communication Skills and Resilience in Nursing during the COVID-19 Pandemic

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Introduction

Health professionals around the world have been under tremendous pressure during the COVID-19 pandemic. In the UK, an already overstretched National Health Service (NHS) has been tested as never before. Existing problems, such as bed shortages, understaffing, staff illness and longer waiting times for patient treatment, have been exacerbated to the point of crisis. Nursing staff have struggled to cope with this added pressure, suffering from burnout and exhaustion. Alongside these issues, there is the ongoing problem of poor communication. For example, in 2016-17 the Belfast-based Patient Client Council identified “poor communication” as the largest source of complaints; incidents of complaints in relation to communication rose by 10% over the following year, 2018-2019 (PCC 2019).

Changes in working practice due to COVID-19, including longer working hours and a higher incidence of trauma, have led to increasing levels of stress. This has affected the resilience of health professionals and their capacity for person-centred care. The large number of stressors in the working environment can make effective communication more difficult, not only between health professionals and patients, but also within staff teams.

In the meantime, despite a campaign encouraging the public to “clap our heroes in the NHS” every Thursday during the first lockdown, the UK government announced a decision to continue the pay freeze that has kept nurses’ salaries static since 2017

(Royal College of Nursing (RCN) 2020, online). This decision has made nurses' lives even more precarious than they were before the pandemic, putting more pressure on nurses' capacity for person-centred practice and resilience.

One new company, Health Action Training (HAT), helps nurses and other health professionals to find sustainable ways to support patients, family members and each other, and renew their passion for the profession and confidence in themselves as nurses. HAT combines the ethos of inclusive, student-led, experiential and dialogical pedagogy typical of applied drama with techniques drawn from professional actor training to improve health professionals' understanding of and capacity for person-centred practice. HAT not only promotes a pragmatic approach to person-centred communication, but also helps learners to develop skills in advocacy, self-care and creating support networks.

This chapter will explore the impact of the recently completed HAT course, a 35-hour course for nurses working in telephone triage (or "tele-triage"), sponsored by the Public Health Agency (PHA) in Northern Ireland. The primary focus is to evaluate the outcomes of the course and how it supported the nurses' capacity for person-centred practice, wellbeing and resilience, including the potential for Post-Traumatic Growth.

Resilience and Nursing

The contemporary concept of resilience has grown out of "positive psychology", which not only looks at the negative impact of stress, but also potential positive outcomes from stressful experiences. According to Hunter and Warren, "resilience is the ability of an individual to respond positively and consistently to adversity, using effective coping strategies" (2013, 7). When a person has resilience, they can return to their normal baseline functioning after stressful events: "The ability to transform disaster into growth experience and move forward defines the concept of resilience" (Polk 1997, 8).

To develop resilience, one must encounter risk factors or negative experiences in order to build confidence, autonomy and adaptability. However, some challenges can seem insurmountable and outside of the power of an individual to control. Austerity policies and their effects on public services can be one such challenge; increased pressure due to staff shortages, overwork, insufficient support from colleagues, and insufficient emotional preparation for the job, can all have a negative impact on the

resilience of nurses (Çam & Büyükbayram 2017, 119).

Certain “protective factors” “seem to protect individuals from becoming overwhelmed by stress” (McAllister et al 2019, 1). “Internal protective factors” refer to personal qualities, such as self-appreciation, positive and realistic thinking, and a capacity to express one’s perspective and manage one’s emotions (Çam & Büyükbayram 2017, 118). Protective “external factors” include opportunities for supportive social communication and establishing intimate relationships with colleagues (Çam & Büyükbayram 2017, 119). Furthermore, Brennan identifies the crucial role of management and team leaders in improving the wellbeing and resilience of their staff (2017, 45).

Potential for Post-Traumatic Growth

The concept of Post-Traumatic Growth (PTG) has also emerged from the field of positive psychology, defined as a positive transformation which “occurs as a result of the struggle with traumatic or highly challenging life circumstances” (Tedeschi et al 2018, p. 3). Tedeschi and McNally devised a framework in which participants can understand their trauma response as a precursor for growth, through learning techniques to regulate their emotions, engage in safe self-disclosure to create a trauma narrative, and develop life principles that are robust to challenges (2011, 22).

Successful interventions to support such growth focus on the cognitive, behavioural and emotional levels and are characterised by three positive domains (Tedeschi et al 2018, p. 6). Firstly “relationships are enhanced in some way,” whereby people derive value, compassion and support from networks of peers, friends and family. Secondly, “people change their views of themselves,” whereby people increase their resilience through accepting their vulnerabilities and improving their self-esteem, confidence and openness to new experiences. Thirdly “people describe changes to their life philosophy” (Joseph et al 2012, 316) through interventions that renew their sense of purpose and core values.

Burnout and Exhaustion: an Impending Crisis?

On the other hand, an excess of stress and a lack of support in a professional environment can lead to burnout. Burnout is defined as a “psychological syndrome involving emotional exhaustion, depersonalization and feeling of reduced personal accomplishment” (Chen et al 2020, p. 104). Burnout leads to loss of motivation, a

depletion of personal resources and a loss of commitment to one's role (Tedeschi et al 2018, 189). Within the nursing sector, there are signs of an impending crisis in relation to burnout. Even prior to the COVID-19 pandemic, a study in the UK reported that up to 50.5% of nurses were feeling emotionally exhausted; up to 32% experienced depersonalization in the workplace and up to 29.9% experienced personal low accomplishment at work (Kinman et al 2020).

The effects of burnout on the resilience and retention of staff could be significantly detrimental to the health service. The RCN reported, in a study of 42,000 of its members across the UK, that over 36% of nurses were considering leaving the profession; 42% cited low staffing levels and another 42% cited a lack of management support as key reasons for leaving (2020).

Çam and Büyükbayram (2017, 124) call on health organisations to provide programmes for nurses to improve resilience, particularly through the creative arts. In particular, applied drama (discussed below) can make a significant difference to health professionals, as participants can shape and embody their own narrative, create active “coping strategies” and develop new perspectives that help them to withstand future challenges.

Person-Centred Practice and “Sympathetic Presence”

Person-centred practice is an approach to care that hinges on “the formation of therapeutic relationships between professionals, patients and their significant others...built on mutual trust, understanding and sharing collective knowledge” (McCance & McCormack 2006, 473). Person-centered practice includes recognition of the “personhood” of the practitioner, as well as the patient. The Person-Centred Practice Framework (PCPF) is an approach “that has an explicit focus on humanising health services and ensuring the patient/client is at the centre of care delivery” (McCormack et al 2015, 2). The framework addresses “macro” elements of the health sector, such as “the care environment” and “policy,” as well as “micro” processes, such as “providing holistic care” and “shared decision-making” (McCormack & McCance 2016; Jennings et al 2020). Though the PCPF is relevant on many levels, here we will focus on the “micro-process” of sympathetic presence.

Sympathetic presence is the “fabric that weaves together other person-centred processes” (McCormack & McCance 2010, p. 103) and focuses on the relational moment between the patient and the health professional. Sympathetic presence

describes “an engagement that recognises the uniqueness and value of the individual by appropriately responding to cues.” (McCormack & McCance 2016, 102). Sympathetic presence relates to “the art of ‘being’ with the person without the need to be ‘doing to’ the person” (McCormack & McCance 2016, 59). In other words, the nurse is “present” with the patient, actively listening and attending to how they feel, rather than trying to assume an empathic understanding of their physical or emotional state (Jennings et al 2020). This emphasis on “sympathetic presence,” as against generalized empathy, is a core principle of both the PCPF and the HAT approach.

Applied Drama

According to Helen Nicholson, the term “applied drama” describes “forms of dramatic activity that primarily exist outside conventional mainstream theatre institutions, and which are specifically intended to benefit individuals, communities and societies” (2005, 3). It is an umbrella term for a range of practices (including educational drama, community-based theatre, performance and conflict transformation, performance and health and so on) which “engage participants cognitively and emotionally” to develop networks and strategies for supporting social change and addressing shared problems (Baxter & Low 2017, 47). “The participants...are generally not skilled as actors, or any kind of theatre artists, but are brought together by a common concern” (Saxton & Prendergast 2013, 2), where the value lies in what the work does for the participants and their wider community.

Applied drama has proven effective as a tool to address people’s personal and social circumstances, to advocate for social change and to improve wellbeing. Saxton and Prendergast describe how applied drama practice can improve teamwork, communication, concentration and commitment (2013, 3). A plethora of other research has indicated improvements in self-esteem, confidence, advocacy, self-care and wellbeing through participation in applied drama (including Stuart-Fisher & Thompson 2020; Fancourt 2017; Baxter & Low 2017). Therefore, applied drama could have an impact on the resilience of nurses and other professionals, as it helps to improve both the internal qualities (self-esteem, confidence and coping skills) and external factors (peer support and improved relationships) that support resilience.

Applied drama practice has been heavily influenced by the “dialogical pedagogy,” or *Pedagogy of the Oppressed*, developed by Paulo Freire (2000), whereby “learners teach and the teachers learn” from each other, while examining the social and

political forces that shape their lives. Participants in applied drama are “experts in their own experience,” who are encouraged to build on their existing knowledge through sharing and exploring the circumstances of their everyday lives. The most direct influence of Freire on applied drama practice has been through the work of fellow Brazilian, Augusto Boal, who titled his groundbreaking book *Theatre of the Oppressed* in tribute to Freire (1979).

One of Boal’s techniques for turning dialogical pedagogy into activist performance is Forum Theatre, whereby audience members with personal experience of the issues presented in a play are encouraged to stop the action and join the performance, becoming “spect-actors” who can intervene and improvise alternative strategies for dealing with challenges. Although HAT does not currently present public performances, it uses Forum Theatre as a workshop technique for health professionals to support each other’s learning, in a process of “rehearsal for reality” (Boal 1979).

Applied drama has long been characterized by its commitment to access and inclusion for marginalized groups. Over the last few years, the “aesthetics of care” has emerged as a key discourse in applied drama. Initially suggested by James Thompson, the aesthetics of care describe arts practices that promote and apply an “ethics of care” (Stuart-Fisher & Thompson, 2020). As we shall discuss further below, HAT explores the ethics and aesthetics of care through applied drama approaches, in combination with techniques drawn from professional actor training, to improve person-centred practice and resilience among health professionals.

Actor Training

Health Action Training supplements the games and improvisations of applied drama with actor training techniques, to enhance the educational value of role play for training and assessment. In this context, “actor training” refers to techniques that actors and directors encounter as part of vocational training for professional theatre and screen performance. The main approaches to actor training explored in HAT are derived from the work of Michael Chekhov and Constantin Stanislavski. Stanislavski encouraged actors to understand what a character wants and feels at any given moment, to listen actively to themselves and others: “you have to listen to yourself in terms of your own inner activity (‘What’s this sensation I am experiencing?’) and at the same time you have to listen to your performance partners (‘What’s she saying? What’s he doing? And how do their words and deeds affect me?’)” (Merlin 2014, 36). The concepts of “Actions” and “Objectives”, developed by both Chekhov and

Stanislavski, can work as effective tools for clear communication. In acting and directing, “objectives are wants...an objective is what a character wants and is trying to obtain from the other characters” (Alfreds 2007, 70-71). In Stanislavski’s Method of Physical Action, actions are not simple activities, but transitive verbs intended to affect other people: “Actions are what characters do to try to achieve their objectives” (Alfreds 2007, 90). In HAT, instead of playing fictional characters, health workers learn to play actions and objectives so that they become more skilled, focused and comfortable in playing their own professional roles (Jennings et al 2020).

A focus on clear objectives (“What do I want to happen?”) and actions (“What am I going to do to make that happen?”) gives health professionals a clear pathway when dealing with patients or colleagues. We begin by identifying what we need or want from a situation, such as persuading a reluctant patient to attend hospital or take their medication. Then we ask ourselves: “What does the other person want that makes them resist our objective?”

Once an actor or professional person establishes clear objectives, they can then identify and rehearse, through improvisation, appropriate and effective actions to achieve their objectives. Actions (always transitive verbs) appropriate to professional healthcare communication may include: “to observe, to listen, to encourage, to advise, to support and to care”. We also need to consider that action causes reaction, so our actions must adapt and change in response to the reactions of others.

The HAT Approach

HAT uses “techniques drawn from actor training and applied drama to teach improved person-centred communication for health professionals” (Health Action Training 2021). Their practical philosophy is influenced by the “ethics of care” (Gilligan 1990; Held 2006; Tronto 2013; Noddings 2013), examining care relationships as a basis for a broader ethical approach to society, politics, and life. As James Thompson states, “a focus on care reveals a normative plea for a better and more caring world” (2020, 3).

HAT training also involves breathing techniques derived from yoga and martial arts, a common practice in actor training. Some of these breathing exercises are described in James Nestor’s book, *Breath: the New Science of a Lost Art* (2020). In HAT, breathing exercises are supplemented by voice training techniques for actors, such as those developed by Patsy Rodenburg (1991) and Kristin Linklater (1976). Improving and paying attention to breath can also make for better communication; a great deal

of non-verbal communication can be perceived from breath. “The breath does not lie”; it always already expresses our emotional and physical state, and sometimes our intentions. The breath is a visceral level of sub-text, communicating unspoken information about how we are feeling and what we want.

“Positive regard” is also a key aspect of HAT’s process, as participants share examples of successful communication in their own professional experience. These are then explored through a Forum Theatre approach, as participants are encouraged to play different roles within the scenario, not just their own - multiple participants can intervene and interact to change the outcome of the scenario (Boal 2008, 23). Participants identify, rehearse and reflect on occasions when they have been able to overcome significant professional challenges, taking pride in their accomplishments and learning to transfer successful strategies to other situations.

Graduate certificate in Health Action Training (HAT for Telephone Triage)

HAT offers a range of short and long training courses, such as *Mental Health OSCE Prep, Coping with Covid: Resilience and Growth, and Introduction to the NHS* for internationally recruited staff. The company also gives participants the opportunity to become HAT trainers themselves, through completion of two advanced courses (*Issues in Health Communication and Teaching and Assessing for HAT*). On successful completion, Health Action Trainers receive an Advanced Diploma in Facilitation for HAT and are qualified to deliver the introductory 35-hour course for the Graduate Certificate in HAT, as well as some of the shorter courses. The Graduate Certificate is accredited by the RCN and the CPD Standards Office (UK).

This chapter will focus on the outcomes of a Graduate Certificate in Health Action Training course, provided by the PHA in Northern Ireland, for nurses working in telephone triage (or tele-triage). The tele-triage course involved six weekly sessions of five or six hours each, within a programme of 36 hours’ contact time, in early 2021.

Tele-triage is “a process where calls from people with a healthcare problem are received, assessed and managed by giving advice or referring them to a more appropriate service” (Bunn et al 2005, p. 956). Tele-triage involves advanced skills in “[p]rioritising client’s health problems according to their urgency, educating and advising clients and making safe, effective and appropriate decisions” (Pygall 2017, 2).

There are many advantages to this service, as it saves costs, can be more convenient

and accessible, even providing opportunities for patient empowerment (Pygall 2017). However, nurses can struggle with telephone triage, as they have no opportunity to assess their patient visually. According to Pygall, 55% of face-to-face communication depends on body language and non-verbal communication (2017, 28).

However, there are some disadvantages, such as “third party” calls, which can be risky and difficult, involving multiple individuals and often family members. Nurses might have to rely on family members for an accurate history, while the lack of visual cues can also lead to misdiagnosis. Also, there are significant time constraints placed on tele triage nurses which can often lead to further stress.

As Pygall points out “we need mandatory formal training in dealing with patients over the phone. It’s one of the riskiest areas in which we can work and yet most practitioners haven’t had any training” (2017, ix). Since the onset of the COVID-19 pandemic, tele-triage has played an increasingly significant role in health practice, as it can minimize the close contact aspect of triage. However, the challenges of tele-triage can contribute to the stress experienced by nurses. Therefore, the need for effective tele-triage training has become even more urgent.

Modes of Assessment

The course recruited seven nurses, working alongside the five drama students and three established applied drama practitioners (including a teacher of secondary school English and drama and a Senior Lecturer in Applied Theatre from a UK university). Participants on the HAT graduate certificate course were assessed through performance of a role play scenario, based on actual clinical incidents of challenging tele-triage communication, followed by a *viva voce* oral assessment. In the role play scenario assessment, the candidates devised and performed scenarios that realistically depicted difficult encounters in the workplace, drawing on their own experiences. This assessment required candidates to demonstrate “sympathetic presence” and other communication skills (such as their ability to identify audible cues and symptoms in the way a caller speaks or breathes) to assist “patients” and family members to agree the best course of action to address their problem.

The second part of the assessment (the *viva voce*) was a reflective discussion on the value and significance of the practices encountered in the course, with reference to relevant reading and research. The *viva voce* is part of the reflective praxis of the course, offering candidates the opportunity to reflect on the relevance of the drama

techniques to their learning and professional practice.

Evaluating the Impact

HAT is dedicated to rigorous evaluation of their courses, assessing the short, medium and long-term impact on participants' communication skills and resilience. Five students of the BA Honours (Drama) programme at Ulster University (Coffey, Connolly, Hughes, Murphy and Taylor) conducted ethnographic research on the project for their final year dissertations and supported HAT staff (Deeny, Jennings and Tizzard-Kleister) in the collection and analysis of various forms of data for evaluation. These included: ethnographic participant observation; one-on-one interviews; a focus group interview conducted six weeks after the completion of the course; and pre- and post-test quantitative surveys with validated questionnaires.

The questionnaire-based instruments used were the Connor-Davidson Resilience Scale (CD-RISC, Connor & Davidson 2003) and the Person-Centred Practice Inventory-Staff (PCPI-S, Slater et al 2014). The qualitative evaluation methods were derived from the field of “non-applied ethnography,” an appropriate approach to research in the field of performing arts practice (Kruger 2008, 58).

Ethnography lends itself to the study of beliefs, social interactions and behaviours in small groups and societies (Naidoo 2012, 1). It is also an apt method for research in health care as it has the “potential to explore complex issues such as shaping the context of care and the nature of care provided” (Savage 2006, 31). Due to the wide variety of findings, there is not enough space in this context to discuss these findings in depth. Rather, this chapter will attempt to summarise some of the key findings, indicating the potential impact of further research and practice.

Findings and Discussion

First Impressions: Quotes from Course Evaluation (Deeny, 2020)

On 26 March 2021, all of the participants in the course filled out a standardized course evaluation, an anonymous questionnaire to assess their level of satisfaction with the delivery and impact of the course. The feedback from this evaluation was highly positive. One nurse found the course to be unique in her experience, as a form of communication training that was practical, collaborative and inspiring: “A completely different way of looking at things that I never would have been taught

before...The drama work gave me confidence.” The training was described as improving competence, as well as confidence: “I was able to focus better...Because I was more focused, I felt more competent.” Such comments, as well as verbal feedback during taught sessions, indicated that participants valued the knowledge sharing and professional validation associated with “dialogical pedagogy” (Freire 2000), whereby each learner was respected as an expert in their own experience, of equal status with peers and trainers.

Another nurse found the training approach to be more “humane” than any previously encountered: “HAT inspired me for the future of nurse training. More hands-on humane training.” Describing the training as “hands on” acknowledges the practical value of experiential learning. The use of terms like “humane” reflects the safe and supportive learning environment, in line with an “aesthetic of care.”

The course included nurses with a wide range of levels of experience, from practitioners with decades of professional work and training, to early career nurses who had only recently registered. While the comments above came from more experienced nurses, one younger participant felt that this training was particularly helpful for early career nurses: “As a newly qualified nurse I found this approach to communication training invaluable.” Again, this reflected the value of a peer-to-peer, dialogical learning process.

Person-centred Practice Index (PCPI) results

As we can see from the table breaking down the results of the PCPI survey, the biggest changes were in the categories of power sharing (20%), improved interpersonal skills (17.25%) and shared decision making (16%). The areas of least change were being committed to the job (5%), and working with patient’s beliefs and values (2.5%). That is most likely due to the scores being so high in test 1 (known as the “high ceiling effect,” where there are a large proportion of responses at the highest end of the scale). Though this data is not statistically significant as sample sizes are low (n=5), and the scores are self-reported, these results are highly encouraging and indicate the potential of HAT to enhance person-centredness.

FACTORS	Test 1	Test 2	Change	%
PRE REQ				
Professionally Competent	4.08	4.73	0.65	13.00
Developed Interpersonal Skills	3.94	4.80	0.86	17.25
Being Committed to the Job	4.55	4.80	0.25	05.00
Knowing Self	3.83	4.47	0.63	12.67
Clarity of Beliefs and Values	3.75	4.40	0.65	13.00
THE CARE ENVIRONMENT				
Skill Mix	4.58	4.87	0.28	05.67
Shared Decision - Making Systems	3.56	4.30	0.74	13.75
Effective Staff Relationships	3.58	4.27	0.68	13.67
Power Sharing	3.50	4.50	1.00	20.00
Potential for Innovation and Risk Taking	3.67	4.27	0.60	12.00
The Physical Environment	2.67	4.33	0.67	13.33
Supportive Organisational Systems	3.45	4.04	0.59	11.80
CARE PROCESSES				
Working with Patients Belief and Values	4.38	4.50	0.13	02.50
Shared Decision-making	4.00	4.80	0.80	13.00
Engagement	4.08	4.60	0.52	10.33
Having Sympathetic Presence	4.08	4.67	0.58	11.67
Providing Holistic Care	4.33	4.80	0.47	09.33
Total	3.94	4.53	0.59	11.76

Table 1

In the midst of these percentage increases, there are some informative changes in response to specific individual questions. Before the course, only one participant answered “strongly agree” to any of these statements: “I pay attention to how my non-verbal cues impact on my engagement with others”; “I have the necessary skills to negotiate care options”; and “I use different communication techniques to find mutually agreed solutions.” After the course, 80-100% of nursing participants “strongly agreed” with these statements. This highlights how candidates had become more confident in and reflective on their communication skills after taking the course.

Connor-Davidson Resilience Scale (CD-RISC) and potential PTG

The results from the Connor-Davidson Resilience Scale (CD-RISC) suggests an overall rise of 15.4% in the resilience scores of the health professionals after completion of the course. If we look at these results in more detail, there are specific rises in the areas associated with PTG and resilience, such as job accomplishment and job purpose. The mean scores rose from 3% to 5% when participants were asked about “taking pride in their professional achievements.” The mean also rose from 3.8% to 4.8% when the participants were asked if they had a “strong purpose in life.”

This statistical information becomes humanised when examined alongside richer descriptions of the experience of participation. The next section of the chapter quotes from the ethnographic research of one of the drama students, Darcy Taylor:

Research Presentation on HAT, Resilience and PTG for Nurses
(Taylor, 2020)

I played a patient who had mental health issues and wanted to leave the hospital. A nurse within the group played a nurse trying to keep me in the hospital...

It became very intense and made the group realise that, when dealing with such difficult issues, a practitioner has to be aware of their own wellbeing and mental state to successfully stay calm and resilient to practice centred person care...

One of the things that we regularly discussed, and all touched upon in our viva, was the team support that we felt and exhibited towards one another. We felt confident that we were going to support one another and therefore we were able to allow ourselves freedom to play in our rehearsals and in our performance.

One of the nurses commented, in an interview, that taking part in the course had taught her how to move away from a task-based, mechanistic approach. Sometimes she had noticed herself performing clinical tasks on ‘auto-pilot’, whereby ‘you forget about yourself. You just go and do the job. Sometimes, you’re not

even thinking about your own mental wellbeing' (Participant C Interview, 29th March 2021). This had changed to an approach where she was more attentive and sympathetically present, to both patients and peers, with a concomitant improvement in her own wellbeing and resilience.

The ability to reflect on our actions, and our cognitive and emotional responses to challenging situations, can be a positive tool in building resilience and the potential to develop PTG...one of the key factors in both resilience and PTG is the acquisition v of new knowledge and changing perspectives. In this case, I would argue that the viva voce at the end of the course is a very effective method, as participants reflect on the readings and materials provided, the exercises used throughout the course and finally their own performance. A key element of resilience is the ability to understand these abstract concepts and implement them in everyday life. The mixed pedagogical approach that HAT utilises can provide a framework for this.

Focus group interview

The Drama students, with the support of Tizzard-Kleister and Deeny, conducted a focus group on Thursday 6 May 2021, 6 weeks after the course had finished. One nurse passionately expressed the view that the course had "renewed her sense of purpose and reminded her why she wanted to be a nurse" (Participant C). Several participants stated that they had found the acting techniques (such as actions and objectives) to be particularly useful in professional practice. Three participants commented that, since completing the training, they had consciously identified clear and appropriate actions and objectives in work-based communication, both with patients and other members of staff, which had improved their communication skills and confidence: "Actions and objectives are helpful outside of tele-triage, even communicating with other nurses" (Participant C). Another participant found themselves "consciously doing actions and objectives" in their personal life (Participant B).

One nurse discussed how these skills could be applied when communicating with their peers: "[When] communicating with other nurses, perhaps about their frustrations...you have to take a step back and think where is this going? How can I manage this situation without becoming frustrated myself? I found actions and

objectives helped you work with your team and your work mates, just as much as patients” (Participant A). Another participant highlighted a renewed sense of accountability in communicating with patients: “HAT has taught me, from a communication POV, how to gain accountability back on myself in a health setting...really thinking and really listening to the patient” (Participant C). This same participant explained that actions and objectives had become essential to their approach to communication; when they did not set an objective, they found that their communication was less effective: “I think it’s a more mature way to approach a conversation” (Participant C). Another participant stated “Before this course, I would have kind of followed a script [during telephone triage]. And that’s not the way you should communicate with people. There are other factors you have to bring in to it” (Participant B). Another nurse said that they found HAT exercises exploring the embodiment of emotions helpful, because it helped them to understand how other people are feeling and to practise “sympathetic presence” (Participant A).

All of the participants agreed that they valued the experiential and dialogical approach to learning, through techniques such as Forum Theatre. Drama participation helped with personal confidence: “Before I would have been very nervous making phone calls not knowing what to expect, but with this you can just take the time...The drama work gave me confidence” (Participant B). All participants agreed that the course helped them to develop skills in active listening: “You get told about the importance of listening but not how to listen...The training has opened my eyes and communication has improved” (Participant B)

Breath exercises and voice training

Relaxation, mindfulness and breathing techniques received some of the most positive feedback from the participant nurses. Every session started with breathing exercises, such as “coherent breathing” and “alternate nostril breathing” (Nestor 2020). As Brennan comments, engaging in these practices has been “associated with decreased levels of stress among health workers” (2017 45). In a state of relaxed presence, an individual is far better equipped to care for others, “being in the present, as accepting or observing” in a calm manner, and this can allow an experience to become less overwhelming (Childs 2007, 367).

In the focus group, one participant acknowledged that the breathing and yoga elements of the course helped to keep them grounded, stressing the importance of taking a step back to breathe: “if you are calm and collected, you can focus on the

patient at hand.” (Participant B). Another nurse had found a wider array of situations in which to apply the breathing exercises: “I went for an interview and I was waiting outside the room. So just as I sat, I was doing my breathing exercises to slow my heart rate down” (Participant A).

Some of the nurses identified that the breathing and voice exercises also gave them increased confidence to advocate for their interests and those of their patients and colleagues: “You started to understand how powerful your voice can be” (Participant C). One nurse found different voice techniques helpful when dealing with controversial conversations, sometimes increasing the “power dynamics” in their voices when they wanted to get their point across, at other times noticing when it was more effective to maintain a lower vocal “power dynamic.”

Conclusion - HAT Helping to Address the Crisis in Communication and Resilience

Data from the 2018 NHS Staff Survey showed that 43.5% out of 127,564 registered nurses and midwives in England reported feeling unwell due to work-related stress (Kinman et al 2020, 12). Over 36% of surveyed nurses were considering leaving the profession. Recent findings show that while 74% of respondents have felt more valued by the general public during the early stages of the pandemic, just 18% said they felt more valued by the government (RCN 2020b). Meanwhile, poor communication continues to be the most significant basis of patient complaints internationally: communication (53 percent); long wait times (35 percent); practice staff (12 percent); and billing (2 percent) (Advisory Board, 2016).

This research suggests that HAT can support resilience and person-centred practice of health care workers, by improving their communication skills, providing them with a support network and increasing their confidence in their professional practice. Participants reinforce their sense of agency and accomplishment as they work through scenarios drawn from professional experience. They also explore risk and vulnerability in a supportive group of peers, discussing their thoughts and feelings around difficult issues. HAT courses are spaces in which an aesthetic of care is practiced and enhanced through dialogical pedagogy, and vice versa, creating a virtuous cycle of caring and learning.

Some of the course participants had experienced burnout themselves, and had left or were planning to leave the profession. They have since stated publicly that they were inspired to return to nursing after participating in HAT (Nursing Now Webinar

2021.). They also said that they had developed the confidence and advocacy skills to stand up for themselves and colleagues when being mistreated by management.

It is clear from the small samples of data provided that HAT successfully improved the interpersonal skills of the nurses who participated in the tele-triage course. HAT can provide the skills required to deal with patients and colleagues effectively, through an understanding of breath, voice, presence, attention, subtext and conscious action. The establishment of a creative space of mutual trust and positive regard facilitates, and is facilitated by, relational processes of dialogical pedagogy and care aesthetics in both applied drama and health practice. This methodology can improve person-centred communication and resilience for health workers, while encouraging post-traumatic growth by fostering supportive relationships, improving self-esteem and renewing participants' sense of purpose.

On the other hand, McCormack and McCance (2016) emphasise the importance of the macro-systemic level of care, including state policy, organisational culture, trusts, hospitals and educational institutions. The challenges that the health sector faces cannot be addressed by individual nurses alone, even within supportive networks. The work of HAT has achieved great success so far, but only so much can be done at the level of interpersonal communication and self-care. The next step must be to bring about systemic, person-centred change within the sector as a whole.

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