

# Practicing (with) Care

Exploring care at work in healthcare  
in Aotearoa - New Zealand

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### **Attestation of Authorship**

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

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Auckland University of Technology Ethics Committee (AUTEK) approval for the research was gained on 11 October 2024 as the nature of my project required attention to ethics in its design and practice (approval no. 24/268). Te Whatu Ora – Health New Zealand approval was given for research within the organisation.

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# 00. Abstract

This design-led research explored ‘care at work’ as whakawhanaungatanga with a group of healthcare professionals in Aotearoa – New Zealand. Through an Appreciative Inquiry approach (participatory action research) we collaborated to empathise with notions of ‘care’, create space for appreciating what works and imagining how ‘care at work’ in a compassionate healthcare system could be. Participant engagement in the co-creation process online was facilitated through practicing whakawhanaungatanga and utilising creative methods, design thinking tools and processes. This informed the creation of a prototype facilitation toolkit for practicing co-creation with care. This contributes to emerging conversations around care and compassion at work in healthcare and the contribution of design for well-being at work. Care at work is complex and evolving – the potential for proactive connection and care could be facilitated through imagining, designing and practicing in more relational, inclusive and responsive ways of working.

# 01. Introduction



a person in place

a moment



to pause

a transition

Figure 1 - a moment in time.

## Here I Am

*a person in place*

I am a woman in her 40s, a mother to one, a partner to an adventurer. Am I along for the ride?

I am part of a blended family

... connected to Aotearoa – New Zealand, Tūhoe<sup>1</sup>, Australia, Scotland, England and more I'm yet to learn about

... Mum, Dad & Linda, Nana & Grandad, brothers, and my partner's family

... I miss koro, Lester, Dardy, Nana Low, Grandad, and Dad...

Dad died in 2021. My daughter was born in 2018. 2020-2021, Covid hit and I was...

... on maternity leave

... trying to study and complete a research project

... taking care of things, and

... returning to teaching, remotely at first...

We navigated the Aotearoa – New Zealand health system when Dad got sick, and when he died during a Covid lockdown, I couldn't see my family... it was a struggle to have the last moments with him...

... a couple of years later, in 2023, I left teaching, after more than 10 years.

It is now or never I thought, take a leap!

In grief – I see opportunity – and I feel tension.

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1. Tūhoe iwi (people) and the Urewera whenua (land), in Aotearoa - New Zealand

I am creative, curious, and I acknowledge I am careful. I value integrity and humility. I love to learn. Before teaching I studied a Bachelor of Science, majoring in Sport and Exercise Science.

While teaching full-time, in 2012, I completed a Master of Professional Studies – exploring identity & subjectivity in ‘active oldies’... I could have called it ‘moving in and through life’...

On a study award, in 2020, I learned about kaupapa Māori<sup>2</sup> approaches to health – making sense of health & well-being through a te ao Māori (Māori worldview) lens. I interviewed interesting people doing interesting things, hauora / well-being practitioners / researchers in this space.

I was inspired by them in many ways...especially Dr Teah Carlson<sup>3</sup>, she encouraged me to practice whanaungatanga<sup>4</sup> and to see hauora (Māori concept of holistic health & well-being) in connected ways – as a way of living, “not like the ‘health’ she learned about at Uni<sup>5</sup>”.

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2. Māori are the people indigenous to Aotearoa – New Zealand.

3. Te Whānau ā Apanui, Ngati Porou, Waikato-Tainui, artist, academic, researcher and evaluator at Massey University. Among other identities, she refers to herself as a ‘story catcher / teller’.

4. Whanaungatanga is described as ‘relationship, kinship, connection’ in Teah Carlson et al., “Whanaungatanga: A Space to Be Ourselves,” *Journal of Indigenous Wellbeing*, 1, 2 (2016): 44–59. [https://journalindigenousewellbeing.co.nz/journal\\_articles/whanaungatanga-a-space-to-be-ourselves/](https://journalindigenousewellbeing.co.nz/journal_articles/whanaungatanga-a-space-to-be-ourselves/)

5. This is a quote from my unpublished interview with Teah in 2020.

She also spoke of deep, embodied listening, ‘whakarongo, whakarongo, whakarongo’<sup>6</sup> and what she’d learned from studying a chant by Te Whanau-a-Apanui/Māori elder Eruera Sterling. She inspires me to explore how I might develop connection and creative communication in my practice.

Te Miri Rangi, Deborah Heke, Hana Tapiata, Wiremu Gray & Kayla Atkins-Gordine, along with Renei Ngawati (Toi Tangata), I give thanks, to their generosity and spirit.

Since leaving teaching, I’ve moved homes, started a well-being support business and now... I am here.

Ready for the next part of my journey.

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6. Whatumanawa - listen with your mind’s eye (logic), Manawa - listen with your heart (emotions), Pūmanawa - listen with your puku (intuition). Tākuta Teah, Whakarongo, *Turama Practise*, October 30, 2020, <https://turamapractise.com/2020/10/30/whakarongo/>

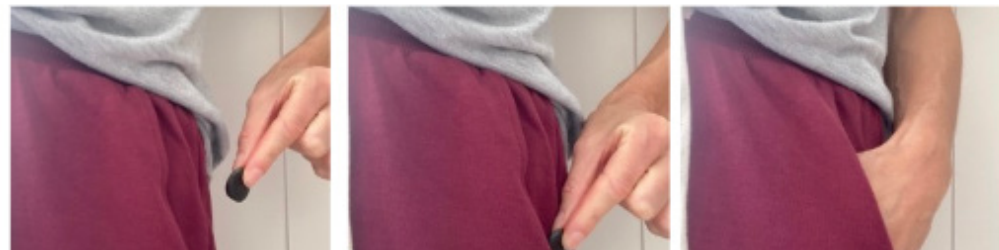


Figure 2 – ‘a touchstone for my pocket’

*a moment to pause*

to make sense of and appreciate where I’m at and where I might go next

...to dream, imagine  
 ...to play a bit (adults don’t do it enough)  
 ...to connect with people & ideas.

I want to explore my values in action, a new way of working, practicing and being.

As I imagine a future for my professional life, I wonder what I might hold on to, carry forward (see Figure 2), & leave behind, from my teaching and learning practice.

I’ve experienced whanaungatanga, felt the care and, I’ve noticed when I felt disconnected and uncared for. The contrast draws me in.

I wonder how I might facilitate care, connection, communication and collaboration in an evolving professional practice.

*“Connection is the energy that exists between people when they feel seen, heard, and valued.*

*When they can give and receive without judgement; and when they derive sustenance and strength from the relationship”.*

Brené Brown (2022)<sup>1</sup>

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<sup>1</sup> Brené Brown, <https://brenebrown.com/art/tgoi-connection/> from Brené Brown, *The Gifts of Imperfection*, 10th anniversary edition, (Hazelden Publishing, 2022). I am inspired by author and researcher Brené Brown’s work in emotional literacy, vulnerability and courage, also found in this book, Brené Brown, *Atlas of the Heart: Mapping Meaningful Connection and the Language of Human Experience* (Random House, 2021).

*a transition*

I am taking a step forward, into uncertainty, eager to discover what I might bring to new places & spaces. I wonder about the possibilities that exist at the intersection of care at work and well-being, in Aotearoa – New Zealand (Figure 3), and how I might contribute through a co-design for health and well-being practice.

Human-centred design acknowledges the power of connection and creativity. Making sense intellectually has been a strength in my professional practice, I want to explore more relational and embodied ways of knowing and connecting to community.

I endeavour to create a safe space for change.

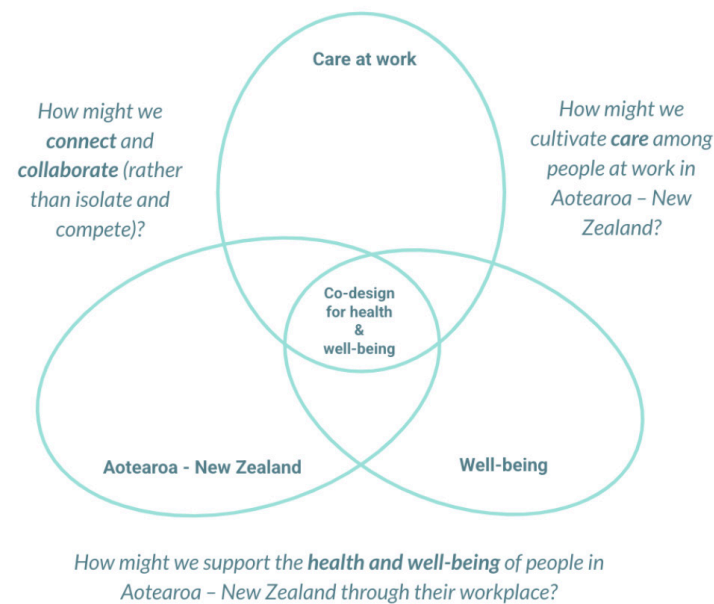


Figure 3 – Positioning co-design for health and well-being

*Practicing design research in healthcare in Aotearoa - New Zealand*

This practice-led design research project explores how a design approach of care and collaboration – alongside healthcare professionals – might support us to explore 'care at work' among colleagues working in healthcare in Aotearoa – New Zealand and inform the development of a transferable co-creation toolkit for engaging 'carefully' with diverse workers and work environments.

Practicing design/research in Aotearoa - New Zealand comes with a responsibility to honour Te Tiriti o Waitangi<sup>1</sup>. I am mindful of how I engage with research participants, care for, and share the learning that emerges from this project.

I hope to contribute to an Aotearoa - New Zealand that is equitable and inclusive.

*“The country has not yet faced its history. There’s a lot of talk about settling the Treaty, but treaties aren’t meant to be settled, they’re meant to be honoured.”*

Moana Jackson (2022)

*“Colonisation is a complex culture and a complex process of maintaining power imbalances. When power imbalances are entrenched, as they are in this country, then all the other inequities and imbalances follow, whether it’s in health or education or whatever.”*

Moana Jackson (2022)<sup>2</sup>

In Aotearoa – New Zealand, access to healthcare is inequitable and clinical engagement can seem to focus on health consumerism rather than communication and connection<sup>2</sup>. While bureaucracy in our health system drives towards outcomes, 'care' sits in relationships between people<sup>3</sup>.

<sup>1</sup> Heather Came, “Institutional Racism and the Dynamics of Privilege in Public Health.” (Unpublished doctorate, Hamilton, Waikato University, 2012), <http://researchcommons.waikato.ac.nz/handle/10289/6397>;

<sup>2</sup> Carlson, “Whanaungatanga”

<sup>3</sup> Sophie Baguley et al., “More than a Feeling? What Does Compassion in Healthcare ‘look like’ to Patients?” *Health Expectations* 25, 4 (2022), <https://doi.org/10.1111/hex.13512>.

I wonder how these tensions might be navigated towards a better future, for all people in the healthcare system, users and providers alike. This research focuses on how we might navigate change with care, and cultivate a culture of care among colleagues working in healthcare.

‘Te Mauri o Rongo - The New Zealand Health Charter’, underpinned by Te Tiriti o Waitangi principles, guides the health sector to ‘care for the people who care for the people’. Through five ‘pou’ (posts), concepts and terms from te ao Māori (the Māori worldview), it states how healthcare organisations and workers are expected to relate to each other<sup>4</sup>.

*‘Te Mauri o Rongo’, the te reo Māori (Māori language) name given to the New Zealand Health Charter, translates to ‘The lifeforce of humanity’*

Te Whatu Ora - Health New Zealand

I wonder how these ‘pou’ might be brought to life in safe spaces for engaging with Māori ways of knowing, relating and being?

Awareness of Māori ways of thinking and acting open the door for more connected, inclusive and equitable ways of promoting well-being and practicing care in New Zealand<sup>5</sup>. Interacting with this mātauranga (Māori knowledge) safely, especially as tauwiwi (people who are not Māori), requires care and consideration. Care is needed to promote understanding, appreciation, and invitation, while respecting the culturally located mātauranga.

Exploring how people working in healthcare think and interact in their work environment is an effective<sup>6</sup> and responsible<sup>7</sup> way to affect relational and transformational change from within a system<sup>8</sup>.

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4 Te Whatu Ora - ‘Te Mauri o Rongo’ translates to ‘The lifeforce of humanity’. Te Whatu Ora, “Changing the System,” 30 June 2024, <https://www.tewhatauora.govt.nz/corporate-information/our-health-system/organisational-overview/changing-the-system>

5 Teah Carlson, et al., “‘You Can’t Really Define It Can You?’ Rangatahi Perspectives on Hauora and Wellbeing.” *Journal of the Royal Society of New Zealand* 52, no. 4 (August 8, 2022): 409–25. <https://doi.org/10.1080/03036758.2022.2074060>.

6 Carlson, “Whanaungatanga”

7 Sandy Kerr et al., “Kaupapa Maori Action Research to Improve Heart Disease Services in Aotearoa, New Zealand,” *Ethnicity & Health* 15, no. 1 (February 2010): 15–31, <https://doi.org/10.1080/13557850903374476>.

8 Pennie G. Foster-Fishman and Erin R. Watson, “The ABLe Change Framework: A Conceptual and Methodological Tool for Promoting Systems Change,” *American Journal of Community Psychology* 49, no. 3–4 (June 2012): 503–16, <https://doi.org/10.1007/s10464-011-9454-x>

*“Design thinking is an approach adopted to generate creative ideas and solutions that enhance human well-being, encouraging us to embrace listening and ask better questions in situations that involve ambiguity and uncertainty.”*

Ku & Lupton (2020)<sup>9</sup>

Design thinking offers a way to navigate positive change in our health system, within a complex and uncertain socio-political climate. It invites humanity while moving towards solutions and possibilities.

In this design research, potential leaders in healthcare were invited as participants and collaborators; they shared their lived experiences and explored what ‘care’ looks and feels like among colleagues in the Aotearoa – New Zealand healthcare setting.

Parallel to this, I reflected on my development as a ‘fledgling’ designer in the context of care at work in healthcare, in the Design for Health and Wellbeing discipline.

In this way, we explored what mattered in relational and compassionate ways of working together.

This design research aimed to explore a novel approach to building empathy and collaboration while creating space for unpacking and empathising with notions of ‘care’ and connection at work, among colleagues working in healthcare.

This involved

- Exploring potentially new ways to think about caring connections at work as whakawhanaungatanga
- Exploring creative methods, design thinking tools & processes for building empathy & collaboration online

This informed the design of a facilitator toolkit for engaging ‘carefully’ in co-creation, in diverse workplace settings.

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9 Bon Ku and Ellen Lupton, *Health Design Thinking: Creating Products and Services for Better Health* (Cooper Hewitt, 2020).

## **02. Contextual Review**

## Working with Care and Compassion in Healthcare

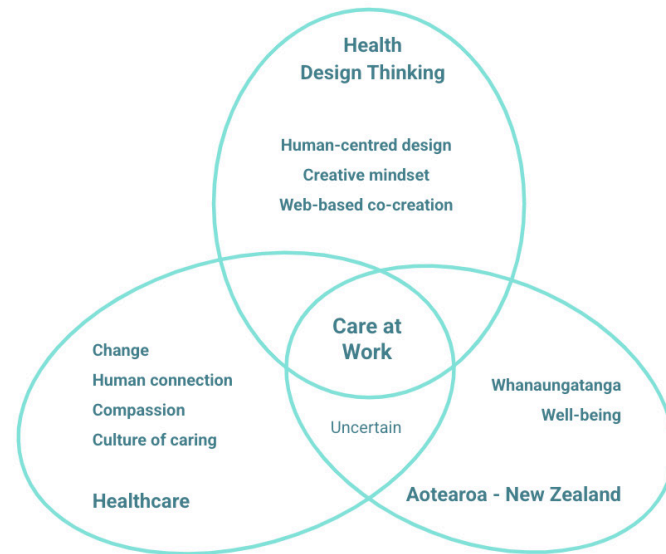


Figure 4 – Contextual Map

In the last couple of decades, health paradigms have shifted. The focus has moved from a reductionist view that centres illness and treatment to an emphasis on maintaining well-being and equipping individuals with the knowledge and tools to live well<sup>1</sup>.

This shift opens opportunities to explore proactive ways of caring and connecting, without suffering as a prerequisite. This chapter reviews the context (see Figure 4), how people working in healthcare might connect and work together in caring and compassionate ways to deliver care, promote collegial well-being, and contribute to a culture of care at work. Attention is given to the Aotearoa - New Zealand context, the recent changes in our health system and the potential of conceptualising ‘care’ as ‘whakawhanaungatanga’. Finally, the novel approach to exploring care through co-creation online with healthcare professionals is outlined.

Currently, hospitals worldwide are under-resourced during increased demand, and healthcare providers are often under strain, with concerns of burning out<sup>1</sup>. A study into our Aotearoa – New Zealand’s workforce, showed that medical doctors were the most at risk of burnout<sup>2</sup>. The critical factor for lowering burnout risk was found to be ‘psychological safety’ among teams, where members feel safe to take risks, express ideas and concerns and admit to mistakes.

Trzeciak et al. (2017), hypothesise that ‘compassionate care’ - healthcare provided in a compassionate manner - is more effective than healthcare provided without compassion, with benefits to patients (better outcomes), healthcare systems and payers (lower costs), and healthcare providers (lower burnout)<sup>3</sup>. Through an emerging field of compassion science in healthcare, called ‘compassionomics’, they propose that human connection can provide distinct and measurable benefits.

According to Benevene, et al. (2022), developing and sustaining compassionate cultures is essential for transforming workplaces to promote human happiness and wellbeing. They also state that compassion is a fundamental human orientation that underpins belonging and psychological safety<sup>4</sup>.

<sup>1</sup> David Rothenberger, “Physician Burnout and Well-Being: A Systematic Review and Framework for Action,” *Diseases of the Colon & Rectum* 60, 6 (June 2017): 567–76. <https://doi.org/10.1097/DCR.0000000000000844>.

<sup>2</sup> Massey News, “Medical doctors most at risk of burnout in New Zealand’s workforce”, *Te Kunenga Ki Purehuroa [Massey University]*, Monday 17 April 2023, <https://www.massey.ac.nz/about/news/medical-doctors-most-at-risk-of-burnout-in-new-zealands-workforce/>

<sup>3</sup> Stephen Trzeciak, et.al., “Compassionomics: Hypothesis and Experimental Approach,” *Medical Hypotheses* 107 (September 2017): 92–97. <https://doi.org/10.1016/j.mehy.2017.08.015>.

<sup>4</sup> Paula Benevene et al., “Editorial: Compassion and Compassionate Leadership in the Workplace.” *Frontiers in Psychology* 13 (December 9, 2022), <https://doi.org/10.3389/fpsyg.2022.1074068>.

<sup>1</sup> Paul Chamberlain and Claire Craig, “Design for Health: Reflections from the Editors,” *Design for Health* 1, 1 (January 2, 2017): 3–7, <https://doi.org/10.1080/24735132.2017.1296273>.

Trzeciak et al. (2017) propose that amplification of leadership behaviours, and the positive emotions and behaviours in and among healthcare providers, contribute to creating a ‘compassionate emotional culture in a healthcare system’. This is described as a “broaden and build”, or “elevation” approach<sup>5</sup>.

According to Wei et al. (2019), ‘a caring culture’ among members of interprofessional healthcare teams contributes to positive outcomes for both users and providers of healthcare<sup>6</sup>. Strategic leadership and efforts of all team members to build caring relationships can result in creating a sense of belonging, and a base for team members to trust, respect and collaborate with each other<sup>7</sup>. A ‘culture of caring’, was referred to as “human connections, which met the needs of healthcare professionals from humanistic and professional perspectives and motivated them to work together and perform at their highest professional level”<sup>8</sup>.

Fox et al. (2024) studied ‘team care’ for care teams - the relational and compassionate dimensions of collaboration and teamwork in teams providing healthcare<sup>9</sup>. They observed that communication practices of sharing, supporting, and leading with compassion (deep listening and responding with empathy), could alleviate healthcare worker suffering and promote well-being.

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5 Trzeciak, “Compassionomics”

6 Holly Wei et al., “The Current Intervention Studies Based on Watson’s Theory of Human Caring: A Systematic Review,” *International Journal for Human Caring* 23, 1 (March 1, 2019): 4–22, <https://doi.org/10.20467/1091-5710.23.1.4>.

7 Holly Wei et al., “A Culture of Caring: The Essence of Healthcare Interprofessional Collaboration.” *Journal of Interprofessional Care* 34, 3 (May 3, 2020): 324–31, <https://doi.org/10.1080/13561820.2019.1641476>.

8 Wei, “Culture of Caring”: p. 328

9 Stephanie Fox et al., “Team Care for the Care Team: A Scoping Review of the Relational Dimensions of Collaboration in Healthcare Contexts,” *Health Communication* 39, 5 (April 15, 2024): 960–71, <https://doi.org/10.1080/10410236.2023.2198673>.

Mete et al. (2022) showed that a focus on clinical leaders’ well-being and development, in areas such as emotional intelligence, social awareness and team communication, impacts leadership effectiveness and stands as a strategy to improve wellness and reduce burnout among physicians<sup>10</sup>.

For effective action, Shanafelt, et al. (2023) state that efforts at the work unit level (department, division, hospital ward, clinic), supported by a system-level approach, are necessary to address many of the specific day-to-day issues that drive clinician well-being, within each specialty and occupation<sup>11</sup>. Along with addressing healthcare system-wide issues and resourcing individual clinicians, Shanafelt et al. (2023) highlight the importance of collective team responses to address the variability and unique needs of different work units. The solution for physician well-being doesn’t lie in more self-care but in changes to the environment of the organisation in which the health professionals work<sup>12</sup>.

In this research project, I met with potential leaders working in healthcare to understand how they see ‘care at work’ and to explore how it might be enhanced within the Aotearoa – New Zealand health system.

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10 Mihriye Mete et al., “Impact of Leadership Behaviour on Physician Well-Being, Burnout, Professional Fulfilment and Intent to Leave: A Multicentre Cross-Sectional Survey Study,” *BMJ Open* 12, 6 (2022), <https://doi.org/doi:10.1136/bmjopen-2021-057554>.

11 Tait Shanafelt et al., “Organization-Wide Approaches to Foster Effective Unit-Level Efforts to Improve Clinician Well-Being” *Mayo Clinic Proceedings* 98, 1 (January 2023): 163–80, <https://doi.org/10.1016/j.mayocp.2022.10.031>.

12 Shanafelt, “Organization-Wide Approaches”

### *Recent Changes in our Aotearoa - New Zealand Health System*

In recent times alone, the Aotearoa – New Zealand health system has undergone significant changes. People working in this system have experienced a lot of uncertainty. Yet, there is hope for a system that cares for both the providers and the users.

Not long after the challenges of working during the COVID-19 pandemic, the Pae Ora (Healthy Futures) Act 2022 instigated transformation of the Aotearoa – New Zealand healthcare system. These reforms aimed to achieve a more equitable, accessible, integrated and people-centred healthcare system to improve health outcomes for all New Zealanders, with a particular focus on addressing longstanding health disparities for Māori<sup>1</sup>.

Since 2022, many healthcare professionals have been involved in significant restructuring - from twenty District Health Boards (DHBs) to a single national entity called Te Whatu Ora - Health New Zealand. In November 2023, the new coalition government came into power; within a year they disestablished the inaugural Te Aka Whai Ora – Māori Health Authority, breaching Te Tiriti o Waitangi and the Treaty principles<sup>2</sup>, and commenced another round of restructuring the health system.

Restructuring was ongoing at the time this research took place and was associated with feelings of uncertainty and frustration among healthcare providers and users alike<sup>3</sup>. Many people working in healthcare, especially in non-clinical roles, have shifted how they work, with more virtual interactions and working from home<sup>4</sup>.

Early in the reforms, as a requirement of the Pae Ora (Healthy Futures) Act 2022, Te Mauri o Rongo – The NZ Health Charter (2023) was developed to foster supportive and inclusive workplaces in the Aotearoa – New Zealand health sector. It aspires to workplaces where all staff are valued and supported to work together to deliver high-quality, equitable care (Te Whatu Ora). It is a statement of values, principles, and behaviours that health entities and health workers are expected to demonstrate at a collective, organisational, and individual level. The charter recognises the value of strong workplace relationships (whanaungatanga) built on mutual respect, trust, collaboration and cultural safety; and leadership (rangatiratanga) that is transparent, authentic, emotionally intelligent and representative of the workforce (Te Mauri o Rongo<sup>5</sup>).

Within this environment, how people and organisations choose to work together in healthcare for more equity and inclusion at the collective and individual levels remains to be seen.

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<sup>1</sup> Te Whatu Ora - Health New Zealand, “Te Pae Tata Interim New Zealand Health Plan 2022”, <https://www.tewhatuora.govt.nz/corporate-information/our-health-system/nz-health-plan>

<sup>2</sup> Joseph Los'e, “Waitangi Tribunal: Crown breached Te Tiriti o Waitangi in scrapping Te Aka Whai Ora - the Māori Health Authority,” *NZ Herald*, 29 November 2024, <https://www.nzherald.co.nz/kahu/waitangi-tribunal-crown-breached-te-tiriti-o-waitangi-in-scrapping-of-te-aka-whai-ora-the-maori-health-authority/Z2NV7CPPPJHP3NC4L232YHOQXY/>

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<sup>3</sup> Ruth Hill, “Relief and frustration from staff over abandoned Health NZ restructuring,” *RNZ*, 31 March 2025, <https://www.rnz.co.nz/news/national/556730/relief-and-frustration-from-staff-over-abandoned-health-nz-restructuring>; Consumer NZ, “Consumer NZ Survey Reveals New Zealanders Face Rising Healthcare Concerns Amid Ongoing Financial Uncertainty,” *Scoop*, 18 February 2025, <https://www.scoop.co.nz/stories/GE2502/S00041/consumer-nz-survey-reveals-new-zealanders-face-rising-healthcare-concerns-amid-ongoing-financial-uncertainty.htm>

<sup>4</sup> Stuff, “‘You’re Awesome’: Important to give support as we adapt to new normal with Covid-19”, *Stuff*, December 13, 2021, <https://www.stuff.co.nz/national/health/coronavirus/300471937/youre-awesome-important-to-give-support-as-we-adapt-to-new-normal-with-covid19>

<sup>5</sup> Te Whatu Ora, “Our Values and Principles,” 8 August 2024, <https://www.tewhatuora.govt.nz/corporate-information/about-us/our-values-and-principles#te-mauri-o-rongo-the-new-zealand-health-charter>

## Exploring Care and Compassion at Work in Aotearoa - New Zealand

### *Exploring 'Care' and 'Compassion'*

Before exploring 'care' and 'compassion' in healthcare it was pertinent to explore what these terms mean. Historical meanings of 'care' are ambiguous; it is described as:

*“to be anxious or solicitous; grieve; feel concern or interest,” (Old English), and*

*“to have an inclination” (1550s) and “to have fondness for” (1520s).*

Online Etymology Dictionary

I am interested in how care among colleagues, might be collective and proactive, promoting well-being and contributing to a culture of care at work.

*‘Caring’ as an adjective can mean, “compassionate, attentive to the weak, sick” (1966)*

Online Etymology Dictionary<sup>1</sup>

Modern definitions of compassion typically involve a desire to take action to alleviate another's suffering<sup>2</sup>. Brown (2021) says “It's not just a feeling, it is doing”<sup>3</sup>. In this way, compassion is like 'empathy in action', or 'empathic action'. The meanings and usage of the terms compassion and empathy interact so that they can be considered interchangeable or distinct at times. According to Sinclair et al. (2016)<sup>4</sup>:

*Compassion is a “virtuous response that seeks to address the suffering and needs of a person through relational understanding and action”*

1 <https://www.etymonline.com>

2 Trzeciak “Compassionomics”

3 Brené Brown, *Atlas of the Heart: Mapping Meaningful Connection and the Language of Human Experience* (Random House, 2021), 118.

4 Shane Sinclair et al., “Compassion in Health Care: An Empirical Model,” *Journal of Pain and Symptom Management* 51, 2 (February 2016): 193,

*Whereas, to Brown (2021),*

*“compassion is the daily practice of recognising and accepting our shared humanity so that we treat ourselves and others with loving kindness, and we take action in the face of suffering.”*

Brené Brown (2021)<sup>5</sup>

*Brown (2021) also goes on to say that,*

*“compassion is fuelled by understanding and accepting that we're all made of strength and struggle....it's a practice based in the beauty and pain of shared humanity.”*

Brené Brown (2021)<sup>6</sup>

Within these meanings, there are notions of agency and power in the relationship between the 'carer' and the 'cared for'. Brown (2021)<sup>5</sup> isn't saying that the 'carer' is 'better than' the person being cared for, nor is the 'carer' saying 'I can fix you' or 'I will rescue you'. She even goes on to quote Pema Chōdrōn, a Buddhist nun and author, who says:

*‘compassion’ is “a relationship between equals, not healer and wounded”*

In healthcare, notions and relationships of 'care' may be ambiguous and multifaceted, involving different dimensions and perspectives that interact in complex ways. Many socio-cultural factors impact how 'care' is understood, experienced and practiced by users and providers in our health system<sup>7</sup>.

5 Brown, *Atlas of the Heart*: 118.

6 Brown, *Atlas of the Heart*: 117.

7 Wilson, “Indigenous Māori-centred model”

*Making Sense of Care as Whakawhanaungatanga*

**The Whakawhanaungatanga Conceptual Model (WCM) is presented in this project as a way of conceptualising care as whakawhanaungatanga<sup>1</sup>, a Māori concept and value.**

The WCM<sup>2</sup> is a culturally located perspective that embeds aroha (care, love), centres relationships, connection and responsibility in narratives of hauora (well-being)<sup>3</sup>, see Figure 5.

Given that well-being is complex and situated, as well as notoriously difficult to define and operationalise<sup>3</sup>, the WCM provides a shared way of thinking about caring connections as well-being.

According to Carlson et al. (2022)<sup>4</sup>, in utilising this framework, we take a step back from Western patterned approaches to well-being, towards embedding mātauranga Māori (Māori knowledge, understanding and wisdom), Māori ways of thinking and acting. In doing so, we might open the door for more equitable ways of relating and providing healthcare in New Zealand<sup>2</sup>.

Teah Carlson, a theorist of the WCM, approved the use of the model in this research project via email to the author on 8 May 2024. She shared that she has used it in many settings, and because the model came from kōrero (conversations) with staff from He Kamaka Waiora (Māori health services) at four Auckland (Aotearoa – New Zealand) hospitals, it is a great reflection of cultural safety, te tai ao (natural environment), hauora (well-being) and aroha (love).



Figure 5 - Whakawhanaungatanga Conceptual Model, Carlson (2021)<sup>1</sup>

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1 Whakawhanaungatanga (the process of building relationships) using tikanga (cultural protocols and processes) informed by cultural values of aroha (compassion and empathy), manaakitanga (kindness and hospitality), mauri (binding energy), wairua (importance of spiritual wellbeing). Denise Wilson, et al., D., Moloney, E., Parr, J. M., Aspinall, C., & Slark, J. (2021). Creating an Indigenous Māori-centred model of relational health: A literature review of Māori models of health. *Journal of clinical nursing*, 30(23-24), 3539–3555. <https://doi.org/10.1111/jocn.15859>

2 Teah Carlson, “Whakawhanaungatanga: meaningful relationships. Introduction to Māori health”. *Massey University*, Auckland, Online, 2021.

3 Carlson, “Whanaungatanga.”

4 Carlson, “You Can’t Really Define.”

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1 Carlson, “You Can’t Really Define.”

## Co-creating Collegial Care with Healthcare Professionals

In this project, a group of healthcare professionals, were invited into a participatory design process to empathise and collaborate (co-create) online around notions of ‘care’ (caring connections) among colleagues at work.

This design research explores more inclusive ways of conceptualising well-being, connection, care and compassion at work. There is a focus on care among colleagues working in healthcare, and care in my own design research practice.

I invited healthcare professionals to think about care in their workplace as *whakawhanaungatanga*, through the WCM, to consider how they relate with colleagues, promote care and compassion in their teams, as leadership.

I think of ‘care’ as ‘ways of connecting – through empathy and action, that promote well-being’. In this way, ‘empathy’, described as “the ability to recognise and share the mental states of others”<sup>8</sup>, is framed as a tool, and the practice of ‘compassion’ is like ‘empathy in action’. Figure 6 visually represents building empathy, both cognitive (thinking) and affective (feeling) dimensions, to support acting with compassion<sup>9</sup>.

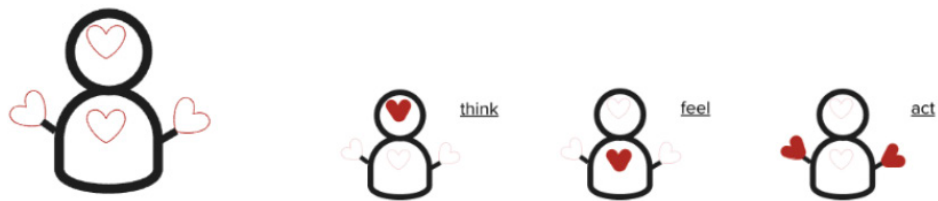


Figure 6 - Empathy and compassion – thinking, feeling, acting

In this project, DT tools and processes were used to empathise with the participants’ notions of ‘care’, to create space for thinking about how caring connections look and feel among diverse people, in different settings, at work in healthcare.

Chamberlin & Craig (2017) stated that design’s strength is creatively responding to complex, ‘wicked problems’, with no one true answer<sup>1</sup>; Langley (2018) viewed design as both a practice (encompassing knowledge, skills and experiences) and a process, a solution focused approach to problem-solving that, through creative methods, helps to elicit experiences and make ideas tangible<sup>2</sup>.

In the Design for Health discipline, design thinking (DT) is applied to healthcare to help people navigate care systems, by enhancing communication, efficiency, understanding and, therefore, the experience of patients and healthcare professionals<sup>1</sup>.

According to Ku & Lupton (2020), design thinking “is an approach to generating creative ideas and solutions that enhance human well-being in the context of medicine”<sup>3</sup>.

Principles and methods purported by Human-Centred Design as outlined in Ku & Lupton’s seminal 2020 book, *Health Design Thinking*, were integrated, in part, in this project. They are:

- human-centredness, empathy, co-design, social determinants of health, &
- creative mindset

1 Paul Chamberlain, et al., “Design for Health: Reflections from the Editors.” *Design for Health* 1, no. 1 (January 2, 2017): 3–7. <https://doi.org/10.1080/24735132.2017.1296273>.

2 Joe Langley et al., “‘Collective Making’ as Knowledge Mobilisation: The Contribution of Participatory Design in the Co-Creation of Knowledge in Healthcare,” *BMC Health Services Research* 18, 1 (December 2018): 585, <https://doi.org/10.1186/s12913-018-3397-y>.

3 Ku, *Health Design Thinking*, 7

8 Ku, *Health Design Thinking*, 60

9 Six Seconds: The Emotional Intelligence Network, “The 3 Parts of Empathy: Thoughts, Feelings and Actions”, accessed May 28, 2024, <https://www.6seconds.org/2022/03/14/3-parts-of-empathy/>

To encourage a creative mindset, DT processes were utilised - storytelling, prototyping, visualising, and questioning<sup>1</sup>. To navigate the context's ambiguity and uncertainty, I endeavoured to embrace listening and ask better questions<sup>2</sup> so relevant solutions could emerge collectively.

Following the Aotearoa – New Zealand health system restructure to a national health entity, people, especially in leadership, managerial and non-clinical roles, are now perhaps more isolated from their colleagues, and the reliance on technology for connection provides both challenges and opportunities that need attention.

As participants in this research were part of a geographically distributed team, which is more common in healthcare post-Covid<sup>3</sup>, design thinking tools and processes were used to engage with participants as co-creators (creative collaborators), through web-based communication, utilising 'MS Teams' video-conferencing and the 'Mural' visual collaboration platform.

Parallel to this process, different creative methods were explored to build empathy, connection and collaboration in an online environment.

As technology increasingly features in the future of healthcare, participatory design provides an opportunity for us to shape our interactions with it, while considering broader issues of inequalities, data security and ethics<sup>1</sup>. As ethics are essentially expressed through actions<sup>2</sup>, this practice-led research project engaged in an iterative process of action and reflection to facilitate the participatory design/co-creation process with care.

Considerations for web-based co-design in healthcare outlined by Mallakin et al (2023) informed the design and delivery of this research - these include facilitation, collaboration, accessibility and equity, communication, sensemaking, tangible tools and games, and web-based research ethics<sup>3</sup>.

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1 Ku, *Health Design Thinking*

2 Ku, *Health Design Thinking*

3 Maryam Mallakin et al., "Web-Based Co-Design in Health Care: Considerations for Renewed Participation," *Interactive Journal of Medical Research* 12 (March 3, 2023), <https://doi.org/10.2196/36765>.

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1 Chamberlin, "Design for Health"

2 Reuben Stanton, "Ethics in Design Research," *Medium*, Dec 6, 2018, <https://medium.com/paper-giant/ethics-in-design-research-d43c56fb8952>

3 Mallakin, "Web-based Co-Design"

The methodology utilised is Appreciative Inquiry (Ai), “a way to engage groups of people in self-determined change. It focuses on what’s working, rather than what’s not working, and leads to people co-designing their future”<sup>1</sup>.

This approach is informed by positive psychology and frames a design opportunity with a focus on appreciating existing strengths as a basis for seeking solutions.

Simultaneously, as a fledging designer/researcher in the context of care at work, I engaged in creative exploration and reflected on the development of my practice.

In this project, ‘care’ was explored in the co-creation process both as a topic and as a design research practice.

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<sup>1</sup> Catherine Moore, “How to Apply Appreciative Inquiry: A Visual Guide”, *Positive Psychology*, May 1, 2019, <https://positivepsychology.com/appreciative-inquiry-process/>





## 03. Methodology

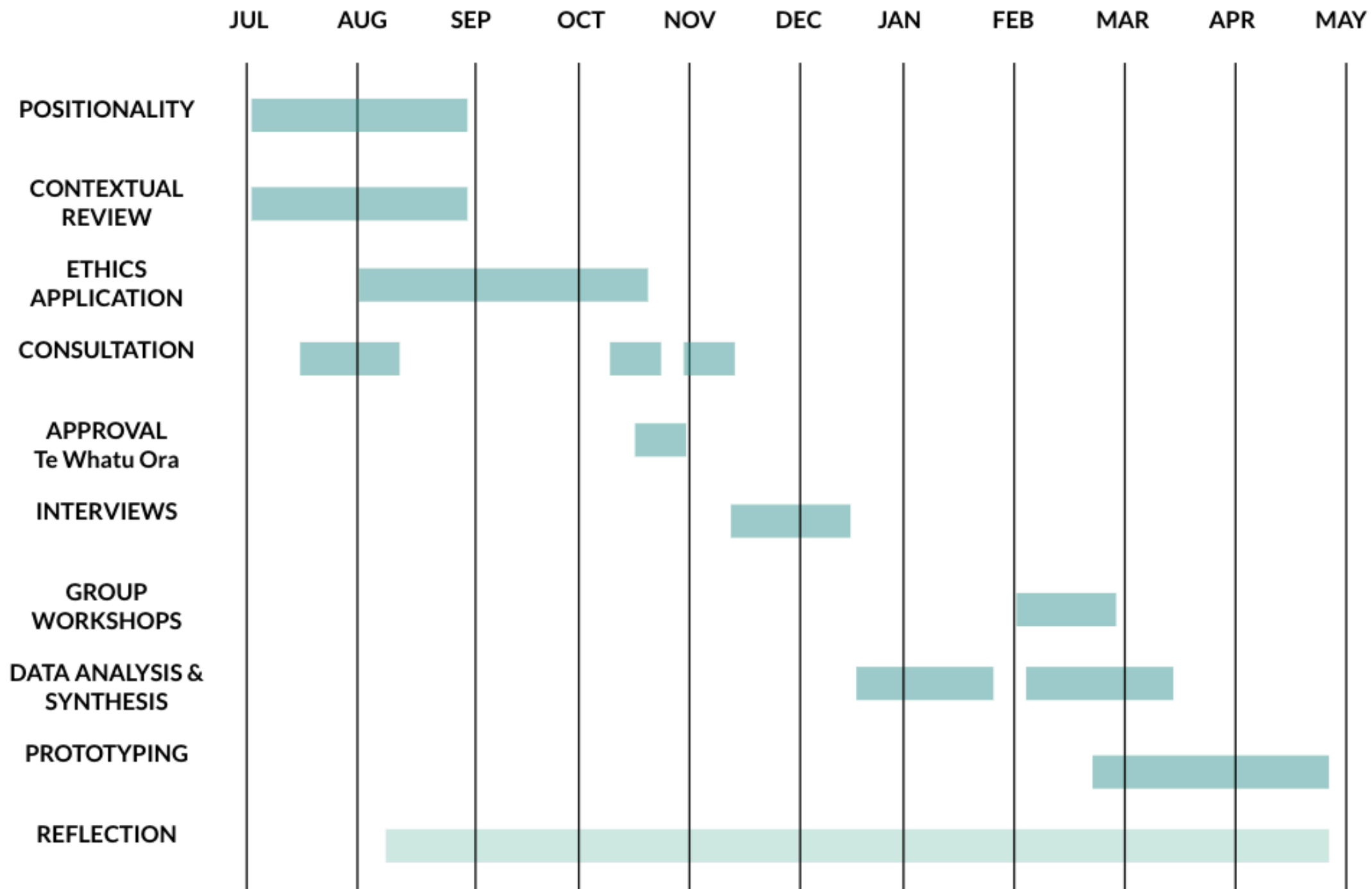


Figure 7 - Exegesis map

This research adopted a Participatory Action Research methodology framework – specifically, an Appreciative Inquiry approach. Creative methods, design thinking tools and processes were utilised to engage with participants as co-creators, in an online setting. Parallel to this process, I explored – through giving form to ideas using creative mediums such as sketching, clay making and bookbinding techniques – and reflected on my own development as a ‘fledgling’ designer in the context of care at work in healthcare.

### Appreciative Inquiry as Participatory Action Research

Action Research (AR) is an iterative process that follows the steps of ‘Plan - Act - Observe - Reflect’<sup>1</sup>. Both action research and design deal in situations with lots of uncertainty and rely on insight for the interpretation of human actions<sup>2</sup>.

Appreciative Inquiry (Ai) is a collaborative and strength-based approach to action research that engages people in self-determined change<sup>3</sup>. In Ai, the iterative phases of inquiry are called Define, Discovery, Dream, Design and Destiny<sup>4</sup> - see Figure 8. These provide an adaptable structure that focuses on exploring, identifying and amplifying what works well within a system/context and leads to people co-designing their future<sup>5</sup>.

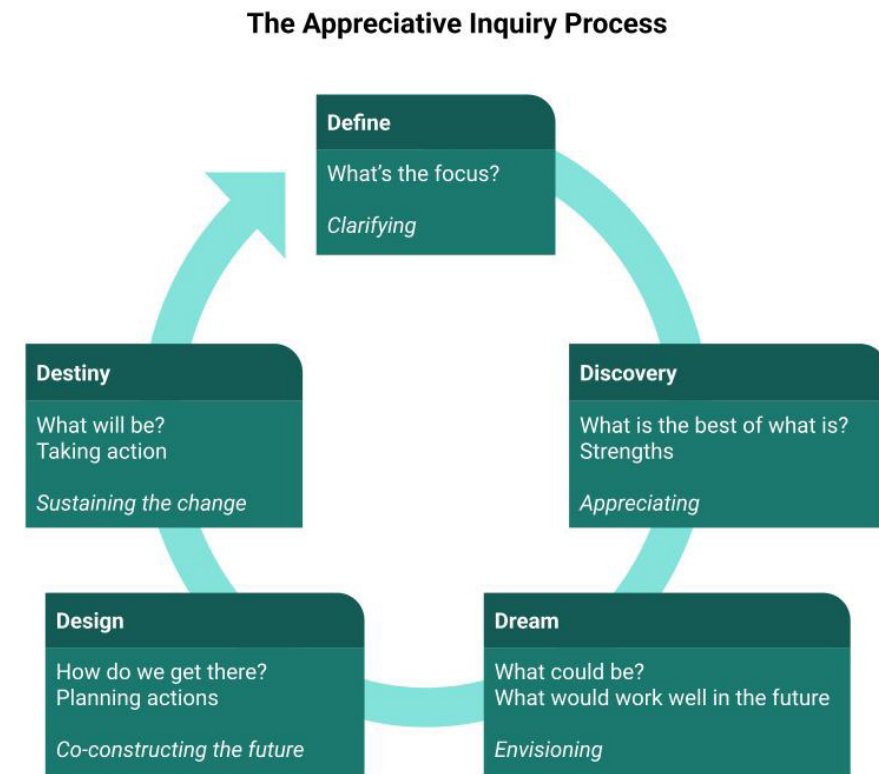


Figure 8 - Phases of the Appreciative Inquiry process

1 Cal Swann, “Action Research and the Practice of Design.” *Design Issues* 18, 1 (January 2002): 49–61, <https://doi.org/10.1162/07479360252756287>.

2 Swann, “Action Research”

3 Sue Hammond, *The Thin Book of Appreciative Inquiry* (Thin Book, 2013).

4 Whitney Cooperrider et al., *Appreciative inquiry handbook: The first in a series of AI workbooks for leaders of change* (Berrett-Koehler, 2003).

5 J. Watkins and B. Mohr, *Appreciative Inquiry: Change at the Speed of Imagination* (Wiley, 2001); Diana Whitney et al., “Appreciative Inquiry: Positive Action Research,” in *Action Learning and Action Research: Genres and Approaches*, ed. Zuber-Skerritt and Lesley Wood (Emerald Publishing, 2019), <https://doi.org/10.1108/978-1-78769-537-520191015>.

Ai is informed by the values of appreciation and generativity to create a sense of possibility and open new avenues for thought and action<sup>1</sup>. It has philosophical underpinnings and is informed by five core principles (Figure 9): Positive, Constructionist, Poetic, Simultaneity, and Anticipatory<sup>2</sup>. It is grounded in social constructionist theory, the idea that reality is subjective and socially constructed through interactions, language and conversations<sup>3</sup>.

An Appreciative Inquiry (Ai) approach offers a way to find and amplify the collective greatness that exists among people working in the health system.

Essentially, Ai is about appreciating and learning through inquiry. This research endeavoured to learn about ‘care at work’ with potential leaders working in healthcare who could create conditions for relational change within the Aotearoa – New Zealand health system, with a focus on collegial interactions.

According to Whitney et al. (2019), Ai is a radically inclusive, relational approach to action research that is participant-guided and co-creative. It provides new understanding and enables participants to create new meaning and ways of doing things that make sense to them, helping them achieve their hopes and dreams<sup>4</sup>.

In this research we explored notions of ‘care’ and ‘care at work’ using stories of participants’ lived experiences and the concept of whakawhanaungatanga, to appreciate and build on what works, to ideate how to inspire care and connection among colleagues in diverse work environments.

Throughout individual interviews and group workshops I intentionally created space for building trust and connection among the participants, to engage them in sharing their stories, perspectives and experiences and building empathy and collaboration.

### The Five Principles of Appreciative Inquiry

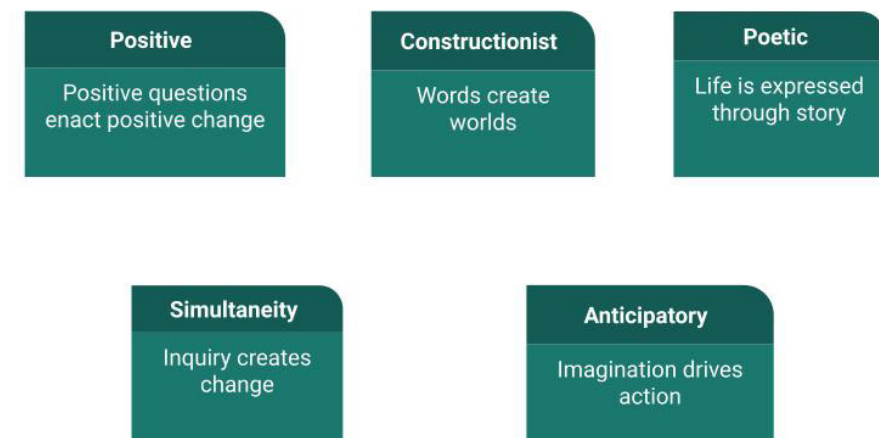


Figure 9 - Principles of the Appreciative Inquiry process

1 Danielle Zandee and David Cooperrider, “Appreciable Worlds, Inspired Inquiry,” in *The Sage Handbook of Action Research: Participative Inquiry and Practice*, ed. Peter Reason and Hilary Bradbury (SAGE Publications, 2008).

2 Watkins, *Speed of Imagination*.

3 Zandee, “Appreciable Worlds.”

4 Whitney, “Appreciative Inquiry: Positive.”

## Methods

This research focuses on four of the five phases of Appreciative Inquiry.

The researcher clarified the 'care at work' topic (Define phase of Ai).

Figure 10 shows the research methods and tools used to collect and analyse data with three subsequent phases of Ai. The colours denote each Ai phase (Discovery in yellow, Dream in blue, Design in pink).

Table 1 summarises these methods and tools, and they are described in more detail below.

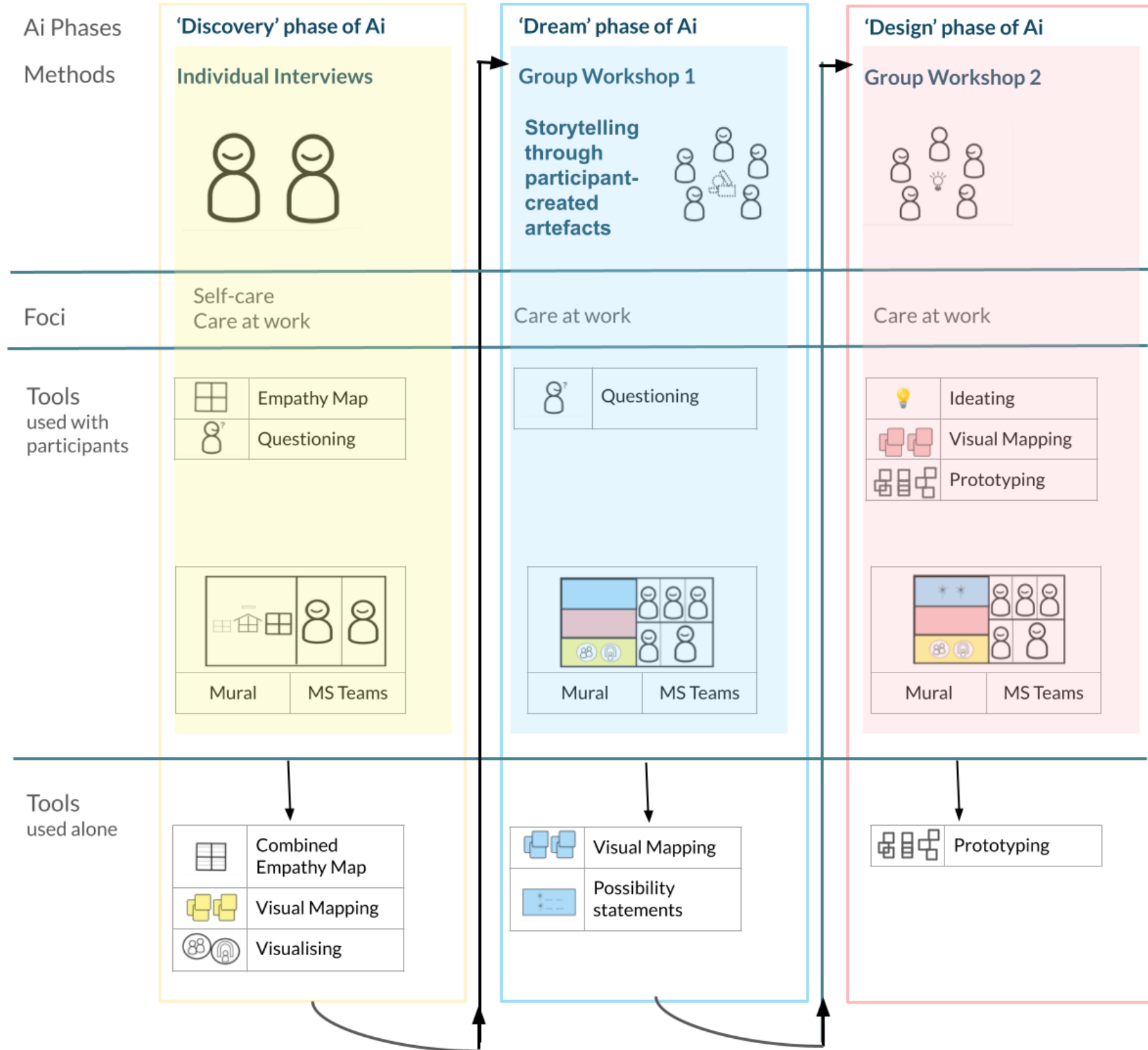


Figure 10 - Journey map of research methods and tools

<b>Phase of Ai</b>	<b>Methods</b>	<b>Tools</b>
<b>Define</b>	<b>Contextual review</b> by researcher to understand the context and topic of ‘care at work’ + <b>Consultation</b> with a leader in the participant group + <b>Positionality</b> (in Introduction) to understand myself (the researcher) in the research	
<b>Discovery</b>	<p>One-on-one online <b>interviews</b> supported by <b>empathy maps</b> (visual tool) to analyse and synthesise the interview data</p> <p>A version of reflective thematic analysis undertaken by the researcher (informed by the interviews and empathy maps), were supported by a <b>combined empathy map and mapping</b> (visual tool) to create themes to facilitate group discussion (in Group Workshop 1)</p>	Video conference on <b>MS Teams</b> , video-recorded, online collaborative workstation (‘Sketchpad in <b>Mural</b> <sup>1</sup> .co) which included the Te Whare Tapa Whā model of Māori health, Whakawhanaungatanga Conceptual Model (WCM)
<b>Dream</b>	<p><b>Group Workshop 1</b> online – supported by <b>storytelling through participant-created artefacts</b> (a generative tool, probes to help unpack complex ideas)</p> <p><b>Mapping</b> (visual tool) undertaken by the researcher to analyse and synthesise the learnings from the workshop into themes / categories &amp; <b>possibility statements</b> (to facilitate discussion in Group Workshop 2)</p>	Video conference on <b>MS Teams</b> , video-recorded, online collaborative workstation (‘Sketchpad in <b>Mural</b> .co) which included visual zones for recording notes in each phase of Ai, workshop activity toolkit (see Figure 12) posted to each participant prior to the first workshop
<b>Design</b>	<p><b>Group Workshop 2</b> online - supported by ‘How might we’ questions to facilitate discussion, &amp; <b>mapping</b> (visual tool) to synthesise the learnings from the workshop</p> <p><b>Prototyping</b> of artefacts undertaken by the researcher with feedback from participants via email &amp; online video calls</p>	Video conference on <b>MS Teams</b> , video-recorded, online collaborative workstation (‘Sketchpad in <b>Mural</b> .co) recording notes in each phase of Ai
<i>Destiny</i>	<i>out of the scope of this research</i>	

Table 1 - Methods and tools utilised within an Ai approach.

<sup>1</sup> Mural is a freely available visual collaboration platform.

## Discovery Phase of Appreciative Inquiry: Individual Interviews

### *Appreciating the best of 'self-care' and 'care at work'*

In Mural, I created a template 'Sketchpad' (like an online whiteboard) (see Appendix 11) for the interviews to visually communicate and invite participants to engage with tools and methods.

I interviewed each participant online for 60-90 min and we created an Empathy Map (described in detail below) together to visually represent how they see 'the best of' 'care at work', 'what works' in their context. I offered participants the option to talk and/or write directly into the Mural document to suit their preferred way of expressing their ideas and collaborating. See Appendix 3 for the interview plan and Appendix 5 for the empathy map template as used on the Mural workstation.

Interviews were video recorded on MS Teams and later reviewed for further analysis. Semi-structured interview questions were positively framed and strength-based<sup>1</sup> to appreciate the 'best of what exists' in the participant's life, in regard to their experiences of: 1) 'self-care' and 2) 'care at work' from colleagues, i.e. what others at work have done, or do, that supports the participant.

To draw out their experiences of 'self-care', participants reflected on, identified and shared what they do or could do to support their holistic well-being in each of the four interrelated dimensions of well-being, i.e. physical, mental/emotional, social, spiritual, as per Mason Durie's Te Whare Tapa Whā model of Māori health<sup>2</sup>. The intention was to promote self-awareness and appreciation of what effectively supports their well-being while fostering a sense of agency and revealing how they see and value 'self-care'.

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1 James Holstein and Jaber Gubrium, *The Active Interview* (Thousand Oaks: SAGE Publications, 1995); 'Appreciative Inquiry', *Organizing Engagement*, accessed May 15, 2024, <https://organizingengagement.org/models/appreciative-inquiry/>

2 Mason Durie, *Whaiora: Māori health development*, 2nd ed. (Oxford University Press, 1994).



Figure 11 -Discovery phase

To initiate exploration of the Māori concept of whakawhanaungatanga, The Whakawhanaungatanga Conceptual Model (WCM) of relational well-being with aroha was introduced<sup>1</sup> (Appendix 4). This provided a potentially new way of thinking about caring connections among colleagues. We reviewed the WCM's 'au' (identities and personal qualities) domain, to offer a way to understand the personal domain of well-being as inherently relational, intertwined with relationships, and the wider socio-cultural context.

To explore the participant's experiences of 'care at work, I asked, "When has care from a colleague supported your well-being?". This question was chosen to emphasise a positive, solutions-oriented approach to exploring what 'care at work' meant to participants, to reveal their experiences and how practicing care might look and feel for them.

Empathy maps (including four quadrants: Say, Think, Do, Feel) were used in Mural (see Appendix 5) to both record and analyse the data, to synthesise what was shared, or 'observed', to start to make sense of the participant experiences and perspectives, identify needs, and draw out unexpected insights<sup>2</sup>. According to Gibbons (2018), empathy maps may uncover needs the person themselves may not even be aware of and reveal what drives their behaviours. As a visual tool, they externalise knowledge about someone to create a shared understanding and aid in decision-making<sup>3</sup>. During the interview, I used questions to support empathy mapping with participants (Appendix 6 for representative questions).

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1 Carlson, "Whanaungatanga."

2 Sarah Gibbons, "Empathy mapping: The first step in design thinking," *NN Group*, 14 January 2018, <https://www.nngroup.com/articles/empathy-mapping/>.

3 Gibbons, "Empathy mapping"

Following the interviews, I reviewed the 'care at work' empathy maps and interview recordings, used a process inspired by reflective thematic analysis<sup>4</sup> (see Appendix 6) supported by visual and creative sense-making, to create themes that represented what 'matters' to the participants, i.e. the best of 'care at work'.

The themes were inspired by personas, as used in design thinking<sup>5</sup>, as a common ground for generative discussion in group workshop 1. However, rather than fictional characters (user archetypes, or traditional 'personas'), the themes were an amalgamation of participants' human needs and modes of caring. The themes were created to empathise with notions of 'care at work' to ensure participants were aware of the 'greatness that exists' in their context that could be built upon when creating potential ideas for future action.

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4 Virginia Braun and Victoria Clarke. *Thematic Analysis: A Practical Guide* (SAGE Publications, 2022).

5 Ku, *Health Design Thinking*

## Dream Phase of Appreciative Inquiry: Group Workshop 1

*Envisioning what 'care at work' could be*

I facilitated two 60-90min group workshops online, with workshop 1 being conducted predominantly in the 'Dream' phase of Ai. According to Ku & Lupton (2020), a workshop is a structured series of activities that primes people to think creatively, share ideas, and make those ideas concrete"<sup>1</sup>. Prior to workshop 1, each participant received a workshop activity toolkit to use in the workshops, hand-delivered to their home address. Each workshop activity toolkit contained: an animal themed spiral notebook, a pen, and art and craft materials (pipe cleaners, two small tubs of playdoh, beads, wooden sticks, coloured plastic ties) (see Figure 12). Both workshops were video-recorded to help with the subsequent data analyses.

See Appendix 8 for Workshops plan. A Mural Sketchpad was prepared for the workshops. Before workshop 1 the Mural showed the themes 'discovered' from the interviews, and visual zones for each phase of Ai (see Figure 13).

Workshop 1 aimed to facilitate collaboration by creating a safe space, building empathy, connection, trust, mutual understanding and appreciation of the group's positive experiences and perspectives relating to 'care at work'.

A notion of empathy with three parts: cognitive, emotive & action<sup>2</sup> was shared with the group, to explicitly encourage empathising through the workshop activities / interactions, and to offer a way to appreciate 'care at work'.

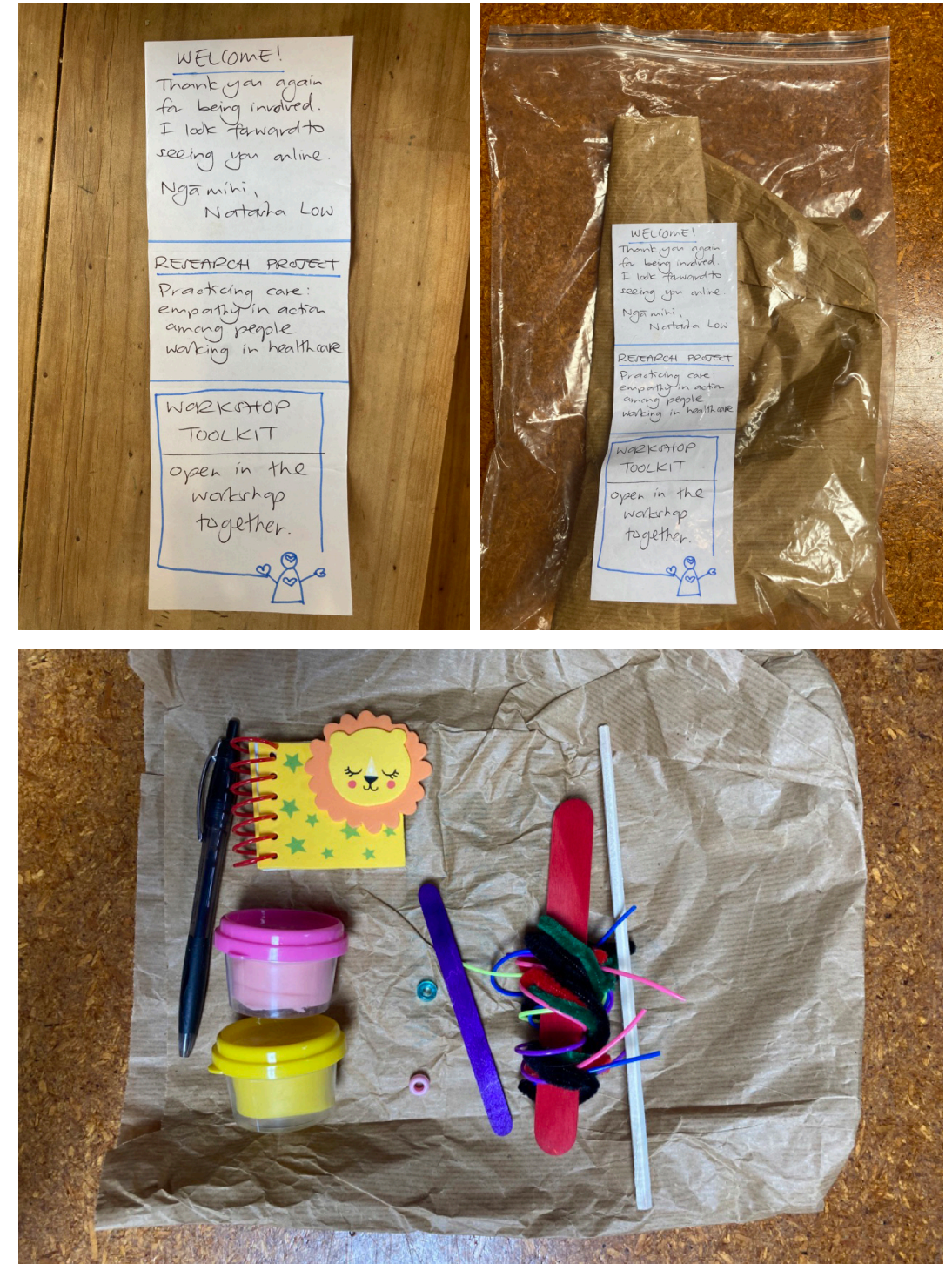


Figure 12 - Workshop activity toolkit

<sup>1</sup> Ku, *Health Design Thinking*, p58

<sup>2</sup> "The 3 Parts of Empathy: Thoughts, Feelings and Actions", *Six Seconds: The Emotional Intelligence Network*, accessed May 28, 2024, <https://www.6seconds.org/2022/03/14/3-parts-of-empathy/>

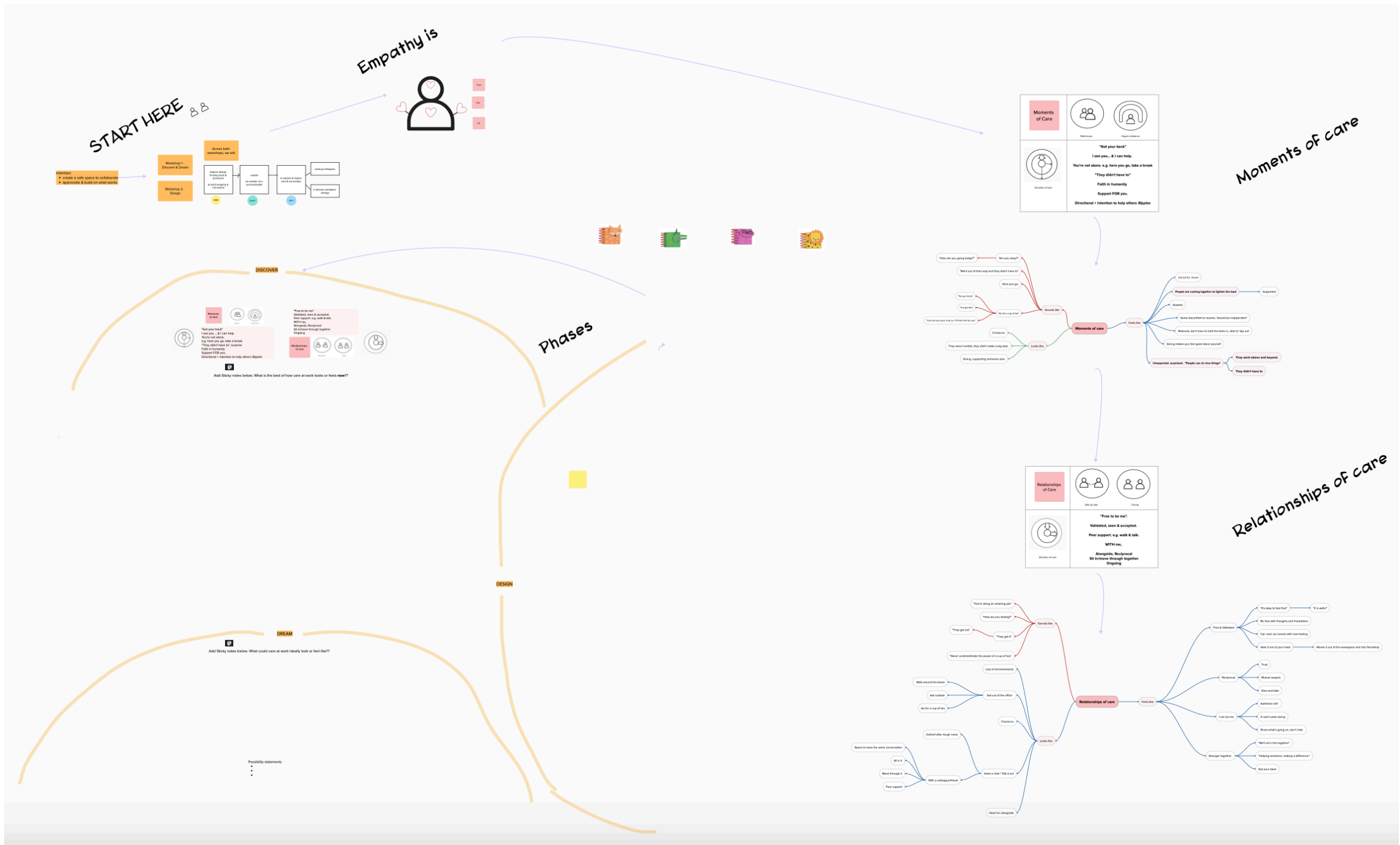


Figure 13 - Mural Sketchpad - Workshop 1

To connect participants to findings from the discovery phase of Ai: individual interviews (themes of ‘care at work’), and to draw out nuance and meaning from the participant experiences of ‘care at work’, a generative discussion was used to appreciate ‘what’s working well’, the best of ‘care at work’. Participants reviewed the synthesised interview findings and were invited to add characteristics to the themes and identify any that felt important but were outside of the themes identified.

According to the Ku & Lupton<sup>1</sup>, by developing a deep, shared understanding and empathy for others’ perspectives and experiences, meaningful opportunities for change can emerge and inform the design process.

As part of workshop 1, to initiate the Dream phase of Ai, participants were invited to engage in a creative activity: storytelling through participant-created artefacts. Prompted by the question, ‘What might care (from colleagues) at work ideally feel like?’ participants were supported to make an expressive artefact from their toolkit items (Figure 11), to elicit and share their idea of the near future through the object, with the small group<sup>2</sup>.

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1 Ku, *Health Design Thinking*

2 Elizabeth Sanders and Pieter Jan Stappers, “Probes, Toolkits and Prototypes: Three Approaches to Making in Codesigning,” *CoDesign* 10, 1 (January 2, 2014), <https://doi.org/10.1080/15710882.2014.888183>. Sanders & Stappers, 2014)

This aimed to provoke the imagining of new ways of thinking about ‘care at work’, to engender emotional engagement and reflexivity<sup>3</sup>. The artefact was used as a probe to enhance dialogue, continue exploring the concept of ‘care at work’ and to start envisaging a future reality.

To promote cognitive and emotive empathy, participants were encouraged to listen deeply to each other, and to notice, and subsequently record on the Mural Sketchpad as ‘sticky notes’, the feelings and ideas shared by each speaker in turn, as well as their own thoughts and feelings, including any gut reactions or ‘wonderings’, in response to what they heard, about how ‘care at work’ could be. Time was given to review the thoughts and feelings recorded, to recognise common and diverse ideas of how ‘care at work’ could be, and to add any new ideas.

Following workshop 1, I reviewed the notes in the Mural Sketchpad and the video recording to add any additional insights for consideration and initial qualitative analysis of the data. Visual mapping, like affinity mapping<sup>4</sup>, was used to group together similar ideas, items, and statements and to recognise diverse elements. This analysis and synthesis incorporated different perspectives to deepen understanding of what ‘care at work’ could be. To support envisioning how ‘care’ could look and feel in diverse workplace settings, I created categories / ‘dream themes’ and “possibility statements” to give shape to the dream, contribute to constructive discussion and inform ideation in workshop 2.

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3 Dawn Mannay, “Artefacts, Third Objects, Sandboxing and Figurines in the Doll’s Housei” in *The SAGE Handbook of Visual Research Methods*, Luc Pauwels and Dawn Mannay, (SAGE Publications, 2020), <https://doi.org/10.4135/9781526417015.n20>.

4 Matt Cooper-Wright, “Design Research from Interview to Insight: Part Two, Synthesising Insight,” *Medium*, Sep 13 2015, <https://medium.com/design-research-methods/design-research-from-interview-to-insight-f6957b37c698>; Matt Cooper-Wright, “Design Research from Interview to Insight: Part One, Synthesising Insight,” *Medium*, Aug 14 2015, <https://medium.com/design-research-methods/design-research-from-interview-to-insight-part-one-summarising-the-interview-dceee9ba0969>; Interaction Design Foundation, “Affinity Diagrams,” accessed November 2024, <https://www.interaction-design.org/literature/topics/affinity-diagrams>.

## Design Phase of Appreciative Inquiry: Group Workshop 2

*Planning actions to build on the best of 'care at work' towards 'what care at work could be'.*

Workshop 2 intended to inspire participants, as potential leaders working in healthcare, to ideate actions for creating the 'care at work' they desired. To support this process, we identified a specific notion of how the 'dream' could be and focused on how to create the desired feelings. This involved an iterative process, going between the 'dream' of how 'care at work could be' (a 'dream theme' and "possibility statements") from workshop 1, while circling back to check the 'care at work' themes 'discovered' from the interviews.

Actions were created to amplify 'the best of what care at work is' and move towards the desired future of 'what care at work could be'. Brainstorming, 'how might we' questions<sup>5</sup> and visual mapping were utilised to ideate, reveal the collective wisdom of the group and create future actions for inspiring caring connections/care at work.

Following workshop 2, I moved into prototyping. I reviewed the 'care at work' findings, used sketching before creating a low-fi prototype to share with participants for feedback. After refining this prototype, it was ready for printing and sharing with participants. Subsequently, I prototyped a resource for facilitators to engage groups in co-creation online. This process involved gathering inspiration, synthesising (creating a design brief), ideating, experimenting and refining. I gave form to ideas through sketching to visualise concepts, methods, tools and design ideas, experimenting with paper-folding (bookbinding) techniques, and making rough paper prototypes to test and refine ideas. I created a hi-fi prototype to share with participants, as potential facilitators, for feedback.

## Reflection

Prior to, during, and after interactions with participants I reflected on my development as a 'fledgling' designer, to notice and question how I might think, do and be as a designer<sup>6</sup>. I applied positionality<sup>7</sup> to revisit my personal and professional identities, background, and experience with respect to the research context – care at work in healthcare, in the Design for Health discipline. I engaged in reflexivity<sup>8</sup>, especially with respect to practicing with care during the design, delivery and documentation of this research. I employed a degree of critical reflection<sup>9</sup> relating to practicing whakawhanaungatanga, utilising the whakawhanaungatanga conceptual model, and creating design outcomes with care.

I reflected, as someone new to design, on my creative exploration – sketching, using clay, bookbinding techniques, digital design - facilitation, and design practice.

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6 Daniela Avendaño, "Boud Reflection Model: Theory and Example", toolshero, March 23, 2025, <https://www.toolshero.com/personal-development/boud-reflection-model/>. Boud Reflection Model; David Walker et al., *Reflection: Turning Experience into Learning*. (Taylor and Francis Group, 2013), <https://doi.org/10.4324/9781315059051>.

7 Sage, Methods Map, accessed 12 November 2024, <https://methods-sagepub-com.ezproxy.aut.ac.nz/methods-map/positionality>.

8 Sage, Methods Map, accessed 12 November 2024, <https://methods-sagepub-com.ezproxy.aut.ac.nz/methods-map/reflexivity>.

9 Sage, Methods Map, accessed 12 November 2024, <https://methods-sagepub-com.ezproxy.aut.ac.nz/methods-map/critical-reflection>.

## Practicing Care in Research: Ethical Considerations

*“Creating safety requires more care and hospitality from people who design and run co-design initiative. People with lived experience do not have to change to suit professionals.”*

Kelly Ann McKercher<sup>1</sup>

As facilitator of the participatory process, I was careful to create a safe space for participants to engage in the creative and collaborative design/research activities, acknowledging the vulnerability that comes with sharing lived experiences.

Participant interactions were set online to accommodate the geographically distributed and hybrid nature of the participants’ work. The informed consent recruitment process was followed (via Participant Information Sheet and Consent Form, see Appendix 9 and 10).

With a holistic, ethical perspective towards design, I practiced empathy and care.

I communicated with participants via email, welcoming them to the study, scheduling online meetings at times that suited the participants and invited dialogue about the study’s activities and intentions.

To set the scene for participant engagement and assure them of my facilitating role, email communications prior to each interaction (interviews, and group workshops) connected participants to the process and offered a layer of informed consent throughout.

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<sup>1</sup> Model of Care for Co-design, cards <https://www.beyondstickynotes.com/model-of-care-for-codesign> A director at Curative, a creative agency inspiring social change <https://curative.co.nz/about/> gave me a set of Kelly Ann McKercher’s Model of Care for Co-design Practice cards, these helped to integrate care into the planning and doing of co-design.



## **04. Documentation of Research**

## Discovery Phase of Appreciative Inquiry: Appreciating ‘Care’

### *Facilitating in the Interviews*

Table 2 provides a summary of how I practiced whakawhanaungatanga and utilised creative methods, DT tools and processes to build empathy and collaboration online during the interviews. This section documents findings from this process.

The process of engaging with participants in this research may be unusual in that we were simultaneously experiencing and exploring care and connection. Both the process and topic were focused on care. While utilising empathy and collaboration online, through three phases of Appreciative Inquiry (Ai), the learning was explicit and experiential.

Four healthcare professionals working in non-clinical roles as part of the Planning, Funding and Outcomes directorate in Te Whatu Ora – Health New Zealand, took part in an individual interview and two group workshops. Participants shared their perspectives and lived experiences of connecting with care at work.

This chapter is a reflection on the design research practice in this project with insights pertaining to facilitating co-creation, making sense of ‘care at work’ findings, prototyping a facilitation resource, and my development as a ‘fledgling’ designer.

Participants interacted with the creative methods, design thinking tools and processes (during the interviews and group workshops) through the Discovery, Dreaming, and Designing phases of Ai. I utilised creative and design ‘tools’ to make sense of findings after the participant interactions.

<p><b>Facilitation aim:</b> To start building trusting relationships supported by understanding each other’s perspectives</p>
<p><b>Practicing whakawhanaungatanga looks like:</b></p> <ul style="list-style-type: none"> <li>• <b>Sharing</b> my experience (self-care) and perspective (WCM) to help prompt thinking &amp; familiarity with the conceptual models</li> <li>• <b>Sharing</b> my background (e.g. teacher, new designer) &amp; intentions explicitly (open &amp; transparent)</li> <li>• <b>Inviting</b> collaboration (for familiarity with the tools) &amp; offering options to engage (e.g. speak &amp;/or write directly)</li> <li>• <b>Modelling</b> active listening &amp; curiosity (to participants sharing their notions of self-care &amp; ‘care at work (C@W))</li> <li>• <b>Practicing with care, empathy/compassion</b>, e.g. providing information, guiding the process &amp; inviting engagement (establish credibility, seeking ongoing consent), communicating process &amp; purpose</li> </ul>
<p><b>Utilising creative methods, DT tools &amp; processes to build empathy &amp; collaboration online looks like:</b></p> <ul style="list-style-type: none"> <li>• Utilising <b>Empathy Map</b> to understand / appreciate (how ‘best of C@W looks &amp; feels)</li> <li>• <b>Visualising</b> Hauora &amp; Whakawhanaungatanga conceptual models to engage with ways of seeing connection, care</li> <li>• Using <b>Mural</b> to visually communicate activities &amp; collaborate on self-care and ‘care at work’ - prepared to invite engagement, establish credibility and trust in me and the process.</li> <li>• Using two <b>windows</b> side-by-side - Mural (visual collaboration) &amp; MS Team (cameras on)</li> <li>• Inviting <b>storytelling</b> (C@W)</li> <li>• <b>Questioning</b> to promote discussion – about self-care &amp; the best of C@W</li> </ul>

Table 2 - Key facilitation actions - Interviews

Prior to the interviews, I suggested a screen set-up for participants to use, with two windows side-by-side: Mural (online visual collaboration) & MS Teams (cameras on) - see Figure 14. Both tools encouraged communication and collaboration, participants commented that this set-up enabled them to engage, not only with the text, tools and concepts presented on the Mural, but on a relational level, using visual cues (such as facial expressions), to support the dialogue.

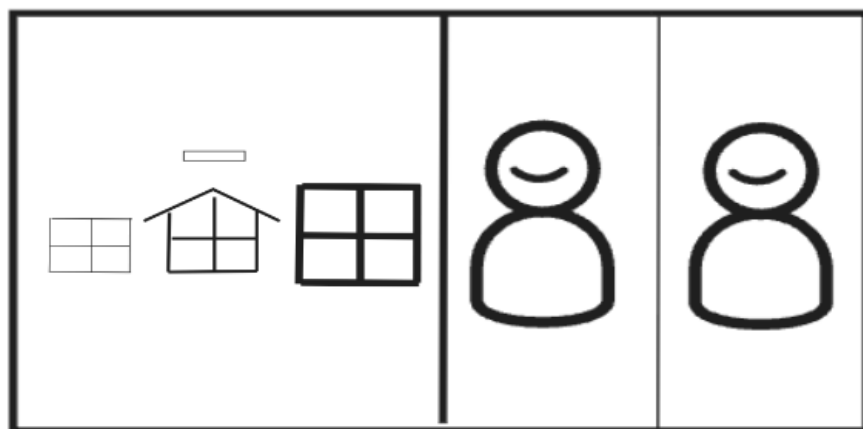


Figure 14 - Interview online set-up

Explicitly sharing my background, i.e. being a teacher and new to design, and the intentions of the interviews, helped establish whanaungatanga and my open and transparent 'position' in the research.

Visuals on the Mural helped to communicate and engage participants in sharing their own experiences and perspectives. Representations of the Te Whare Tapa Whā model of hauora and the Whakawhanaungatanga Conceptual Model (WCM), engaged participants in ways of seeing care, connection and well-being. Participants were familiar with the former model and easily related to the physical, social, mental/emotional dimensions of well-being in their own lives. I shared my experiences of self-care and how I think about the spiritual dimension of well-being. This helped participants connect what they knew of the model with their own self-awareness, to identify self-care actions that support their

well-being. I did not initiate engagement in the whenua dimension of well-being presented in the Te Whare Tapa Whā model, but some participants offered their connection to it freely.

The participants were not familiar with the WCM model. When I shared my understanding of it through the visual, and they were invited to read, or listen to me reading, the written resources on the Mural, they were able to reflect on how it related to their own lives and well-being.

Providing options for engaging with the written resources enhanced accessibility and participant's willingness to be engaged in a way that suited them at that time. I was mindful of the interview being a part of a potentially busy day of work, with lots of reading on a computer screen. The WCM model could be more engaging when participants are more familiar with it, and/or the concept of whakawhanaungatanga.

During the interview, at times, I acted as 'scribe' as well as 'interviewer', to allow participants to speak freely about their notions of 'self-care' and 'care at work'. They could see how I used the quadrants (say, think, do, feel) of the empathy map (on the Mural) to record and analyse what they said and did, or seemed to think and feel in their stories about 'care at work'.

For some participants, I modelled active listening and curiosity as they shared their experiences and perspectives. I took notes on paper and then subsequently, prompted them to recall what they talked about, and we categorised aspects of their story together. As some participants had not used an empathy map before, sharing my own examples for each quadrant, helped to facilitate each participant's understanding of the quadrants.

This tool encouraged us to question what they (e.g.) felt and did, and to explore why. In this way, we revealed insights together. Before finishing the interview, participants had written their name into the document and practiced navigating around the Mural so were somewhat familiar with using it as a tool prior to the group workshops. Having two 'care at work' questions (e.g. "When has care from a colleague supported your well-being?") helped to initiate participant storytelling as it seemed one question or the other resonated with each person and prompted their thinking.

### *Making Sense of the Interview Findings*

Post-interviews, to complement reflective thematic analysis (see Appendix 7) I created a Combined Empathy Map to help reveal the participants' needs and insights, and utilised visual and creative methods (sketching and modelling with clay) to make sense of the 'care at work' themes.

The themes represented 'modes of care' - 'Moments of Care' and 'Relationships of Care'. Akin to 'personas', these represented an amalgamation of (the best of) participants' experiences of care at work, with their colleagues - what great 'care' looks and feels like, essentially what matters and has worked well in their healthcare context.

The themes were:

- Moments of care (MOC)
- Relationships of care (ROC)
- Not alone / Being connected together
- Feeling supported, seen & heard
- Faith in humanity

The stories of 'care at work' seemed to revolve around peer interactions, not necessarily with people they knew well. 'Moments of care' stories were moments with people the healthcare professionals didn't expect support from, but people they worked with or alongside. This focus may have come about as my question directed them to think of collegial interactions. This revealed my bias towards thinking of care as directional rather than relational at this stage of the research, i.e. my question referred to care 'from' a colleague.

One story shared was set in a clinical ward in the hospital, and the unexpected moment of care impressed on me that proximity doesn't always foster immediate connection, perhaps especially in shiftwork, people might come and go, move around each other without any (significant) interactions.

Examples of individual quotes from the interviews include:

*"You can't judge someone from the outside."*

*"Maybe everyone is struggling."*

*"Others were aware of how I was feeling."*

Participant quotes

Notions of 'struggle' were implied in some of the interviews, as participants reflected on their own experience and wondered about the experience of their colleagues. After experiencing a 'moment of care' participants shared that they felt surprised, and a 'faith in humanity' that motivated them to 'pay it forward'.

*"They didn't have to"*

*"They went above and beyond"*

Participant quotes

In contrast, the 'relationships of care' stories, were with colleagues who the participants already considered 'friends' at work or at least someone they trusted and had worked with for a long time.

I used sketching and clay to make sense of the themes, specifically the connections between an individual and the colleagues in their stories of 'care at work' (Figure 15).

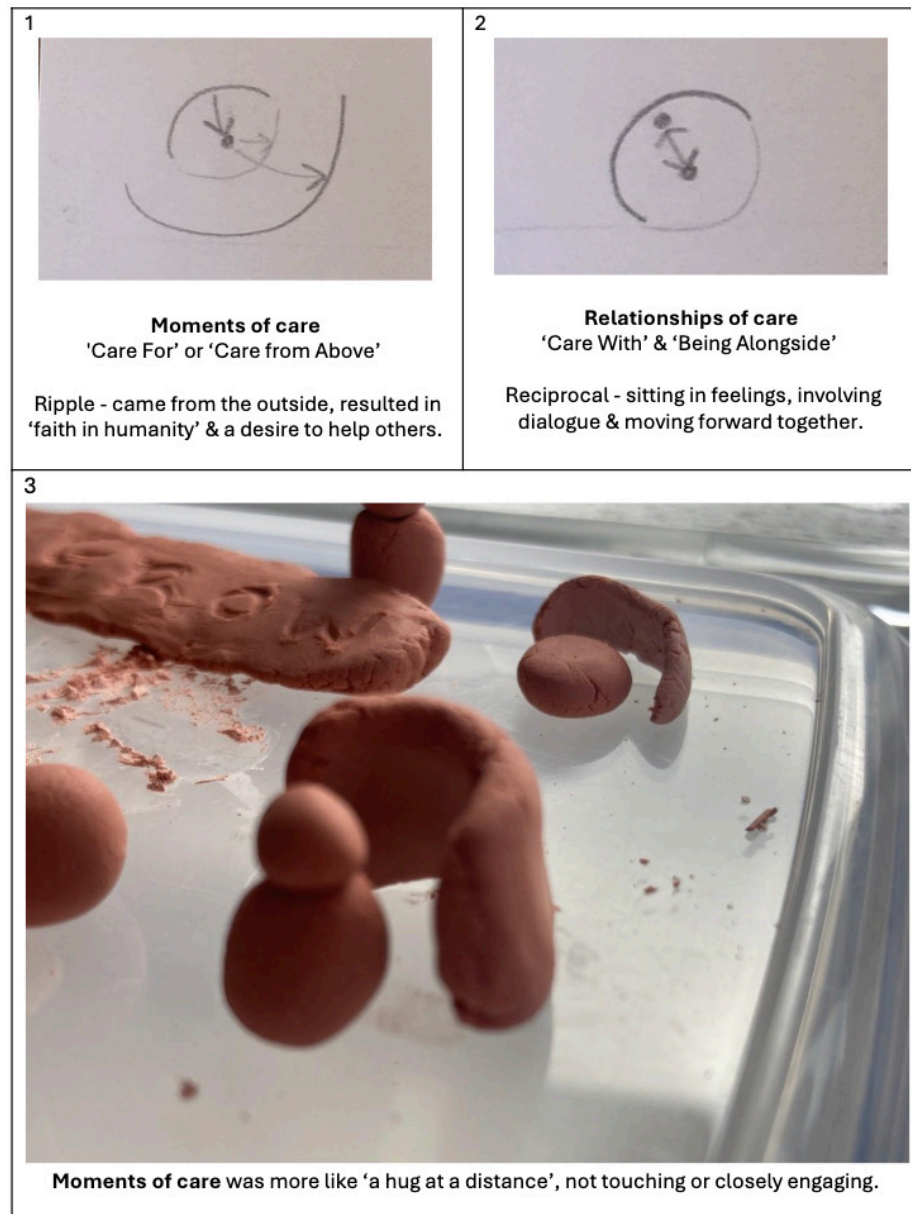


Figure 15 - Sketching and clay-making - exploring themes

Visual representations (digitised sketches and mind maps) to conceptualise and communicate the 'care at work' findings/themes facilitated the subsequent discussion in group workshop 1 about what 'care at work' looks and feels like.

I used Mural (the 'Shapes and Connectors' and 'icons' tools) to digitise sketches and show the direction of care between the giver and receiver of care (Figure 16).

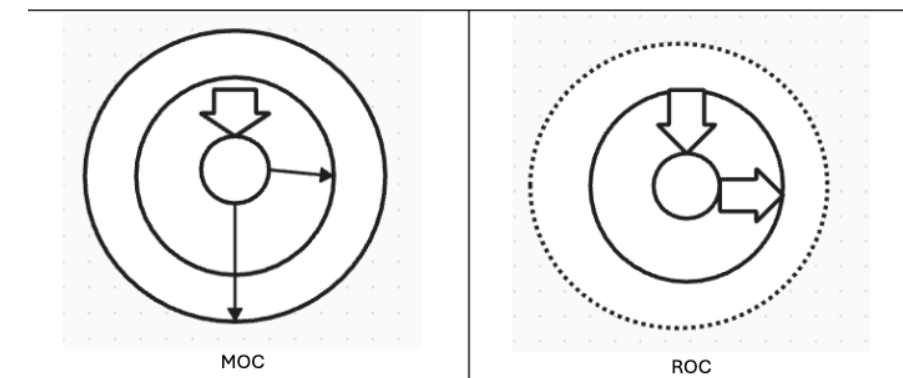


Figure 16 - Direction of care in themes

I developed visuals, descriptors and phrases to represent the themes/findings (Figure 17). Through this process I came to understand the meaning of the concepts more deeply, from my perspective, but they still required explanation to communicate with participants.





Moments of care		Relationships of care	
'I get it' 'I got your back' 'I'm behind you'		'I get it' 'I got <u>you</u> ' 'I get <u>you</u> '	
			
Standing behind	A hug	Holding hands Walking side by side	Facing Chatting

Figure 17 – Representing 'care at work' themes

A summary tile of each theme is presented in Figures 18 - 19.



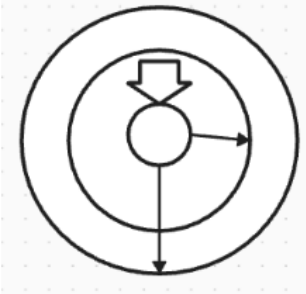
<b>Moments of Care</b>	 Standing behind	 A hug
		
<p><b>"Got your back"</b></p> <p>I see you... &amp; I can help.</p> <p><b>You're not alone. e.g. here you go, take a break</b></p> <p><b>"They didn't have to"</b></p> <p><b>Faith in humanity</b></p> <p><b>Support FOR you, directional + intention to help others <i>Ripples</i></b></p>		

Figure 18 – Moments of care summary tile



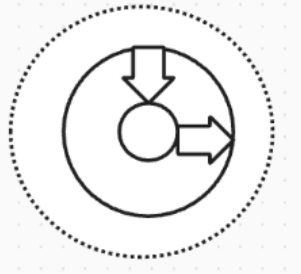
<p><b>Relationships of Care</b></p>	 <p>Holding hands Walking side by side</p>	 <p>Facing Chatting</p>
	<p><b>"Free to be me".</b></p> <p><b>Validated, seen &amp; accepted.</b></p> <p><b>Peer support. e.g. walk &amp; talk.</b></p> <p><b>WITH me,</b></p> <p><b>Alongside, Reciprocal</b> <b>Sit in/move through together</b></p>	

Figure 19 – Relationships of care summary tile

I created Mind Maps (Figure 20-21) in the hope that providing more detail might help participants appreciate a broader understanding of how the best of 'care at work' looked and felt, to complement the summary tiles. They conveyed similar information to an empathy map – sounds like, feels like, looks like - but without the 'thinks like' category as its sentiment seemed to be captured in the other three categories.

In preparation for the upcoming group workshop 1, I set-up a new workshop Mural and presented the themes discovered in the interviews to generate discussion, engage participants in the discovery of what works and to invite feedback.

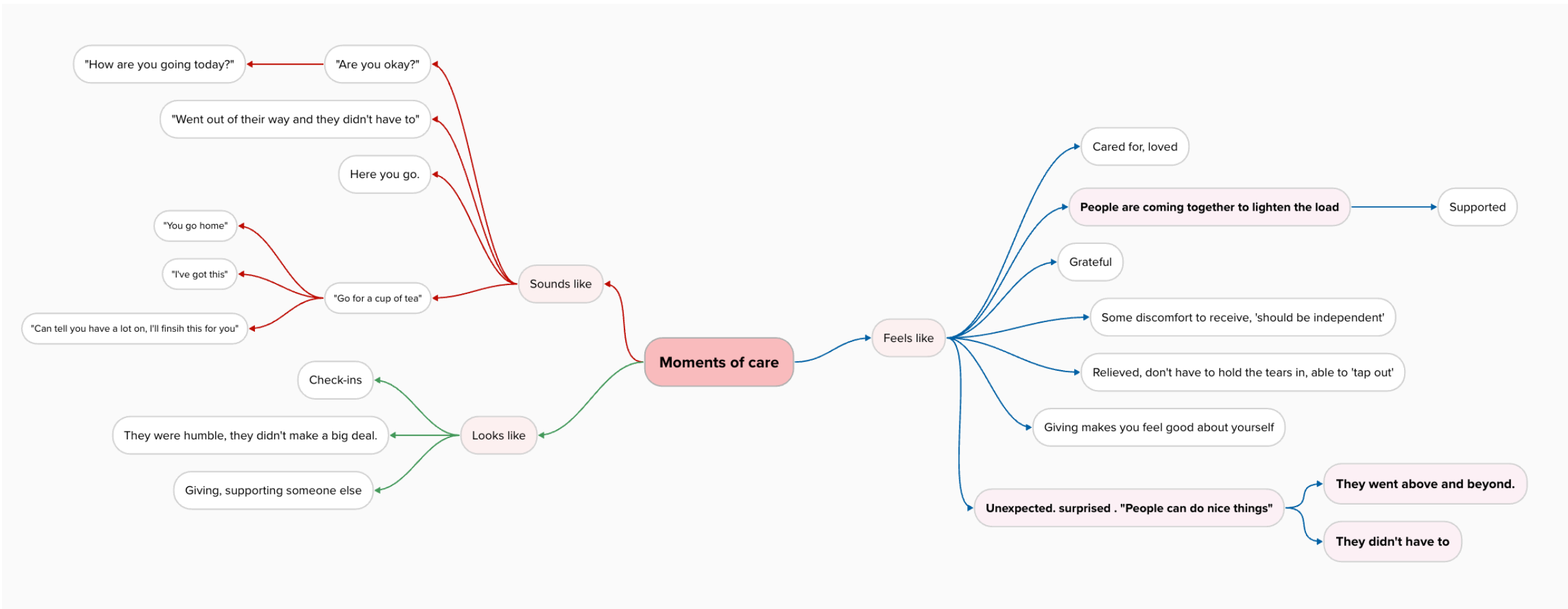


Figure 20 – Mind map - moments of care

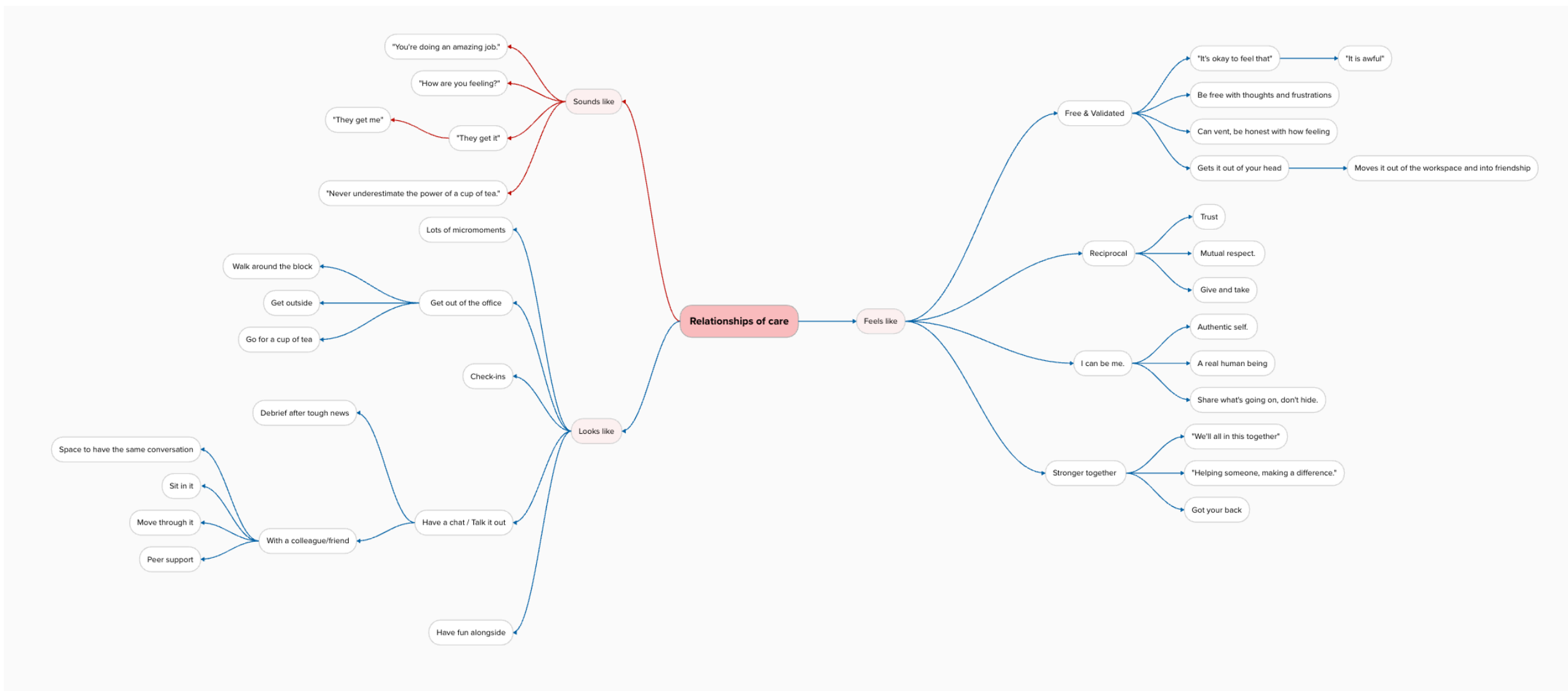


Figure 21 – Mind map - relationships of care

## Dream Phase of Appreciative Inquiry: Envisioning 'Care'

### *Facilitating in Group Workshop 1*

Table 3 provides a summary of how I practiced whakawhanaungatanga and utilised creative methods, DT tools and processes to build empathy and collaboration online during group workshop 1. This section documents findings from this process.

<p><b>Facilitation aim:</b> To create a safe space for collaborating, appreciating &amp; building on what works.</p>
<p><b>Practicing whakawhanaungatanga looks like:</b></p> <ul style="list-style-type: none"> <li>• <b>Inviting</b> mutual listening &amp; sharing (their self-care actions) at the beginning, ('Round' activity)</li> <li>• <b>Intentional start</b> - slow &amp; calm</li> <li>• <b>Inviting</b> engagement with the creative activity (Play-Doh warm-up activity)</li> <li>• <b>Explicitly sharing/communicating</b> workshop intentions, guidelines &amp; activities</li> <li>• <b>Practicing with care, empathy/compassion</b>, e.g. check about recording sessions, reassuring of process</li> </ul>
<p><b>Utilising creative methods, DT tools &amp; processes to build empathy &amp; collaboration online looks like:</b></p> <ul style="list-style-type: none"> <li>• Using <b>Mural</b> (workshop intention &amp; activities, C@W themes, link phases/findings) + icons (empathy &amp; compassion, C@W themes) to visually communicate &amp; invite collaboration</li> <li>• Utilising creative methods, e.g. <b>participant created artefacts</b> to help thinking and sharing stories (imagining ideal C@W)</li> <li>• <b>Questioning</b> to promote discussion – e.g. sharing how C@W could be</li> </ul>

Table 3 - Key facilitation actions - Group Workshop 1

Prior to meeting participants in group workshop 1, I set-up my laptop screen with two windows side-by-side: Mural & MS Teams (cameras on) - see Figure 22. Both tools encouraged communication and collaboration and participants commented that this enabled them to engage, not only with the text, tools and concepts presented on the Mural, but with each other, using visual cues to support the dialogue.

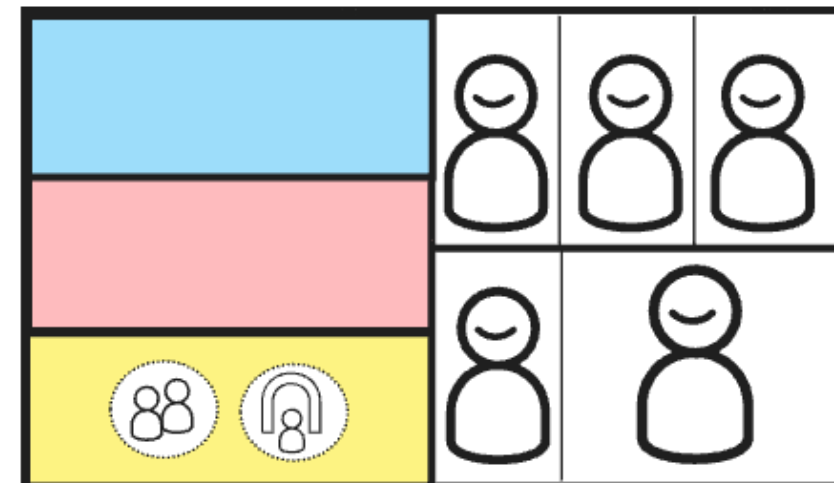


Figure 22 - Workshop online set-up

I introduced the workshop Mural to invite collaboration. The workshop intentions (Figure 23) and activities were displayed using a combination of text and visuals to cultivate a shared sense of clarity and trust in the process.

Visual representations of the concepts ‘empathy and compassion’ (Figure 24), and the ‘care at work’ themes/findings from the discovery phase (summary tiles and mind maps, see Figures 18 - 21) were presented to support effective communication.

Participants were invited to consider, compare and give feedback on the themes / modes of care - ‘moments of care’ (care for) and ‘relationships of care’ (care with), and this generated discussion at the start of group workshop 1. I am not too sure if the mind maps provided too much information or if they contributed to participant engagement. In the Mural, participants recorded their ideas and feedback on virtual ‘sticky notes’ (Figure 25), enabling them to read and appreciate a range of responses among the group.

I started this session intentionally calm, taking time beforehand to be prepared and feel ready. We started this session with listening to each other sharing personal notions of self-care, to link back to the interviews, appreciate diverse ways to see and support self-care, and to realise everyone had ideas and perspectives to contribute. Each person had a chance to feel heard, and this seemed to build trust in the group. Participants were respectful of each other and listened quietly with focus. On a group video call, ‘focus’ was interpreted like in-person ‘eye contact’ but was when I could see people looking towards their computer’s camera and what would be the other participants on their video call display screen.

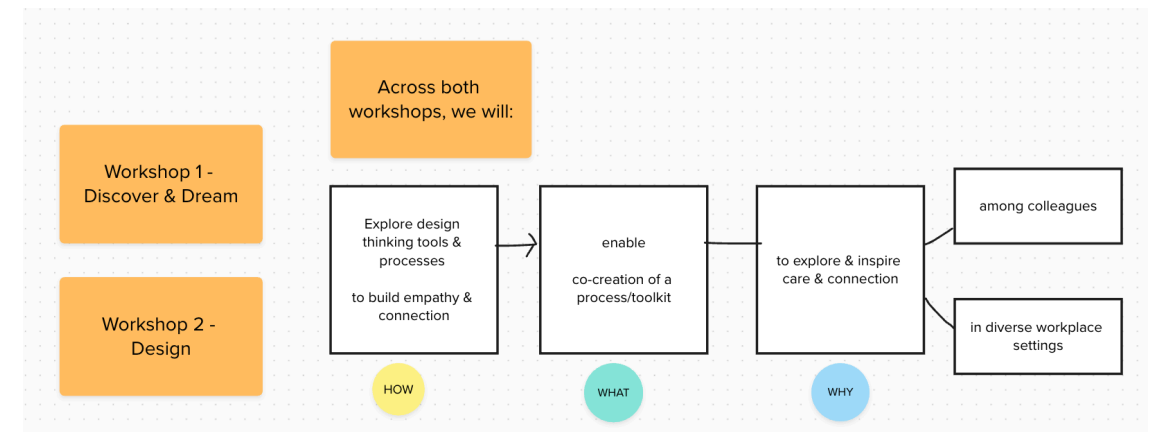


Figure 23 - Workshop intentions

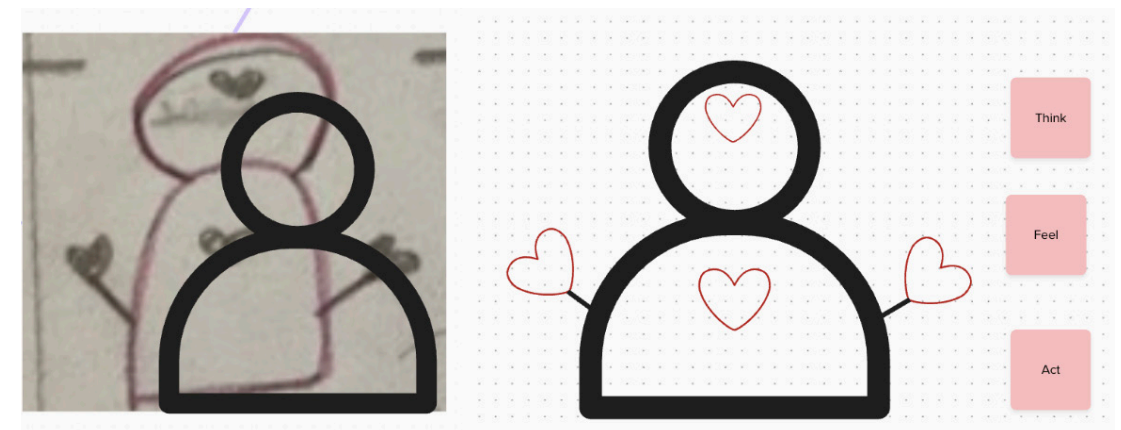


Figure 24 - Empathy & compassion

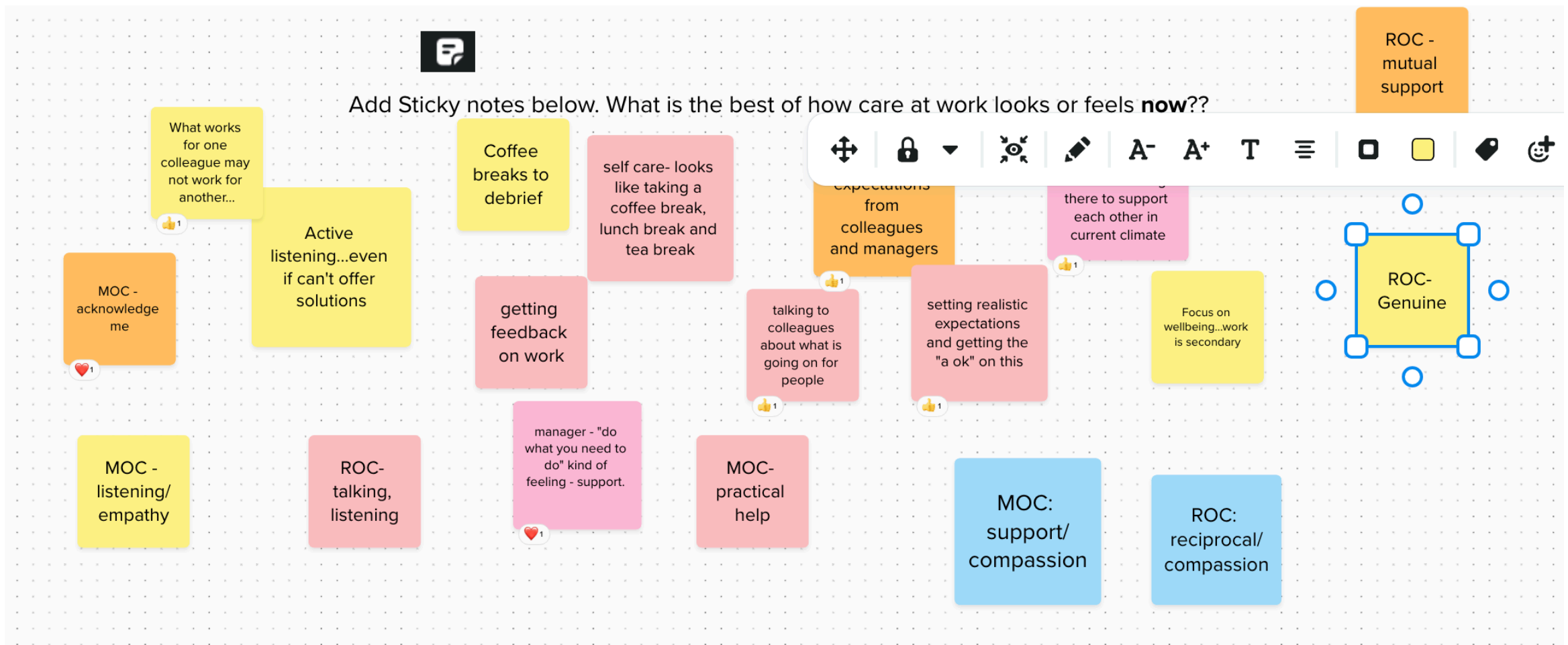


Figure 25 - Participant feedback to the care at work themes



Figure 26 - Dream phase

Opening the workshop activities toolkit together was a standout moment of joy fuelled by anticipation and an invitation to use play-doh (Figure 27).

Next, we entered the dream phase. Creative methods, specifically, storytelling through participant-created artefacts, were utilised to facilitate thinking and sharing stories about how participants imagined care at work ideally. Aware that using creative methods might provoke apprehension in some participants, I shared the purpose of the activities, offered different modes of expression and practical icebreaker/warm-up activities (e.g., ‘roll into a ball, smash it’, see Appendix 8 for Group Workshop activities), to invite participants to contribute with confidence. Sharing that I was also new to creative activities may have helped to create a sense of learning together and to model and invite a creative, playful mindset/ approach.

*“We make because it helps us to think about the topic, engage all senses, and take our time.”*

*“The toolkit is for creative activities, simple, fun making with craft materials. There is also a pen and paper to use if you like for notes or to share ideas visually.”*

I tried to connect the participants back to their interviews and to elicit an emotional response. I intentionally used the following prompts:

*“Since your interview, what have you been thinking about how care at work could be? See if you can make something that represents what you’ve been thinking and feeling about ‘care at work’ since the interviews.”*

*“How do you imagine it could be, if there was a culture of care among colleagues and in healthcare as a workplace broadly?”*

*“You might like to dream of an ideal day or team, let go of constraints. What does this look like in your ideal scenario?”*

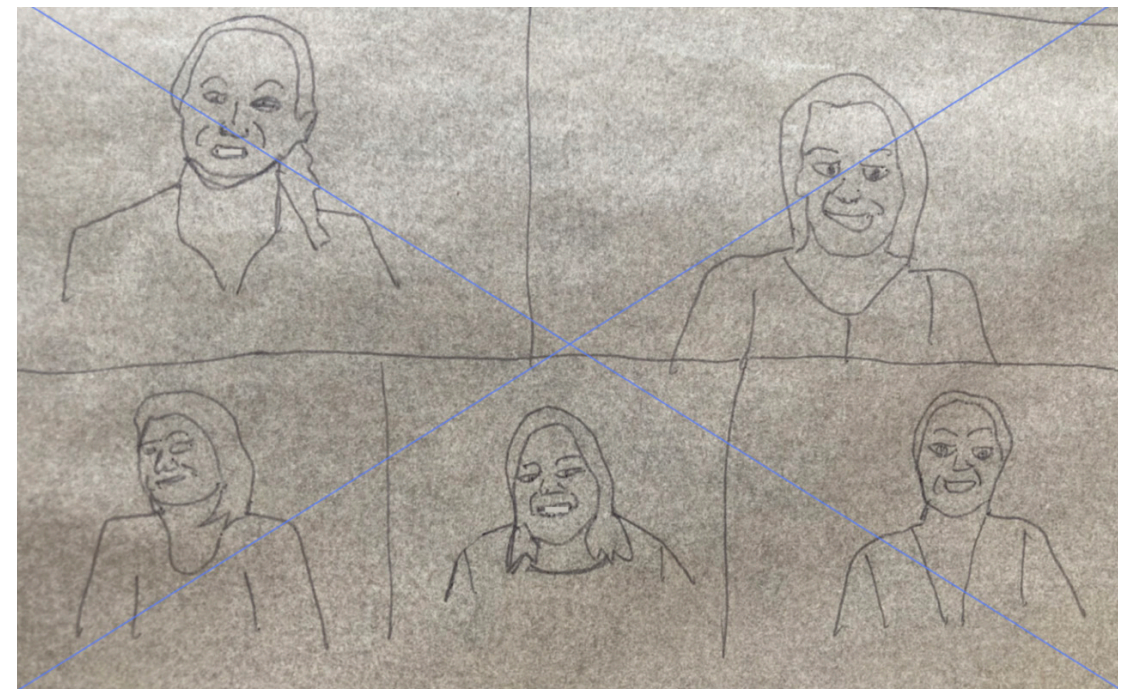


Figure 27 - A moment of joy in the workshop

I gave the participants time to think, sat with the silence and encouraged them to just start playing and see what happens. I reassured them “it will come” and it did. I was careful not push but to encourage, the balance seemed to work, participants gave making a go over the two-minute period. During their making time, I played a song. Unfortunately, in error, it wasn’t the orchestral version but had loud singing in it, I apologised for that afterwards and participants seemed relaxed as I modelled ‘failure’ and ‘giving it a go’ as I had asked of them. This may have invited empathy, compassion, connection and trust among us.

Pleasingly, the creative making sparked joy, the participants were smiling, shared their artefact, engaged in articulate, rich storytelling and a range of responses – see Figures 28-29.

During and after each of the participants shared the story of their artefact, participants were given time to generate ‘sticky notes’ on the workshops Mural to share their ideas of how ‘care at work’ ‘could be’. The workshop Mural was a collaborative document that could be modified by all participants simultaneously, data was collected using the ‘sticky note’ tool – see Figure 30.

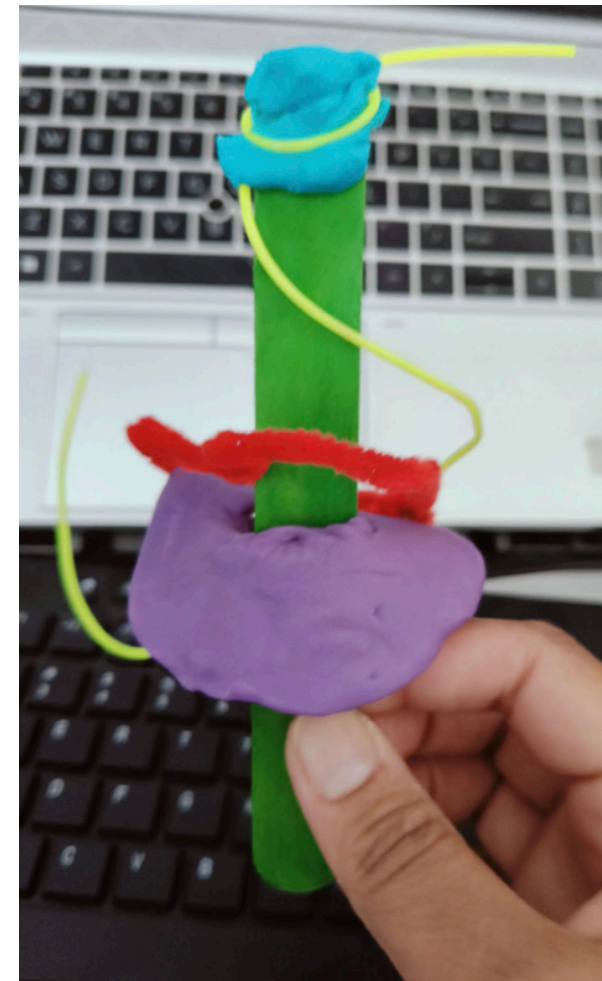


Figure 28 - Participant-created artefacts

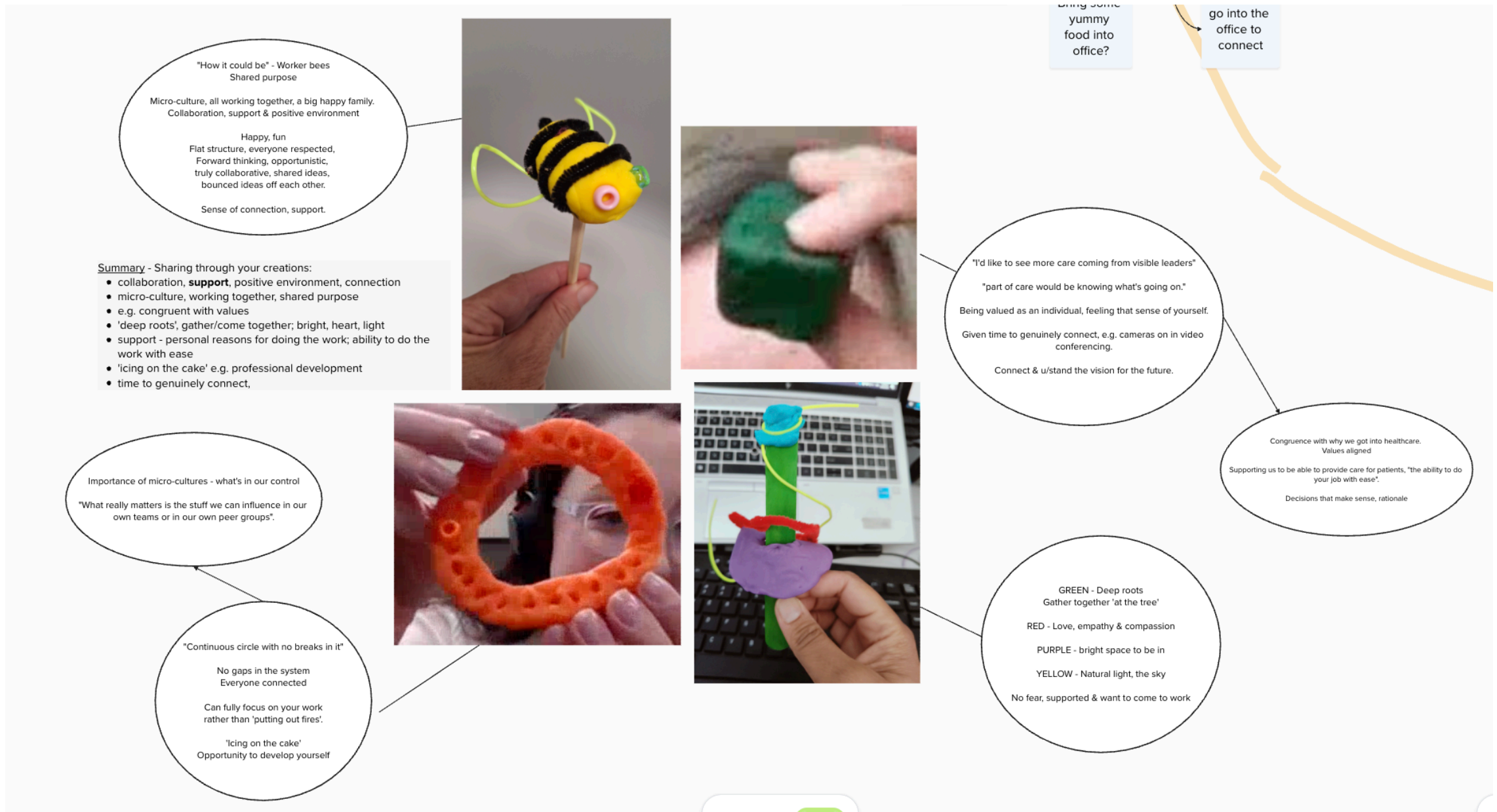


Figure 29 - Participant stories

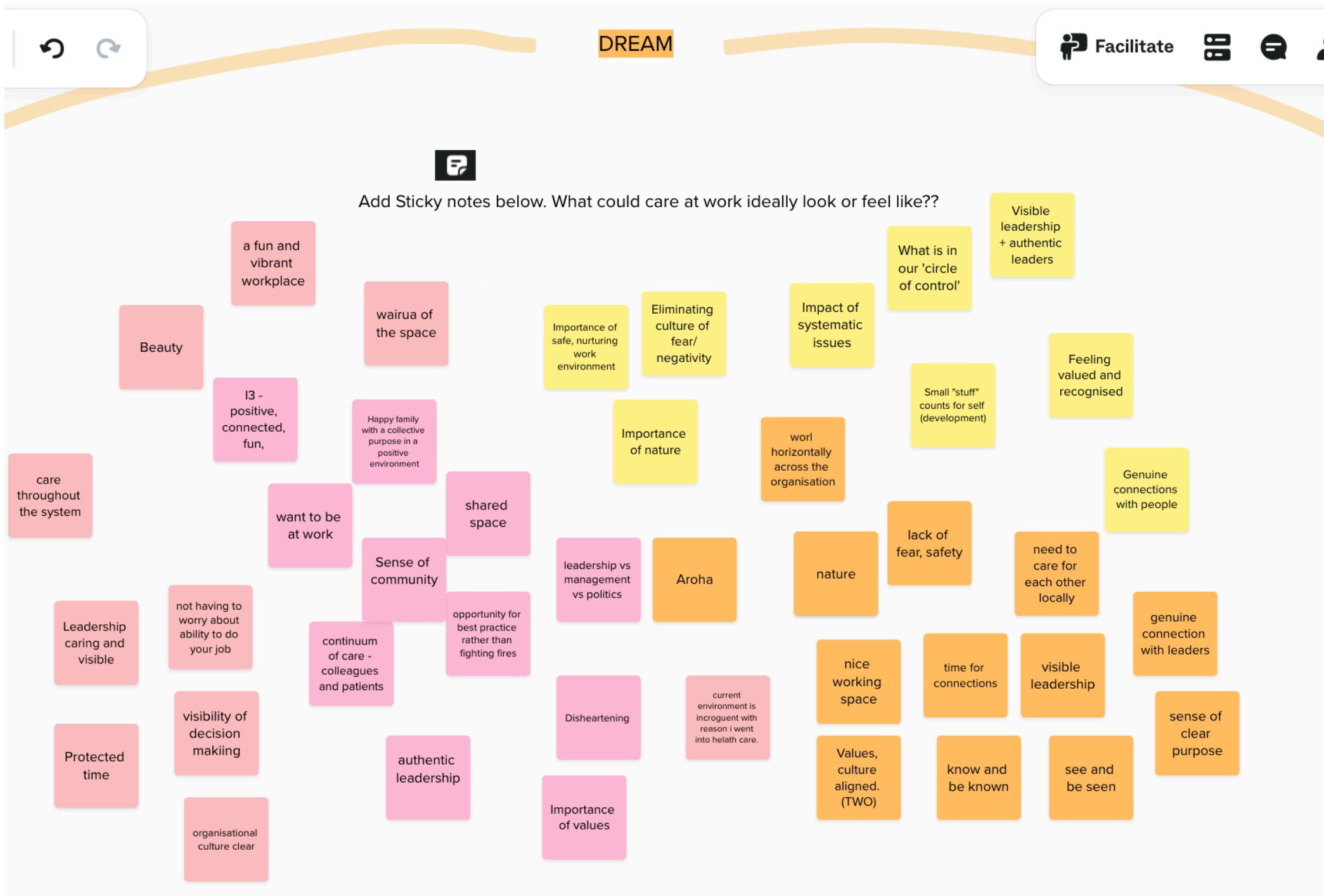


Figure 30 - Participant ideas in the dream phase

### Making Sense of the Group Workshop 1 Findings

Post-workshop I continued to evolve the Mural document rather than it being a static resource. To analyse the participant responses to the discovered 'care at work' themes, I visually sorted the sticky notes (from Figure 25 above), to show which responses complemented MOC (Figure 31, top), ROC (Figure 31, middle) and other ideas (Figure 31, bottom). In this way, 'discovery' was an iterative process that involved participant input and led to refining how 'care at work' was represented on the Mural for the subsequent 'dream' & 'design' phases.

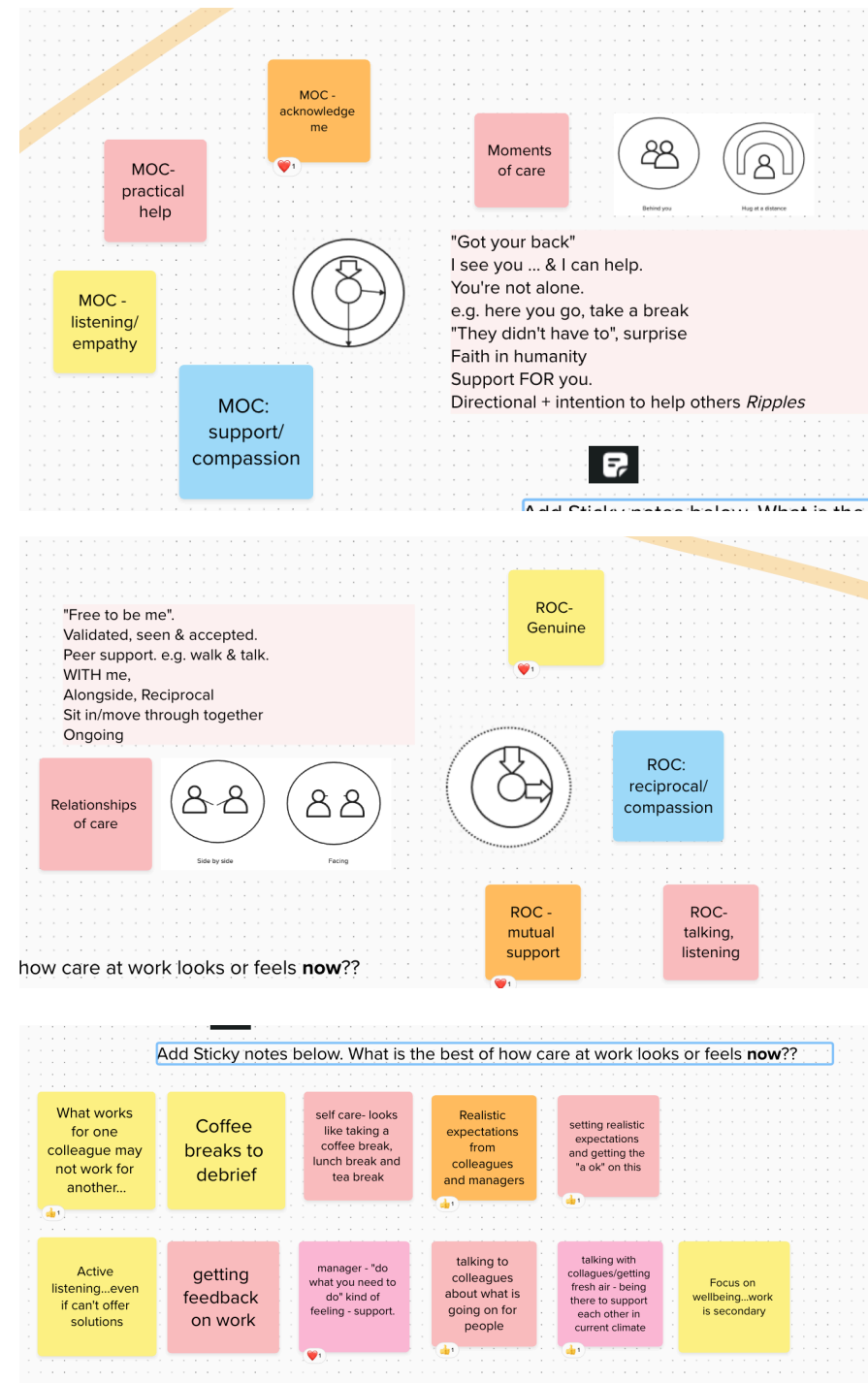


Figure 31 - Participant feedback to themes of 'care at work' now

Interestingly, in the dream phase, a participant mentioned the importance of

*“Being valued as an individual, feeling that sense of yourself (at work)”.*

Participant quote

This spoke to the spiritual dimension of well-being (in the Te Whare Tapa Whā model of hauora), brought to light the influence of work on worker’s well-being and the opportunity for self-care to occur while at work. Participant storytelling through the artefacts they created,

Participants ‘dreamed’ of a workplace that aligned with their values.

*“Supported us to be able to provide care for patients; The ability to do your job with ease”*

*“Where decisions make sense, there was a rationale; Was congruent with why we got into healthcare”.*

Participant quotes

I grouped (analysed) participant sticky notes to visually represent how ‘care at work’ could be. A desire for ‘care at work’ to extend beyond interpersonal interactions with colleagues was evident - connection and care were desired in multiple areas of ‘work’ - connection with people (teams and leaders), the physical environment, and with the system (Figure 32).

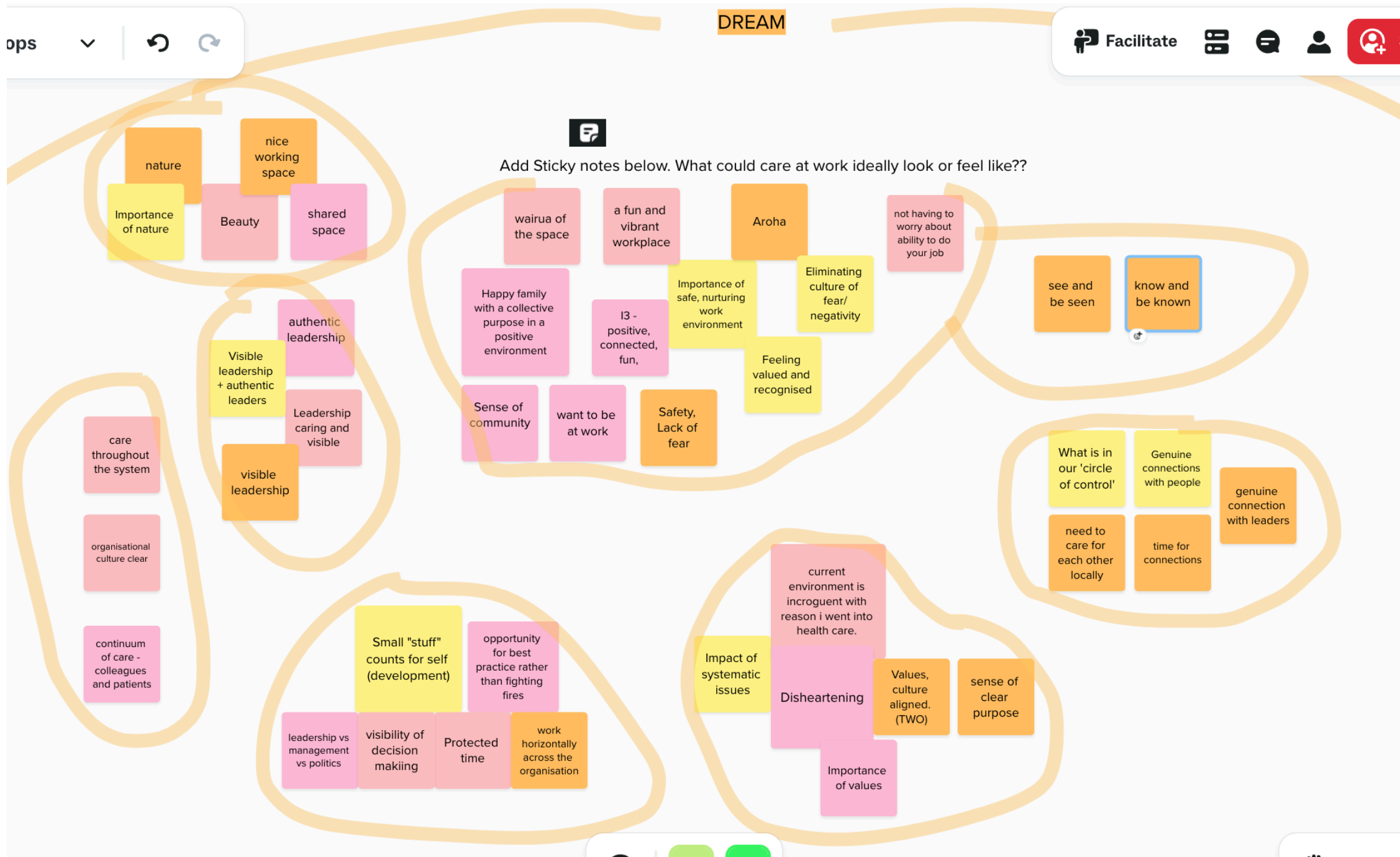


Figure 32 - Dream categories

Carlson's (2021) Whakawhanaungatanga Conceptual Model (Figure 5), provided a way to conceptualise 'care' as well-being with multiple domains of connectedness. As 'whakawhanaungatanga' is understood within a relational world, among the complexities of participants' personal and professional lives, in Aotearoa – New Zealand, considerations for healthcare professionals' well-being sit within and beyond the context of 'care at work'.

To evoke a collective sense of the 'dream' - the vision that might inspire action in the next phase and future - I created 'possibility statements' (see Figure 33) and captured the 'dream' more succinctly as 'genuine connections', with keywords such as 'local, seen, known, fun, safe & supported' (Figure 34).



Figure 33 - Possibility statements

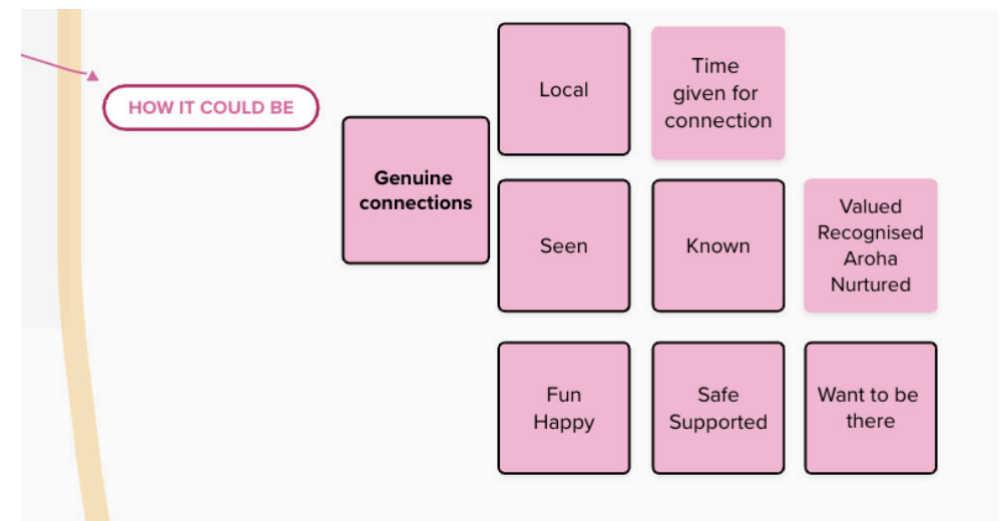


Figure 34 - Capturing the dream

To focus the ‘designing’ phase we chose to work towards an aspect of the dream that participants felt was within their control - a ‘micro-culture of care’. Participants suggested that:

*“What really matters is the stuff we can influence in our own teams or in our own peer groups”*

*“Given time to genuinely connect”*

Participant quotes

Figure 35 represents a stylised version of the WCM with the corresponding five domains of connectedness.

To ‘capture the dream’, I visually conceptualised and communicated the connection between notions of ‘care’ revealed in the research, in a similar way to the WCM’s five domains of connectedness (Figure 35),

Figure 36 shows self-care centrally, surrounded by friends and family, then care at work with peers (MOC & ROC), and a ‘micro-culture of care’ towards the outside.

In this research, ‘care at work’ was revealed as connections.

Carlson et al. (2016) explain that the centre of the word ‘whakawhanaungatanga’ is au (a hau), the self and identity, which extends to whānau relationships, and whanaunga which “represents connections of shared interest and passion, including friendships, peers, leaders and activists. The next layer is whanaungatanga, relational practices and the act of nurturing relationships.”<sup>1</sup>.

<sup>1</sup> Carlson, “Whanaungatanga”, 412

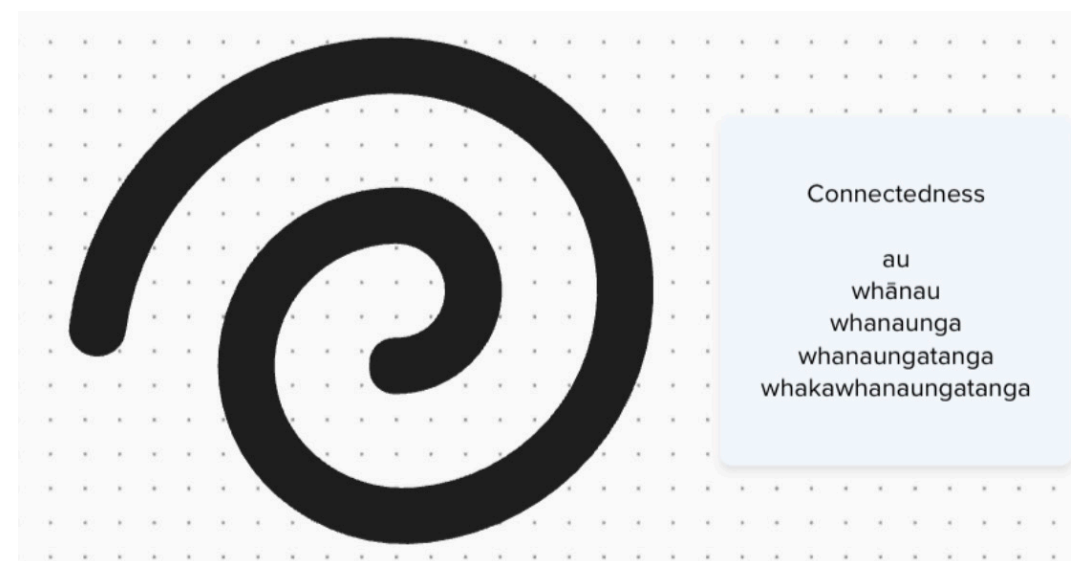


Figure 35 - Stylised WCM



Figure 36 - Stylised WCM with findings

‘Whakawhanaungatanga’ is a way to conceptualise and inspire care and compassion throughout the health system in Aotearoa – New Zealand. This complements research into team and system-wide care into healthcare<sup>1</sup>.

Figure 37 provides a way to think about the findings as whakawhanaungatanga, domains of connectedness.

Findings from the ‘dream’ phase were displayed in the workshop Mural (Figure 38) to represent how ‘care at work’ could look and feel, for participants to consider in group workshop 2, as we moved into the ‘designing’ phase.





<b>au</b>	<b>whānau</b>	<b>whanaunga</b>	<b>whanaungatanga</b>
Self & identity	Family & friends	Friends, mentors, colleagues	Relational practices & the act of nurturing relationships
			
<b>Self-care</b>	<b>Collective care</b>	<b>Connected care</b>	<b>Compassionate care</b>

Figure 37 - Domains of connectedness and findings

<sup>1</sup> Trzeciak, “Compassionomics”; Wei, “Current Intervention”, Shanafelt, “Organizational-Wide”; Mete, “Impact of Leadership”, Carlson, “Whanaungatanga”..

## Design Phase of Appreciative Inquiry: Creating Actions for ‘Care’

### *Facilitating in Group Workshop 2*

Table 4 provides a summary of how I practiced whakawhanaungatanga and utilised creative methods, DT tools and processes to build empathy and collaboration online during group workshop 2. This section documents findings from this process.

<p><b>Facilitation aim:</b> To create a safe space for collaborating, appreciating &amp; building on what works.</p>
<p><b>Practicing whakawhanaungatanga looks like:</b></p> <ul style="list-style-type: none"> <li>• <b>Inviting</b> conversation &amp; extended time to settle into the space activity at the beginning (Check-in activity)</li> <li>• <b>Being adaptable</b> / responsive</li> <li>• <b>Practicing with care, empathy/compassion</b>, e.g. appreciating &amp; incorporating discovered notions of ‘care’ in practice, e.g. to see &amp; hear participants.</li> <li>• <b>Inviting</b> participant sharing (what worked in WS1 to connect online) to promote empathy</li> </ul>
<p><b>Utilising creative methods, DT tools &amp; processes to build empathy &amp; collaboration online looks like:</b></p> <ul style="list-style-type: none"> <li>• Using <b>Mural</b> to visually collaborate, especially during idea generation</li> <li>• <b>Questioning</b> – especially HMW questions - to promote discussion and ideation</li> </ul>

Table 4 - Key facilitation actions - Group Workshop 2



Facilitation in the ‘designing’ phase was driven by a desire to build on what was ‘discovered’ and move towards what was ‘dreamed’ through creating shared understanding and ideas for action.

I started this session slowly and acknowledged the need for some crosstalk conversation among the participants. As they talked, I noticed participants seemed ‘heavy’, tired and sad, in response to the prolonged uncertainty in their work context, e.g. among ongoing restructuring and potential job losses. Also, they turned up, were hopeful and mindful of being constructive. I facilitated an extended check-in activity, to give participants time to settle in and connect with each other. I shared that I had just moved houses, and this invited participants to share where they were working from – at home, in their ‘old’ office, in their ‘new’ office – and mentally/emotionally, how they were dealing with all the change going on. I came to appreciate their context, perspectives and experiences more deeply through the exchange that followed. Participants responded with mutual support and care for each other in ways that suggested not just ‘moments of care’, but towards reciprocal ‘relationships of care’. I felt little doubt of the value in giving time to connect and engage in dialogue at that time. This interaction reminded me to be adaptable in response to participant needs and reinforced the importance of sharing a bit about myself, to encourage participants to be vulnerable and share where they were at in return.

I explicitly asked participants to share what they had appreciated in group workshop 1 to help them connect, build empathy and collaborate. They shared very practical examples such as having our videos on in the MS Teams calls, using a two window/screen set-up (with Mural & MS Teams, side-by-side), starting with a ‘round’ of each person sharing one at a time, in response to a specific question.

As I had come to appreciate the participants' 'notions of care' from the interviews and group workshop 1, I was able to practice whakawhanaungatanga in ways that were relevant to the group. As it was revealed that 'care' can feel like being 'seen' and 'heard', I could listen to show 'care' during the co-creation process. Although it is hard to show the impact of whanaungatanga, participant responses, during the online video call, such as smiling, laughing, sharing (their stories, perspectives and lived experiences), listening, asking questions and engaging in conversation suggested they were engaged in the co-creation process.

To initiate collaboration at the start of group workshop 2, the Mural presented findings from group workshop 1, questions and considerations. In Figure 38, you can see the 'discovery' (in green) and 'dream' (in pink) phases were intentionally positioned with space for collaborating in the 'designing' (yellow) phase between them, like a 'bridge'. Questions included 'What will help us get to the Dream?' and 'What do we do practically to get there?'. The points and tools for consideration were designing for 'diverse people' in 'diverse settings', towards a 'micro-culture of care', using 'listening' and 'empathy & compassion' to amplify 'care at work' – see Figure 38.



Figure 38 - Key findings in three phases

To complement what was displayed visually on the Mural, I attended to the language I used. To help us move from ‘what works’ and matters (‘discovered’) to ‘how it could be’ (‘dreamed’), ‘design’ was framed as ‘how we get there’. I spoke about ‘moving towards genuine connections at work by building on, or amplifying, ‘moments’ and ‘relationships’ of ‘care’, for people to feel ‘seen, heard, and supported’.

To begin ideating how to create the desired future (the ‘dream’), we reviewed what was presented in the Mural and proceeded through two stages, an ‘idea dump’ and ‘answering ‘how might we’ (HMW) questions - see Figure 39.

Participants shared and discussed ideas from working through and in the wake of the Covid pandemic, where they felt people got creative about ways to connect with friends, family and colleagues. They recognised parallels to their situation at the time of the research. This included benefits and challenges of working from home. Benefits such as having access to the outdoors and a comfortable workspace, and challenges like loneliness, isolation and disconnection from a work community. The informal, in-person interactions were emphasised for their contribution to building relationships at work.

By discussing certain points, we came to appreciate more fully what might work or not, for example, the distinction of ‘fun’ versus ‘forced fun’. Participants shared their experiences and perspectives of what’s worked well in the past and what to avoid. In this way, the Ai process allowed the participants’ wisdom to be revealed, not just the ‘good’ but the ‘bad’ too. I appreciated that the Ai process didn’t just provide a ‘rose-tinted’ view.

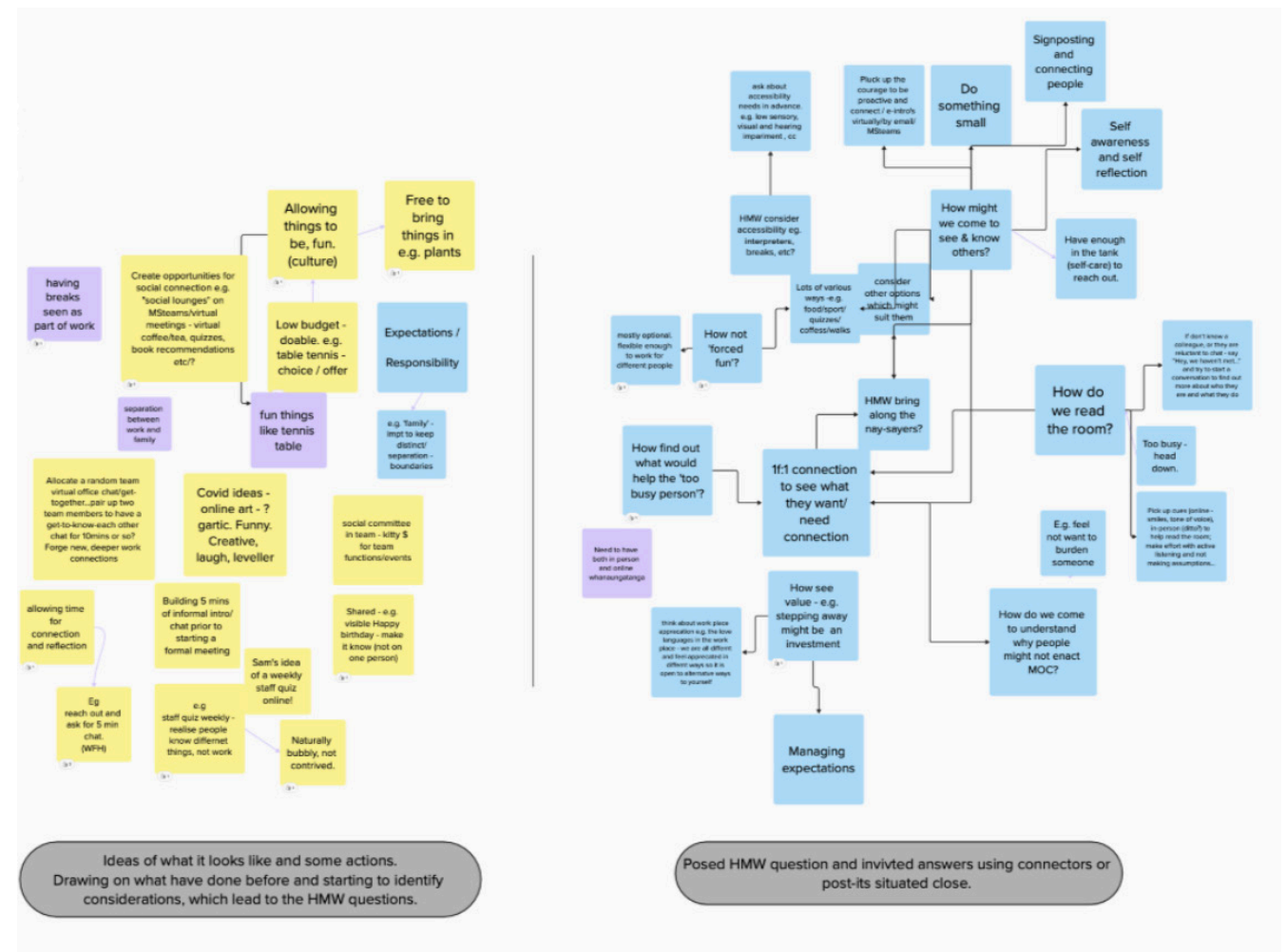


Figure 39 - Design phase - participant ideation

Figure 40 shows the section of the Mural that captured 'designing' in group workshop 2.

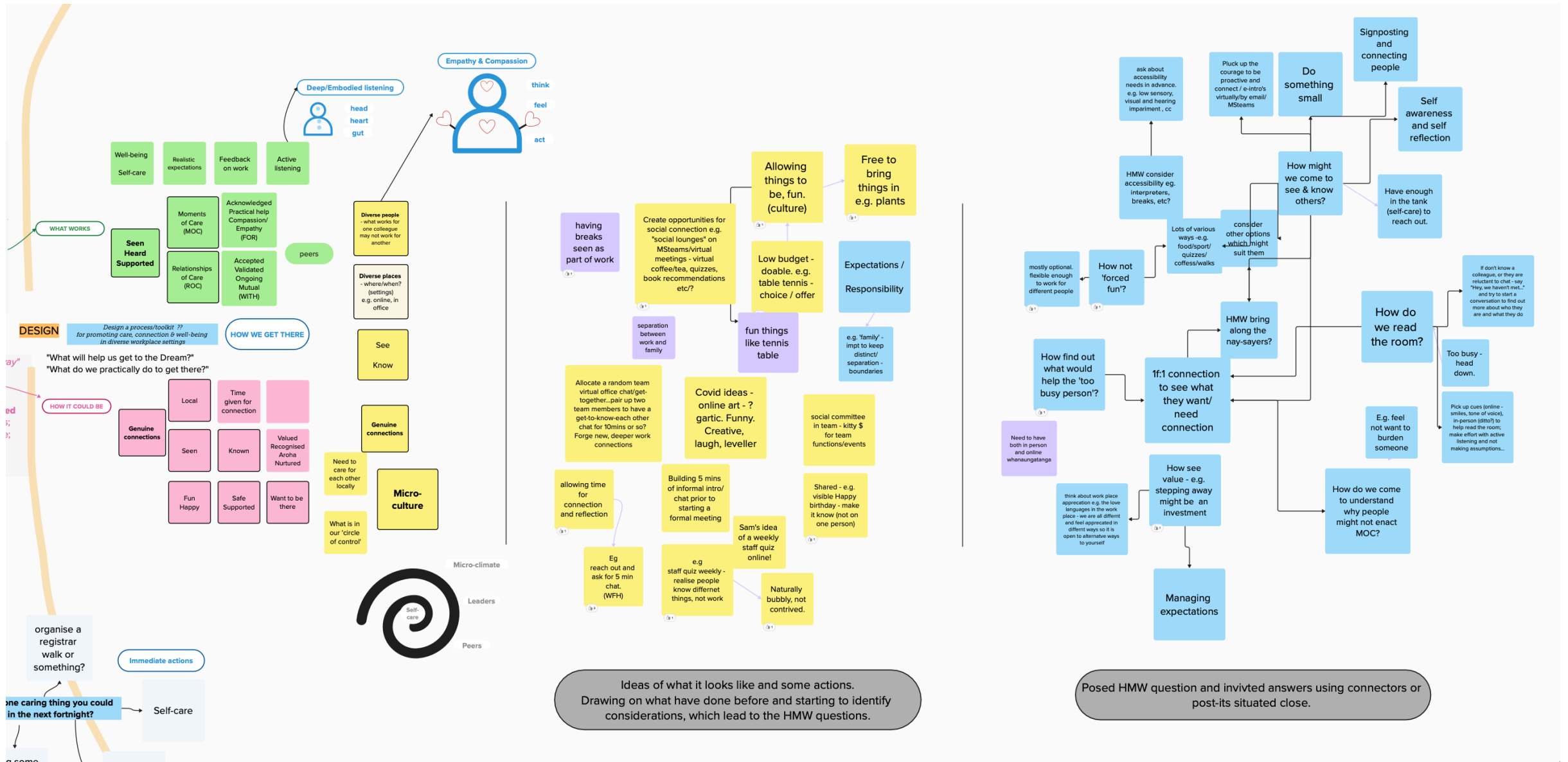


Figure 40 - Design phase on the Mural

### *Making Sense of the Group Workshop 2 Findings*

Post-workshop 2, I ‘untangled’ the HMW questions and answers in Mural to make sense of what was shared. To my surprise, something that resembled a flow-diagram appeared (Figure 41) that more clearly showed participants’ ideas for action.

Key ideas to come to see, know and genuinely connect with diverse colleagues, in diverse workplaces (e.g. online and in the office), to create a micro-culture of care, included one-on-one conversations with colleagues to understand what they find engaging (for connecting with other colleagues), providing a range of options for connection, and giving time for ‘informal’ connection, e.g. in meetings, during the office day.

As we had both explored and experienced ‘care’, ‘connection’ and ‘empathy’ in this co-creation process, I gathered findings from each phase of Ai (the ‘collective wisdom’), and reflected on the process (how the wisdom was revealed), to identify further opportunities for inspiring care and connection in their work teams (see Figure 42).

Figure 42 also shows how I was starting to explore ways to represent the phases of the Ai process visually – discovery in the middle, dream to the top left and designing to the right – to see connections between findings more clearly.

Subsequently, I prototyped a resource for participants to capture the findings and the co-creation process, which informed prototyping a ‘toolkit’ for facilitating co-creation with care.

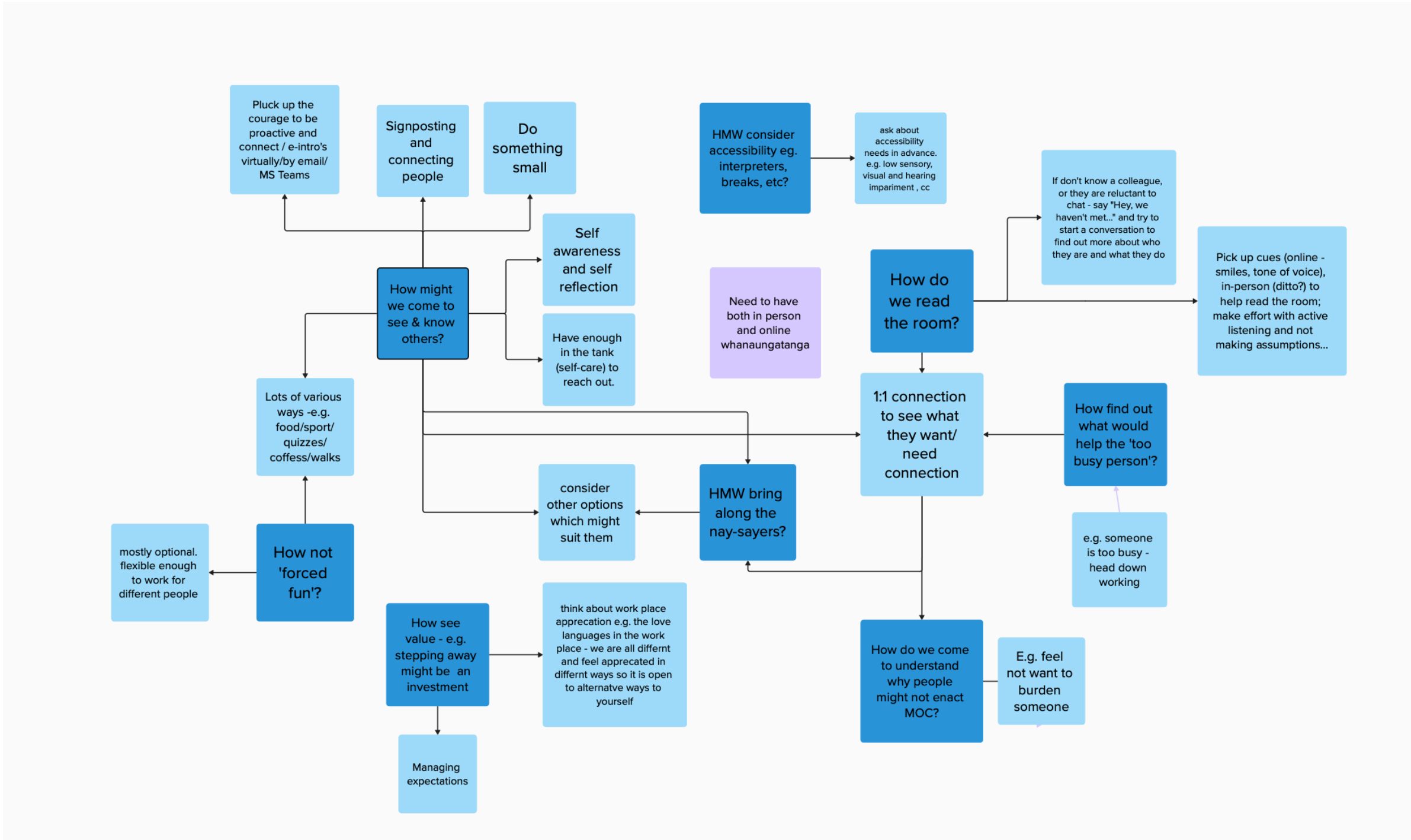


Figure 41 - 'Untangled' ideas generated by participants

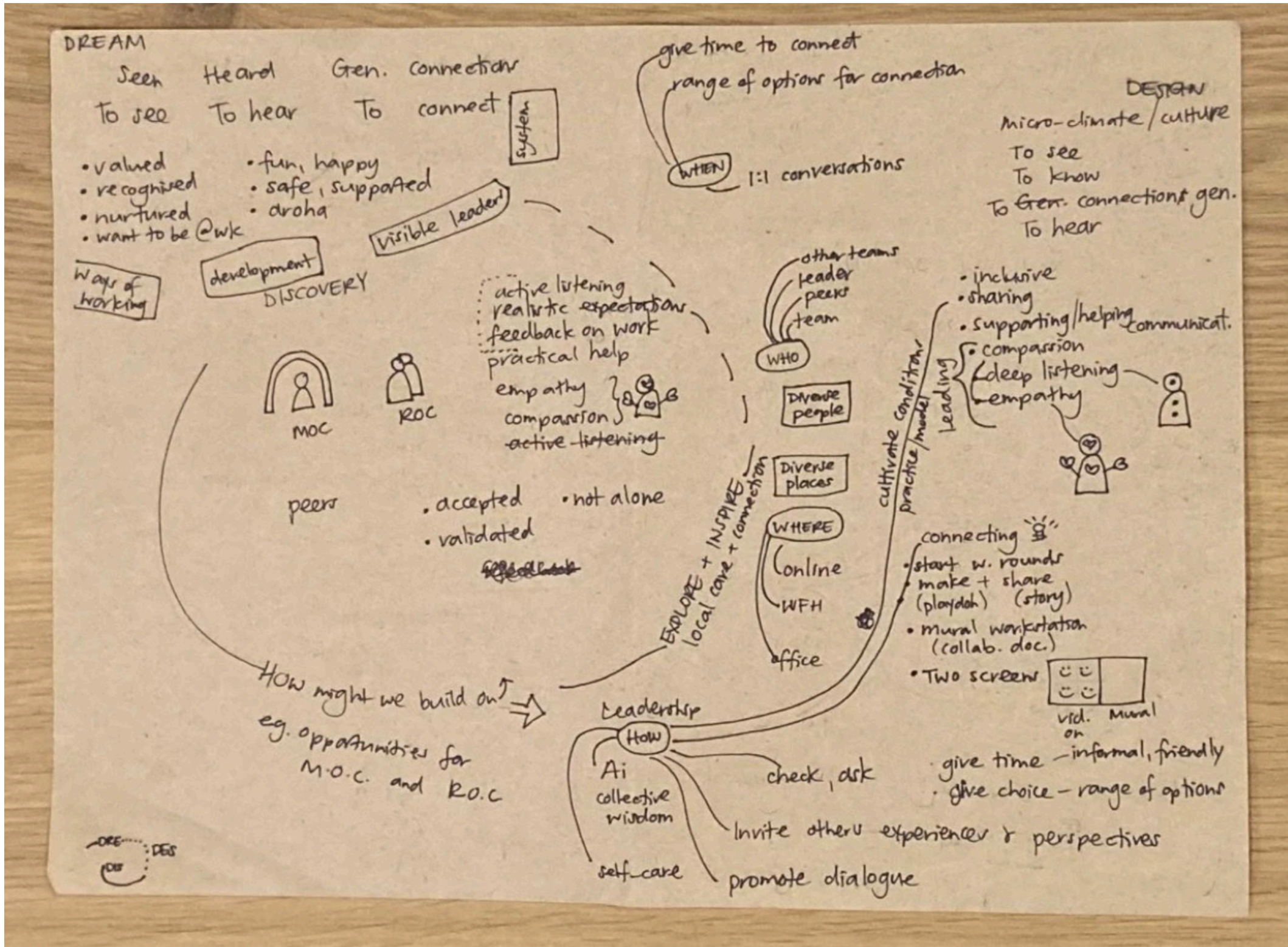


Figure 42 - Early notes - gathering findings

*Prototyping a Resource for Participants*

Through making, sketching and digitising, I created a two-sided booklet to capture the finding for participants; something to hold as a reminder of the project experience - what we discovered about the best of care at work, what we dreamed it could be, and ways to create care and connection at work – Figures 43-46.

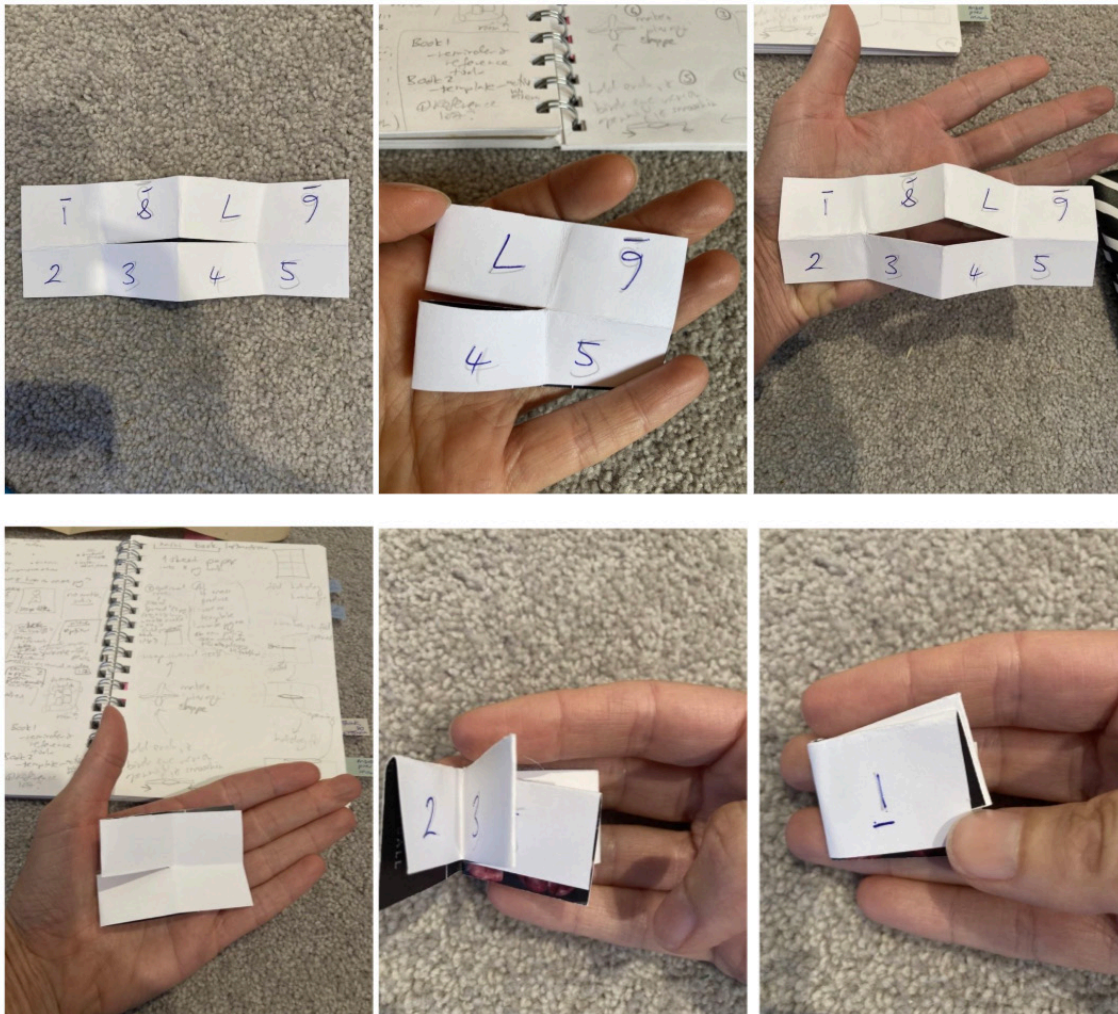


Figure 43 - Booklet testing

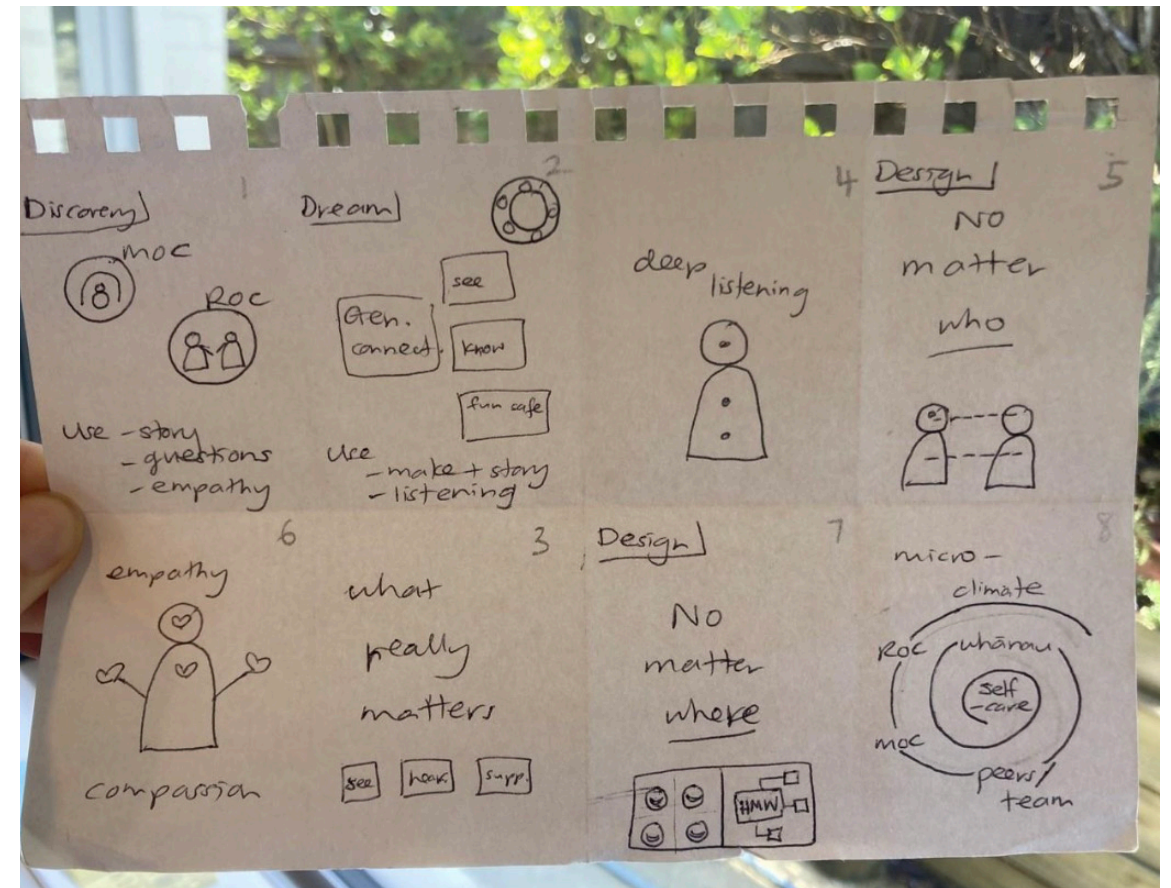


Figure 44 - Booklet sketch




<p><b>Cultivating a microclimate of care</b></p> <p>Reminders &amp; Tools</p> <p><i>For you &amp; your team in the office &amp; online</i></p>	<p><b>Foster</b></p> <p><i>Self-care, peer &amp; team connections</i></p>  <p>Resources from 'care at work' in healthcare study, 2025, Natasha Low</p>	<p><b>When meeting online</b></p> <p>Make time for connection first</p> <p>e.g. start with a 'round' of sharing</p> <p>Windows side-by-side</p> <p>E.g. Mural (collaborative document) + videos on</p>	<p><b>Move towards Genuine connections</b></p> 
<p><b>Amplify</b></p> <p><i>Moments of care (MOC)</i></p>  <p>peers</p>	<p><b>Amplify</b></p> <p><i>Relationships of care (ROC)</i></p>  <p>peers</p>	<p><b>Build on what's great</b></p> <p><i>Care as...</i></p> 	<p><b>Empathy &amp; Compassion</b></p>  <p>think feel act</p> <p><b>Use your head, heart &amp; hands</b></p>

Figure 45 - Digitised booklet front

## Exploring 'care at work' (C@W) among your team

### Phases of Appreciative Inquiry

**Discovery**

What are our best examples here of 'care at work'?

What currently works & matters?

**Dream**

What could 'care at work' ideally be like?

**Design**

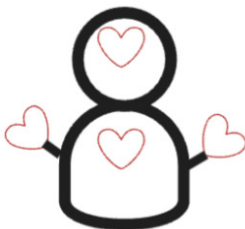
How might we amplify what we 'discovered' works & matters, to move towards our 'dream'?

**Destiny**

Take action

Reflect & Refine

### Cultivating an empathic & compassionate approach to exploring C@W



Think	For us, what does 'care at work' mean?
Feel	What does 'care at work' feel like?
Act	How might we inspire 'care at work'?

Made by:  
Natasha Low

Figure 46 - Digitised booklet back

Feedback was sought from participants on the usefulness, usability and relevance of the prototype booklet. They were also asked to assess (on a scale from 1-5) how engaging they found the prototype and if they had any ideas for how it could be improved. Participant feedback gave me a richer appreciation for their contexts and perspective and affirmed the importance of providing artefacts that could be adapted. Participants shared that they appreciated the visuals to remind them to practice care and hoped, if displayed at their desk, that an artefact might promote discussion with colleagues. They requested extra copies of the images for displaying at home as reminder cards and a second copy of the booklet for working from home. They also suggested, a template for action that they could use for exploring 'care at work' with their teams.

Two copies of the booklet (front) will be printed on A4 paper, assembled and posted to each participant, along with a set of cards (the front page of the booklet cut into eight cards). It will also be emailed to participants, together with a supplementary instruction sheet I sourced from Pinterest for assembling the book using a single sheet of paper (Figure 47), for reprinting or sending to others.

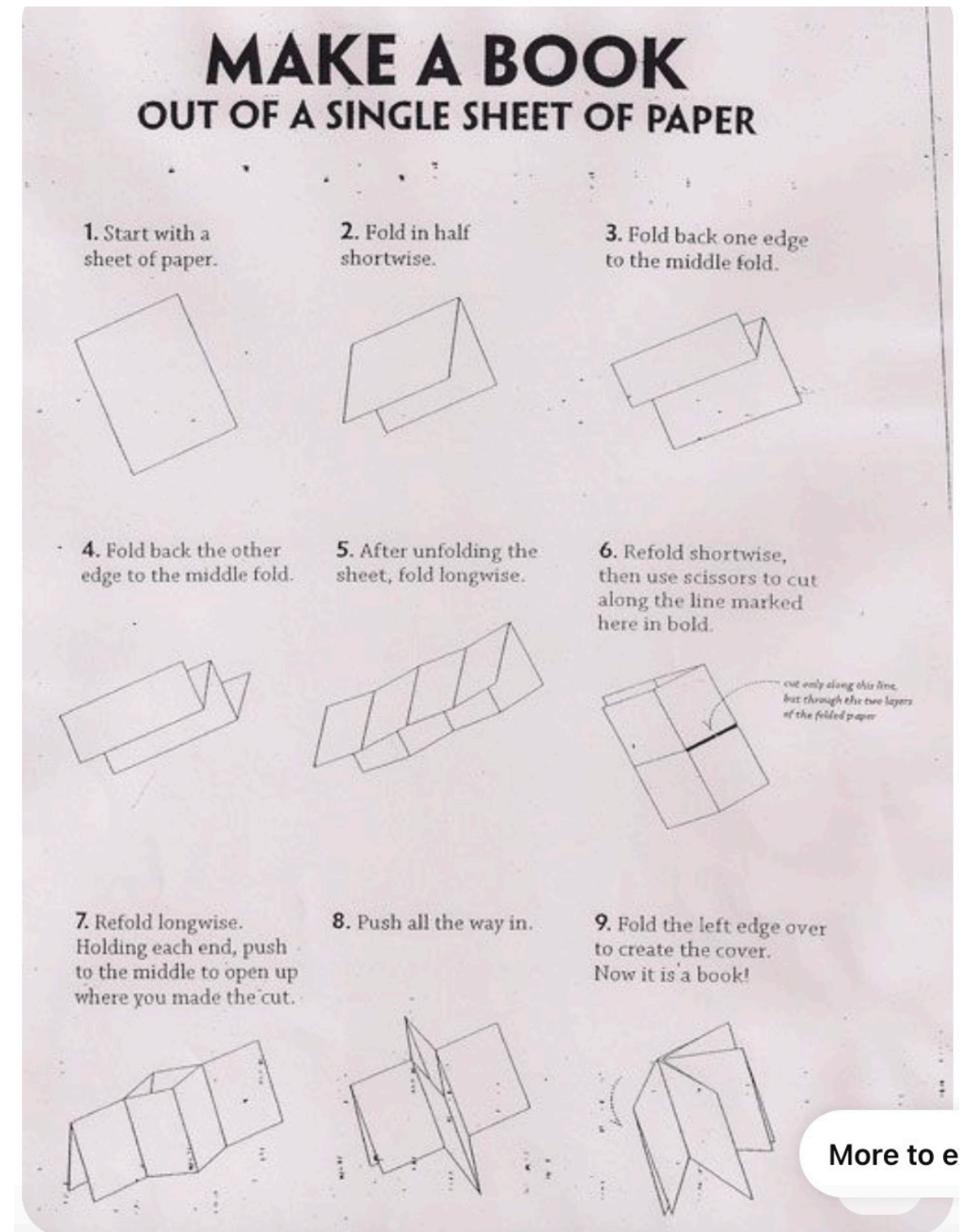


Figure 47 - Supplementary instruction sheet for making a booklet, created by Daniela Bustamante Canales <https://nz.pinterest.com/danibc/>

## Prototyping a Toolkit for Facilitating Co-creation with Care

The artefacts above inspired the creation of a toolkit for facilitators to engage groups in a process of co-creation online with care, to explore tricky to articulate topics, such as ‘care at work’, using a combination of Appreciative Inquiry, practicing with care (PWC), and design thinking tools, methods and processes. The resource endeavours to communicate a process that is transferable for use in different contexts, exploring different topics with different groups of people - in and beyond healthcare.

*Design brief – pocket guide for facilitators*

### What is it?

This resource will be a pocket guide for facilitators to feel ready to ‘give it a go!’, to co-create with care online.

It will outline key actions for preparing and practicing as a facilitator to engage a small group in co-creation online (‘PWC actions’, and ‘Tool actions’), utilising three-phases of inquiry (Appreciative Inquiry) over three 60-90 min interactions with group members (individual interviews, two group workshops), creative/design thinking ‘tools’, and practicing with care.

### Who is it for?

This resource is for facilitators/fledgling designers to prepare for, and use during, a series of co-creation interactions online with a group (e.g. at work).

It is for facilitators who are:

- New to Appreciative Inquiry &/or Design Thinking & creative methods
- New to online co-creation/collaboration – e.g. they might be translating their existing practice from in-person to online & wondering how to use technology to enable this
- Wanting more care in their online creative collaborations – e.g. in a new/uncertain context such as engaging a new team or team member, or situations such as changes in the work environment (e.g. restructuring) that might need more caring, empathetic connections in a group.

### How will it work?

The resource will help promote understanding, a sense of confidence & action by being:

Qualities	Description
<b>Informative</b>	<ul style="list-style-type: none"> <li>○ clearly communicating <b>who</b> it’s for, <b>when &amp; how</b> to use it, e.g. via an instruction sheet</li> <li>○ enable zoom out/in perspective to prepare for the co-creation journey – outlining the <b>process</b> (e.g. an overview), each specific <b>phase</b>, each specific <b>action/tool</b> (e.g. cards), including how to open/close the group space ‘with care’.</li> </ul>
<b>Engaging</b>	<ul style="list-style-type: none"> <li>○ user-friendly, tangible, somewhat playful/fun, &amp; experiential</li> </ul>
<b>Accessible</b>  Readability & usability  Easy to make, send & copy	Considering: <ul style="list-style-type: none"> <li>○ text - font size, text orientation, jargon free</li> <li>○ visual – images, colour coding, standard format e.g. headings, categories for actions / interactions / tools</li> <li>○ practical – easy to hold &amp; use</li> <li>○ materials - common office supplies (at home or work), e.g. paperclip, A3 or A4 size paper, readily available cardboard.</li> <li>○ weight/size - light, flat, small - ideally cheap to mail</li> <li>○ possibly digital/online version to email for facilitator to view, or print &amp; assemble themselves</li> </ul>
<b>Portable &amp; Durable</b>	<ul style="list-style-type: none"> <li>○ easy to carry, e.g. in pocket - small and light components, (e.g. cards)</li> <li>○ perhaps foldable into a box / placed in sleeve (up to A4)</li> <li>○ easy to set-up and pack away</li> <li>○ hardy enough to last, e.g. put in &amp; out of pocket/box/sleeve</li> </ul>
<b>Transferable</b>	<ul style="list-style-type: none"> <li>○ for different contexts/groups</li> </ul>

Table 5 – Toolkit design brief

### Developing an overview sheet

I started my exploration by first considering how I might visually represent the overall co-creation process to locate progress across three phases of Ai. I wanted to suggest a 'journey' or adventure through the process, and incorporate an element of 'fun', something unexpected and engaging. I appreciated images that had a clear start, path/direction and finish.

I gathered inspiration from tangible products like maps and board games, which lead me to think of spinners, compasses and dials (Figure 48), the overview sheet taking on a form of a 'game board' of sorts.



Figure 48 - Toolkit overview inspiration

I envisaged displaying three different types of information on three dials, layered on top of each other:

- **Three phases of Ai**, e.g. discovery
- **Six PWC actions** - facilitator to practice with care (intentional start, sharing, inviting, active listening, empathy & compassion, being adaptable)
- **Ten Tool actions** - facilitator to utilise tools (this includes tools, methods & processes – empathy map, visualising concepts, Mural, MS Teams, storytelling, creative-making, questioning, combined empathy map, mind-maps, prototyping)

I imagined that each dial could be rotated clockwise to view at the 'three o'clock' position, for a specific combination of phase (top) + practicing with care action (middle) + utilising tool action (bottom), throughout the co-creation process. From there I imagined descriptive 'cards' would provide information on how and why to enact each action, in each relevant phase.

As each dial would be used in combination throughout the co-creation process, e.g. discovery phase + listening (practicing with care action) + questioning (utilising tool action), I tested how they might work as three different sized dials on top of each other using a rough paper prototype - three Ai phases on the small dial, the six care actions on the middle dial and the ten tool actions on the bottom dial (Figure 49).

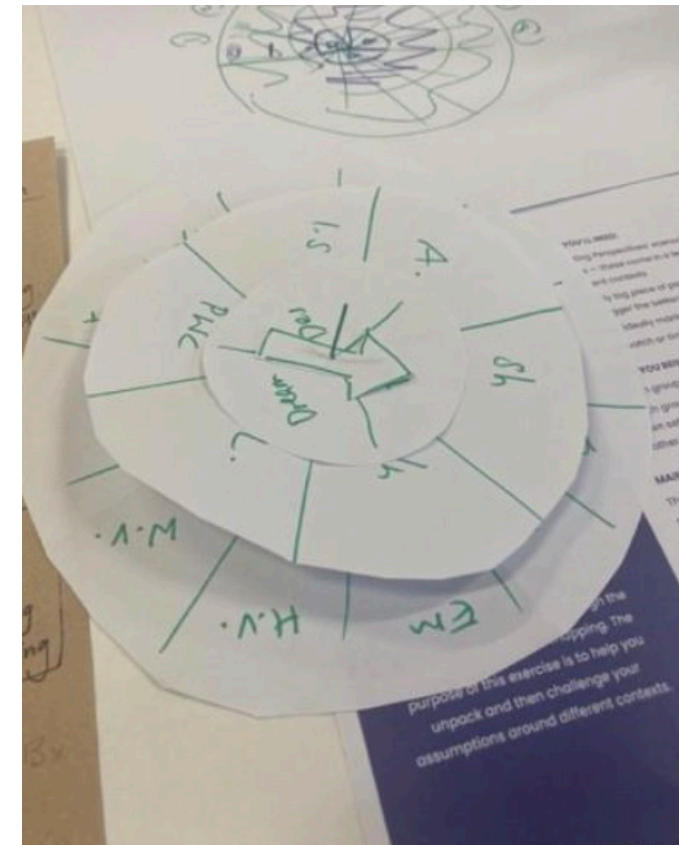


Figure 49 - Paper prototyping, dials

I soon realised that moving and aligning three dials was a bit of a hassle, so I tried to display all the PWC and tool actions sequentially on a single dial with a cover and window for viewing – 31 actions in total - all the actions in the discovery phase (13), then all the actions in the dream phase (9), then all the actions in the designing phase (9). I thought this set-up could allow a facilitator to turn the dial through 360 degrees to get a feel for the whole process and then focus on one Ai phase at a time.

I sketched how it might look, with 24 sequenced segments, one-two actions per segment, PWC actions on the outer part of a segment and tool actions displayed on the inner part of a segment (Figure 50 - left). As it looked very busy, I tried grouping and displaying the actions in a different way that required fewer total segments, but it still looked too busy (Figure 50 - right).

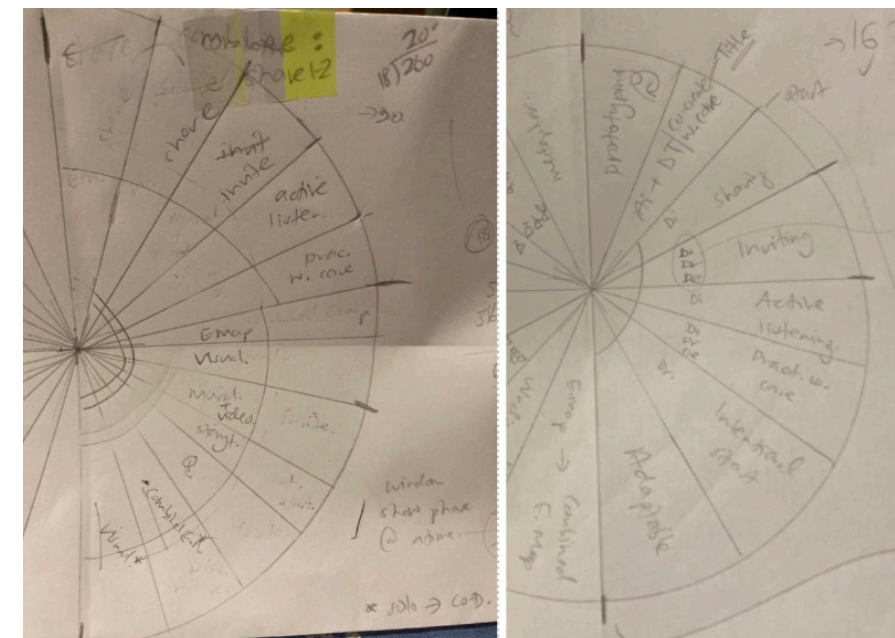


Figure 50 - Sketching, dials

While the dial was tangible, I realised that it was not that engaging; although it introduced the process and the cards effectively, it was a bit unnecessary. Before settling on a flat A3 sheet to display the overview of the co-creation process and ‘reveal’ each Ai phase separately, I experimented with using flaps, inserts, and pockets, while considering durability and ease of making the resource (Figure 51).

I also experimented with different ways to present the process and the Ai phases on a static image, as a ‘journey’ – taking the form of a spiral, a wave, a circle/cycle, with key words and visuals to represent each PWC/tool action (Figure 52).



Figure 51 - Paper testing, toolkit overview

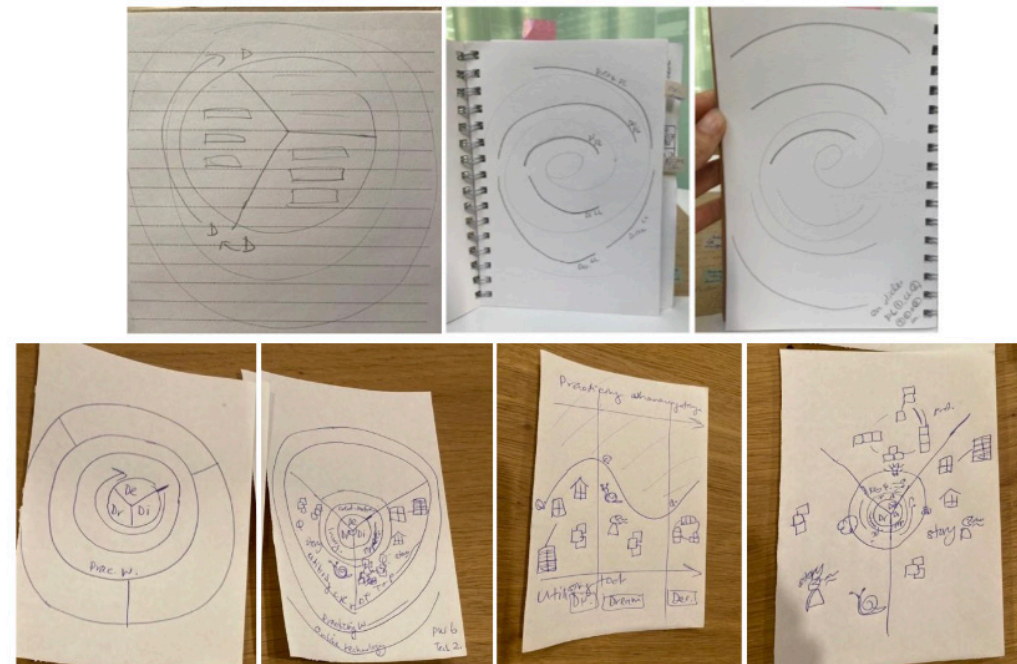


Figure 52 - Sketching the co-creation process, toolkit overview

Figure 53 shows variations I explored, and Figure 54 shows the final overview sheet, front and back. This will be printed on 120 gsm card, A3, double sided, with slight pre-folds so it could be folded into a quarter of the size (A5) and carried with other resources – the pack of corresponding cards, is outlined below. The overview sheet will also be available as a pdf for sending to facilitators. Both the hard copy and pdf copy are designed to be easy to use and to copy, for sharing with others.

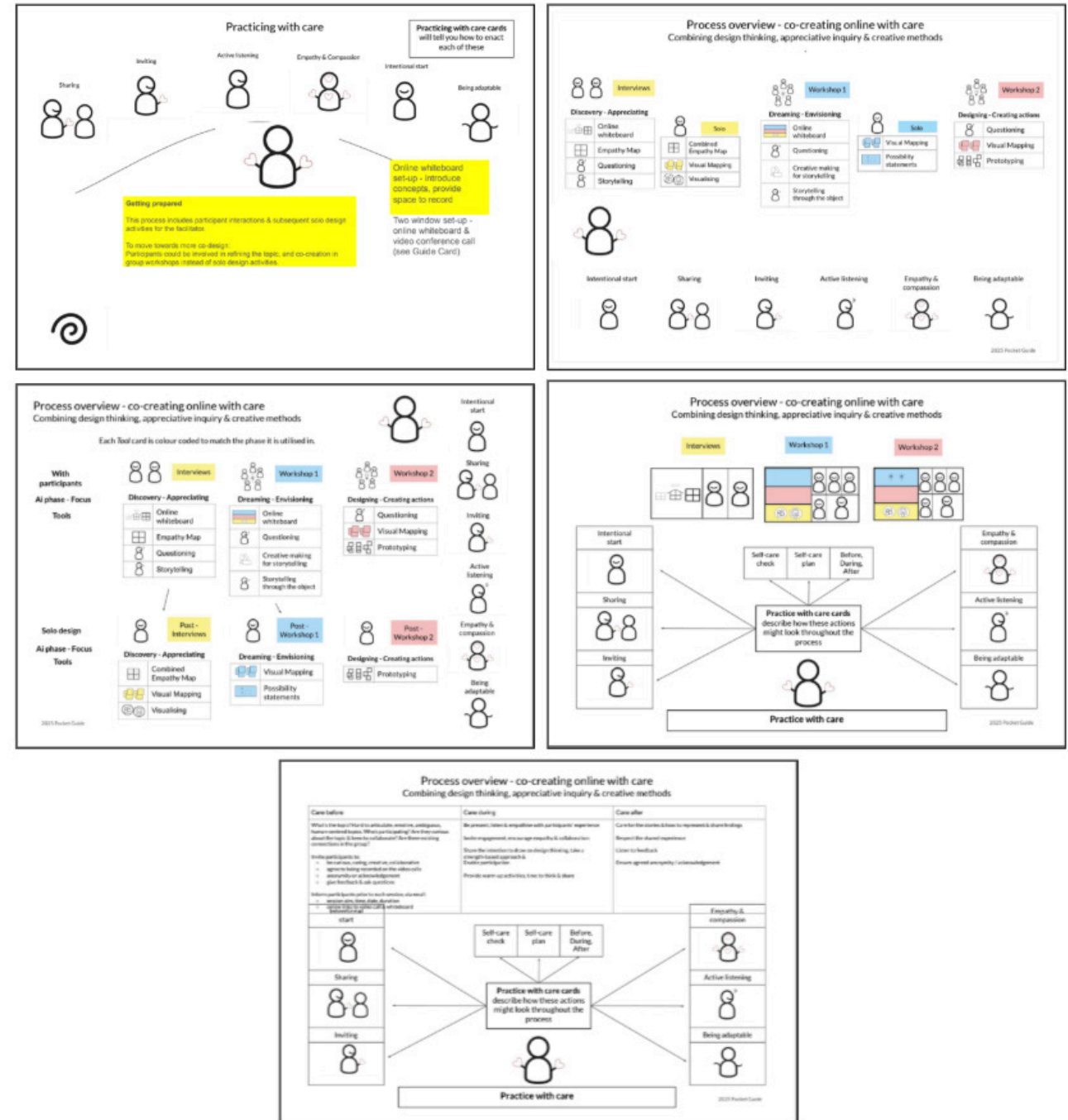
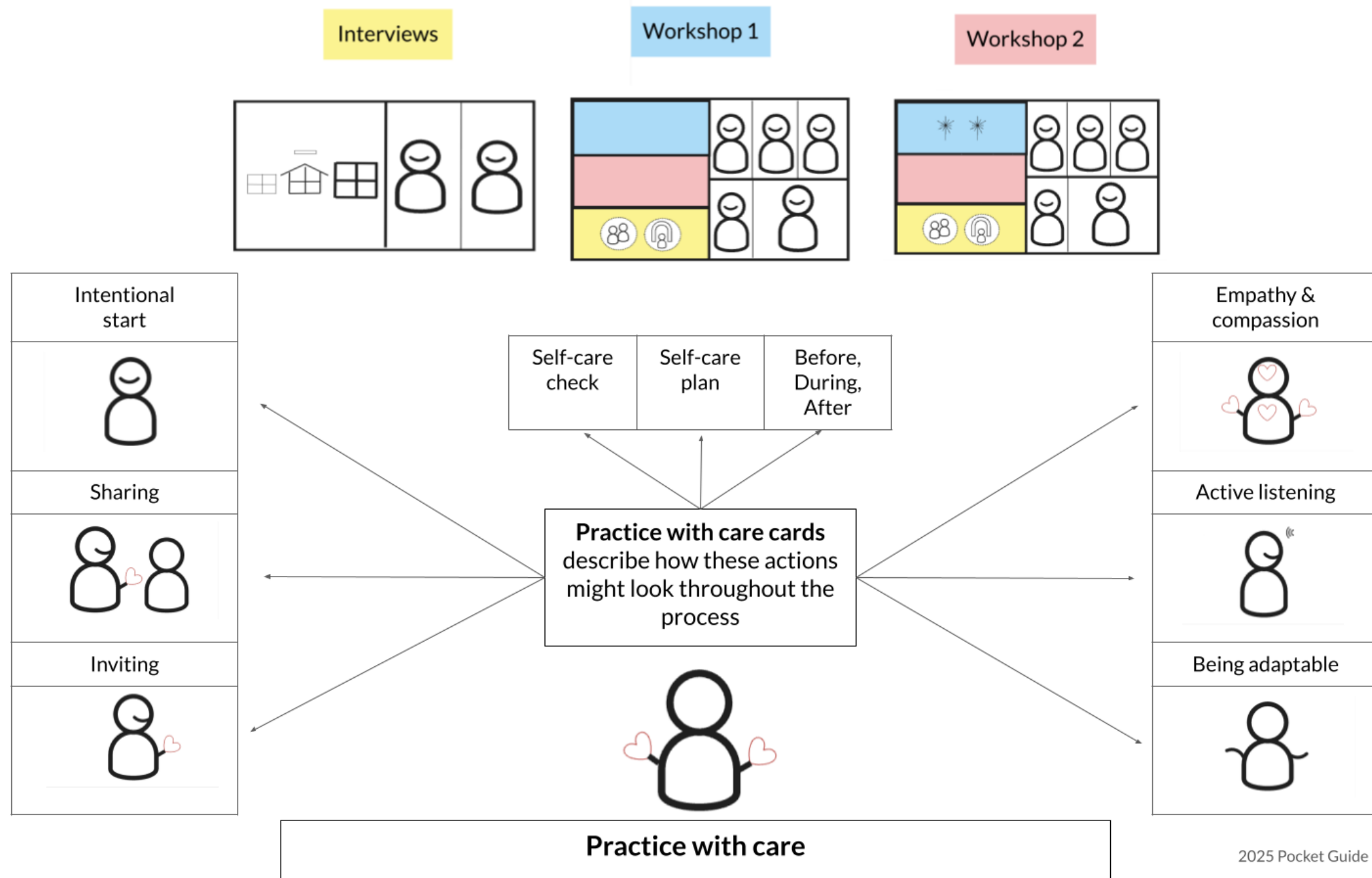


Figure 53 - Testing and refining, toolkit overview

# Process overview - co-creating online with care

Combining design thinking, appreciative inquiry & creative methods



2025 Pocket Guide

Figure 54 - Overview front prototype

# Process overview - co-creating online with care

## Combining design thinking, appreciative inquiry & creative methods

**Utilise tools in participant engagements & solo-design activities**

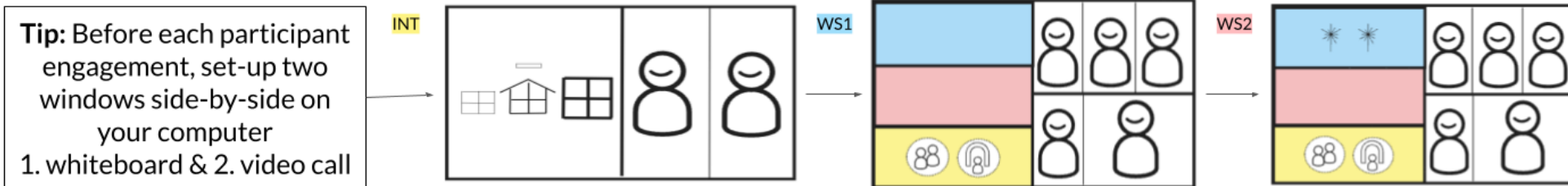
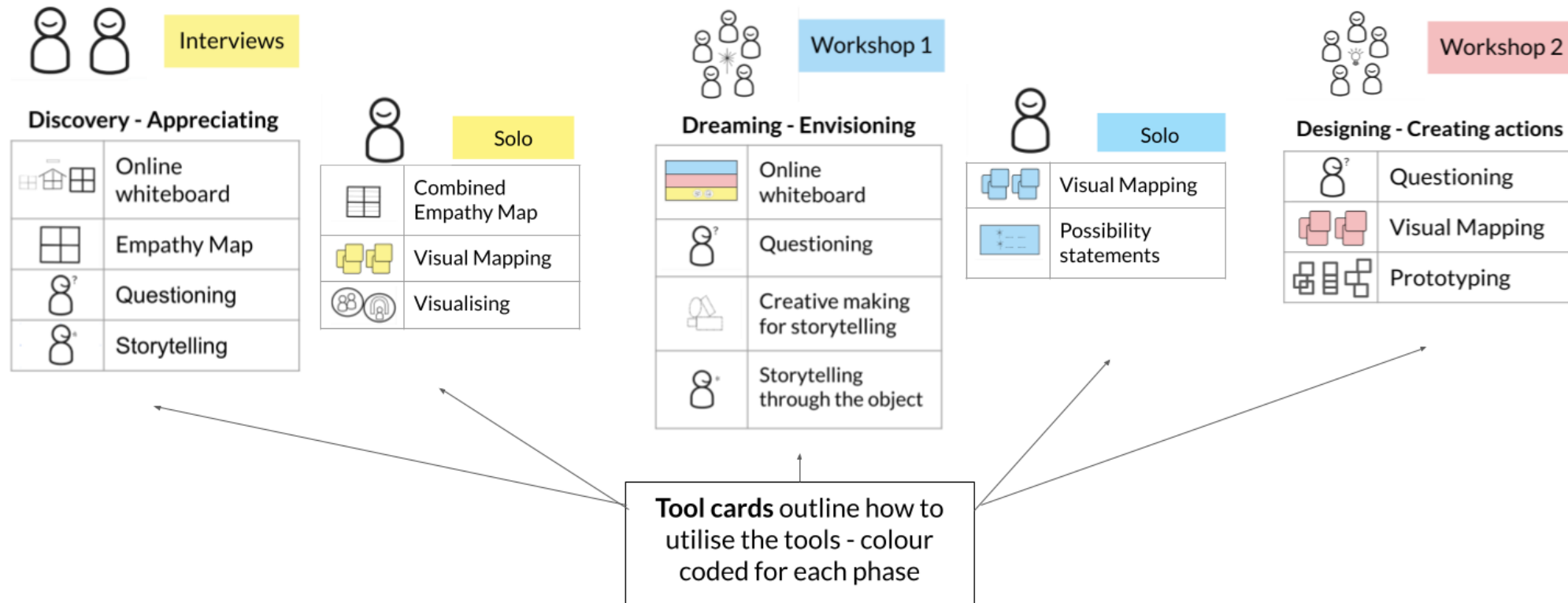


Figure 55 - Overview back prototype

## Developing the cards

To communicate the actions (practicing with care, utilising tools) in each phase of the co-creation process, I gathered inspiration from card 'games' I've found useful & enjoyable (see Figure 56). This informed decisions around card size, materials, use of visuals, text & layout.



Figure 56 - Cards and instruction sheet inspiration

[www.ridersandelephants.com/the-emotional-culture-deck](http://www.ridersandelephants.com/the-emotional-culture-deck), [www.twoa.ac.nz/](http://www.twoa.ac.nz/), [www.goodhealthdesign.com/initiate-collaborate/home](http://www.goodhealthdesign.com/initiate-collaborate/home), [www.ideo.com/journal/method-cards](http://www.ideo.com/journal/method-cards), [www.beyondstickynotes.com/model-of-care-for-codesign](http://www.beyondstickynotes.com/model-of-care-for-codesign)

I experimented with the layout and size of the cards to minimise the use of printed paper, while not compromising the legibility of the content on each card. I sketched visuals to represent each of the action cards, reviewed and refined them (see Figure 57).

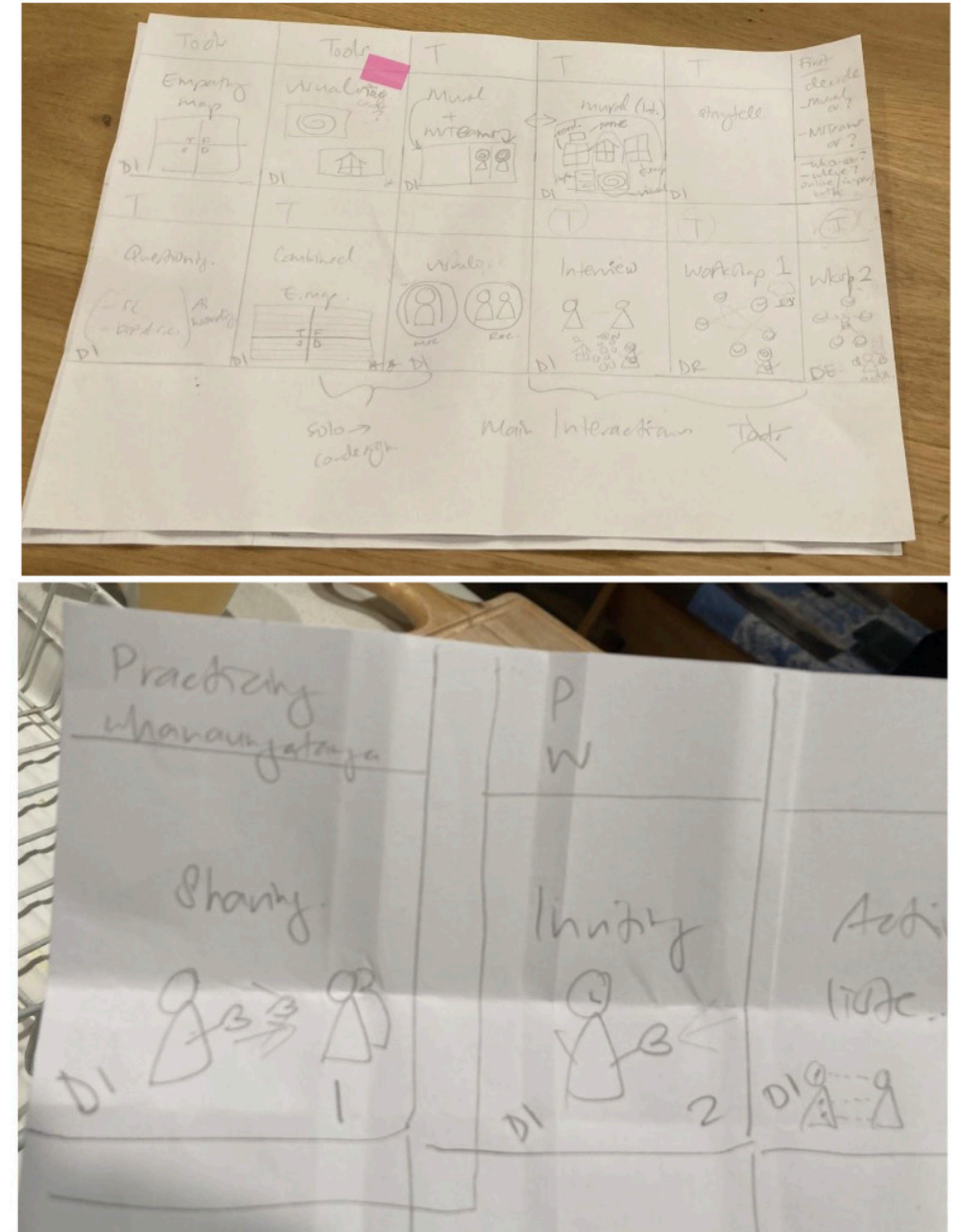


Figure 57 - Sketching, cards

I used Mural to digitise the sketched images for each card, to achieve a consistent, clear style for the front and back of the cards; I mostly used a combination of icons - inspired by my visual to represent 'empathy & compassion' (Figure 24), as used on the group workshop Mural - and explored how I might use imagery to communicate a sense of the process, e.g. growth and nurturing findings and each other (participants), through the Ai phases (Figure 58 - 59).

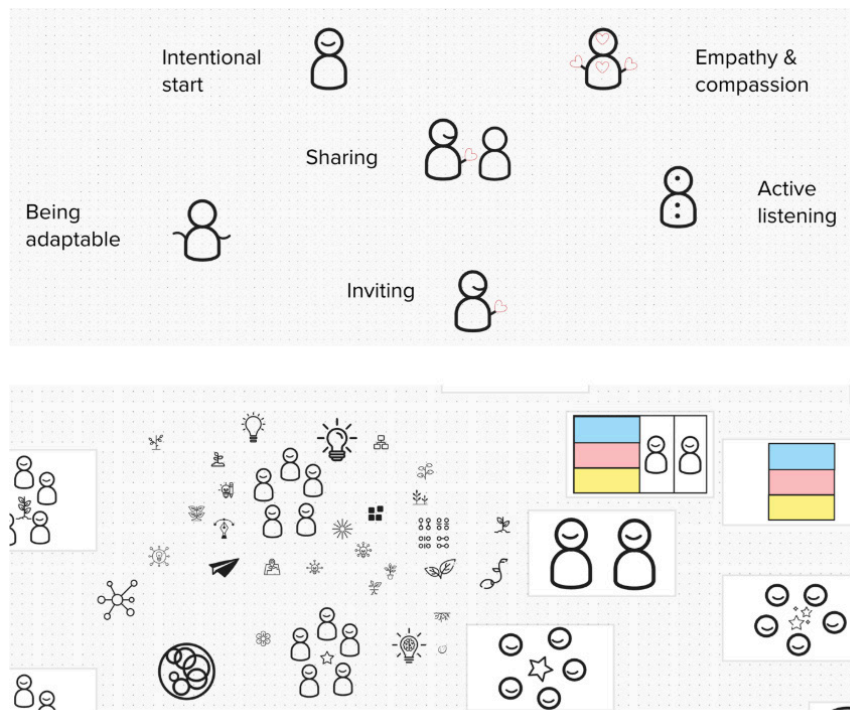


Figure 58 - Digitising images for cards

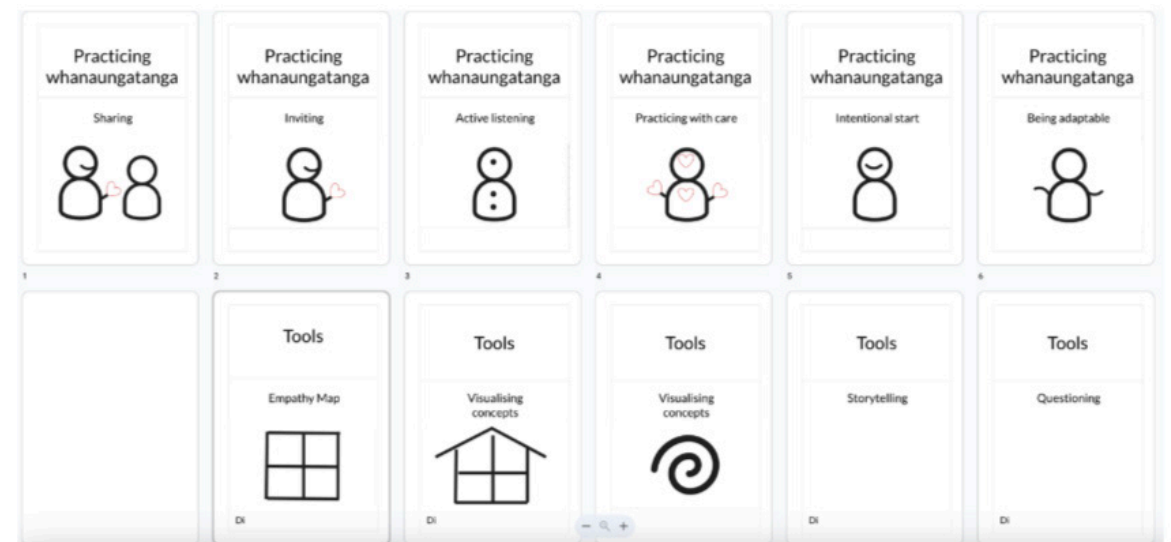


Figure 59 - Developing visuals and layout for cards

After creating the content for the cards, I realised that I needed to introduce a new category to describe the interviews and group workshops as separate methods within each phase of Ai. I also expanded the original ‘practicing with care’ category to include ‘self-care’ for the facilitator and information about how to show care before, during and after the co-creation process (see Figure 60).

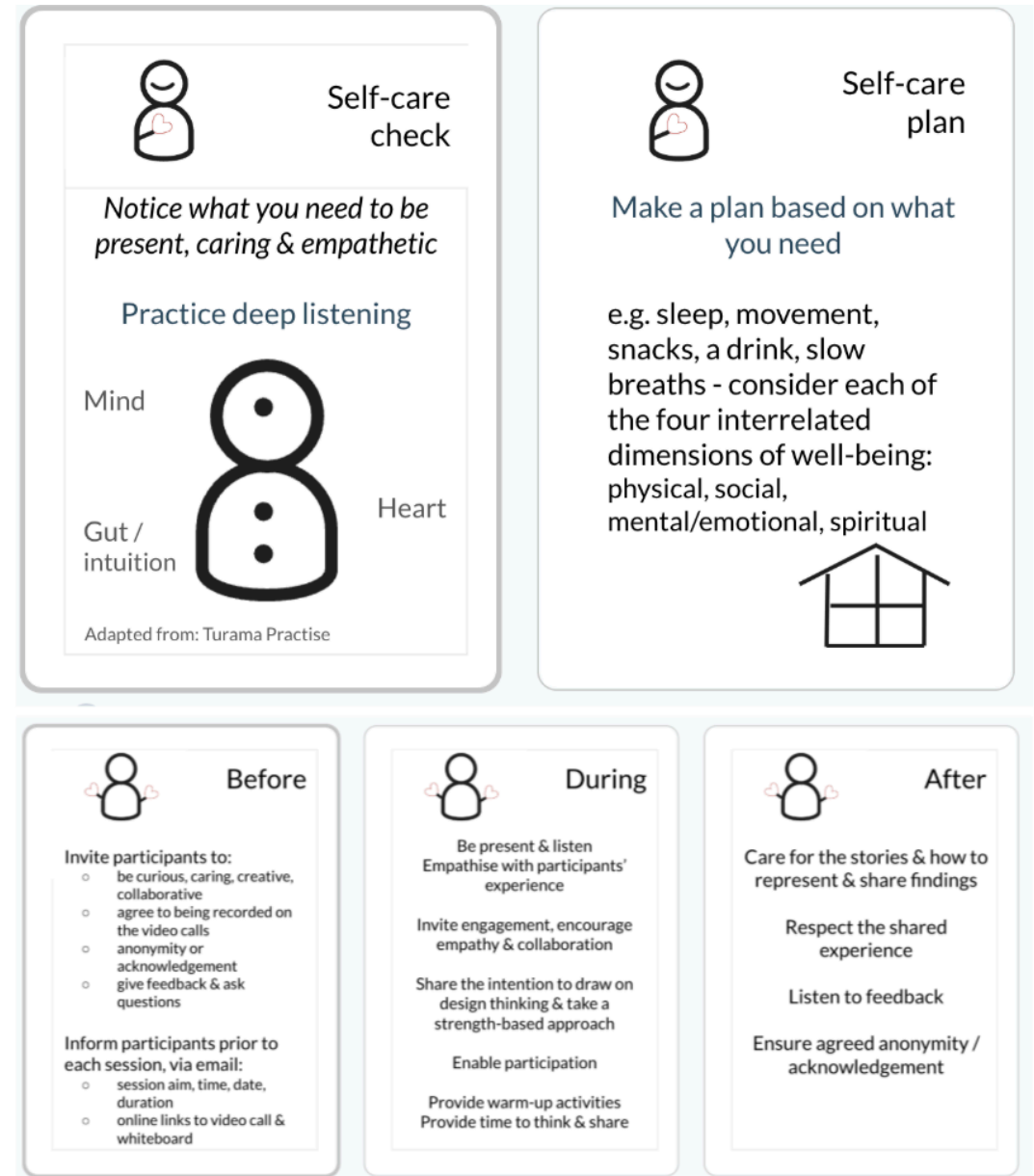


Figure 60 - Self-care and care before, during and after cards

Aware that Mural may not be the online interactive workspace of choice, and that using this kind of technology might be new to some facilitator, I referred to Mural as 'online whiteboard' and described how I set it up for each interaction (Figure 61). This is an example of my commitment to being jargon free.

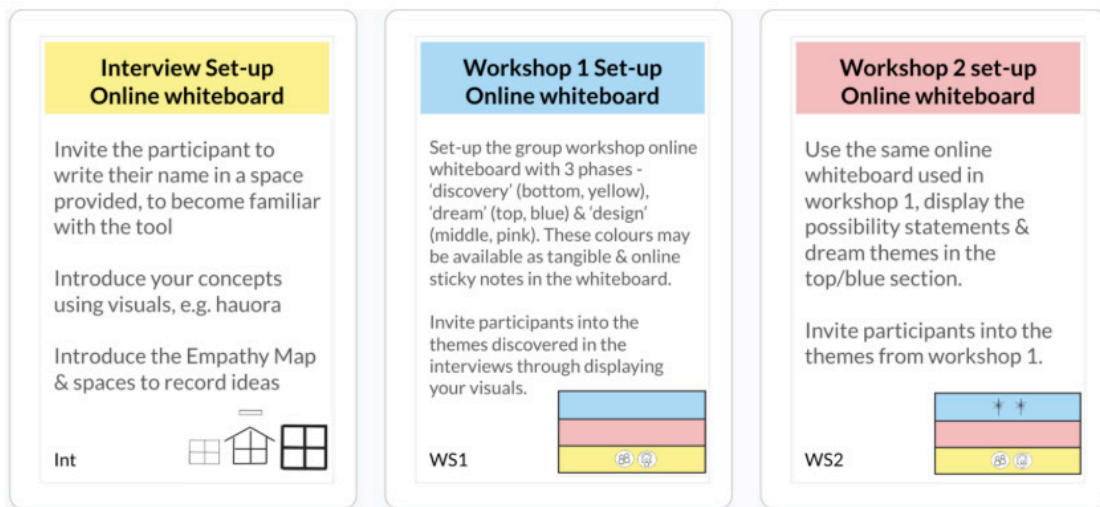


Figure 61 - Online whiteboard set-up cards

After testing the cards for ease of use and understanding with 'a user', I removed cards that seemed repetitive (Figure 62).

Colours considered for the cards were intended to communicate the distinct phases of Ai and were subsequently chosen to complement the colours of sticky notes available in common office supplies & on Mural (the online whiteboard), and to hint at the nature of the phase as a part of the overall 'journey'. Yellow (like gold) for 'discovery' phase, blue (like the sky) for 'dreaming', & 'pink' for design (see Figure 63 for the exploration of colour themes).



Figure 62 - User testing cards

	Heading Background colour	Alternative background colour	Corresponding sticky notes - green, blue, yellow, & more. In Mural - pink, green, yellow, blue, orange	CHS colours	Text size
Phase - dreaming	Light blue 3 Light blue 3 Light blue 3		White (Black black)	white	
Phase - designing	Light green 3	Light green 1 white	Black black (dark yellow 1 custom blue Green, pink)	white	
Phase - discovery	Light yellow 3	Dark yellow 1 + poppins bold	White (Black black)	white	
Practicing whanaungatang a	White			white	white

Figure 63 - Card colour exploration

Figure 64 (right) shows the development of the cards, table 6 (below) summarises the contents of the cards (quantities and categories), and the final prototype version of the cards is shown in Figures 65 - 66.

Card categories & quantities	Types of cards in each category
11x practicing with care (PWC)	2x practitioner self-care, 3x overall care before/during/after the process, 6x for use throughout the three phases of Ai
11x discovery phase of Ai	2x focused on the interviews purpose & plan, 1x setting up the online whiteboard, 8x tools
8x dream phase of Ai	2x focused on group workshop 1 purpose & plan, 1x online whiteboard set-up, 4x tools
6x design phase of Ai	2x focused on group workshop 2 purpose & plan, 1x online whiteboard set-up, 3x tools

Table 6 - Cards summary

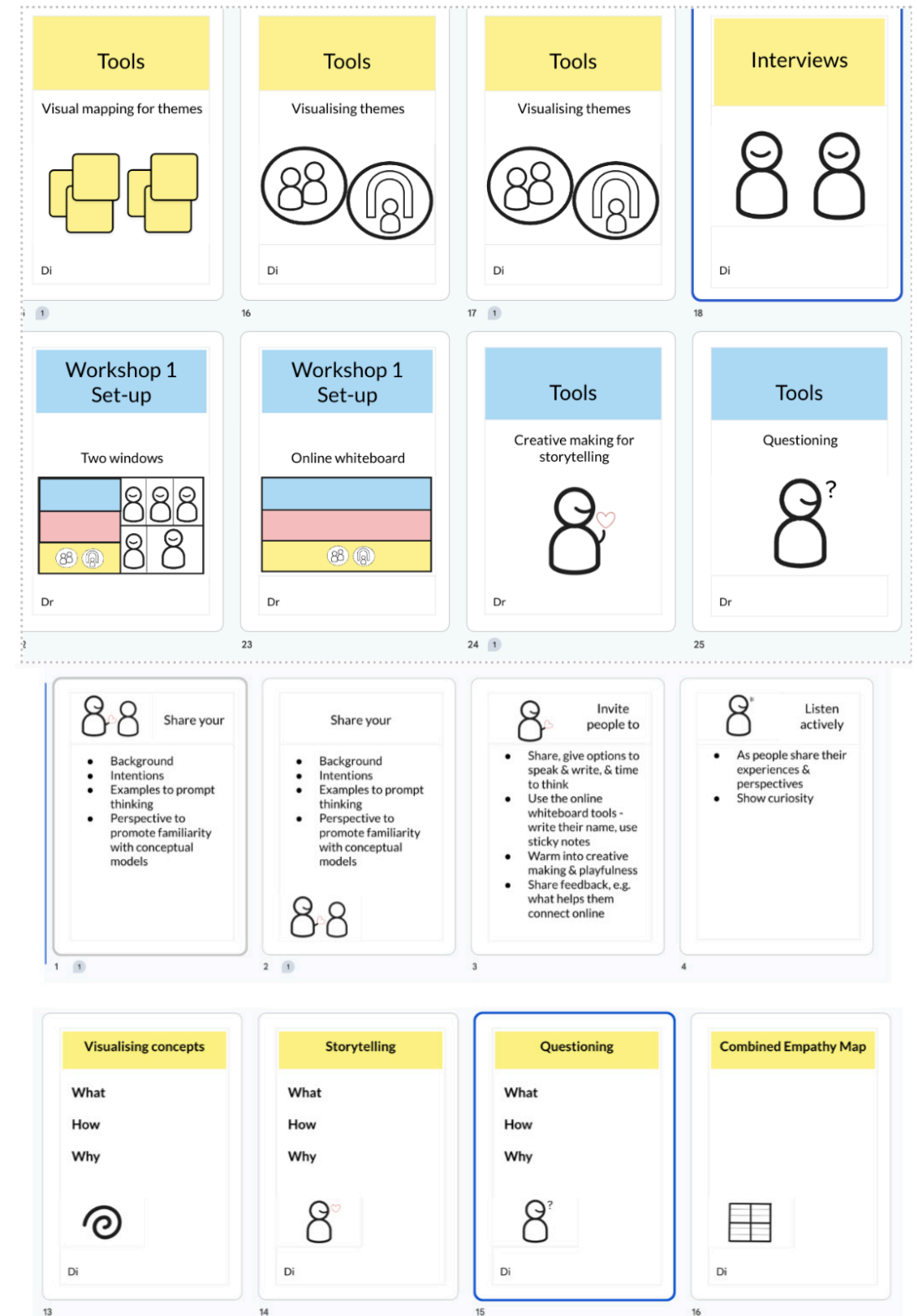


Figure 64 - Cards in development - colour and visuals

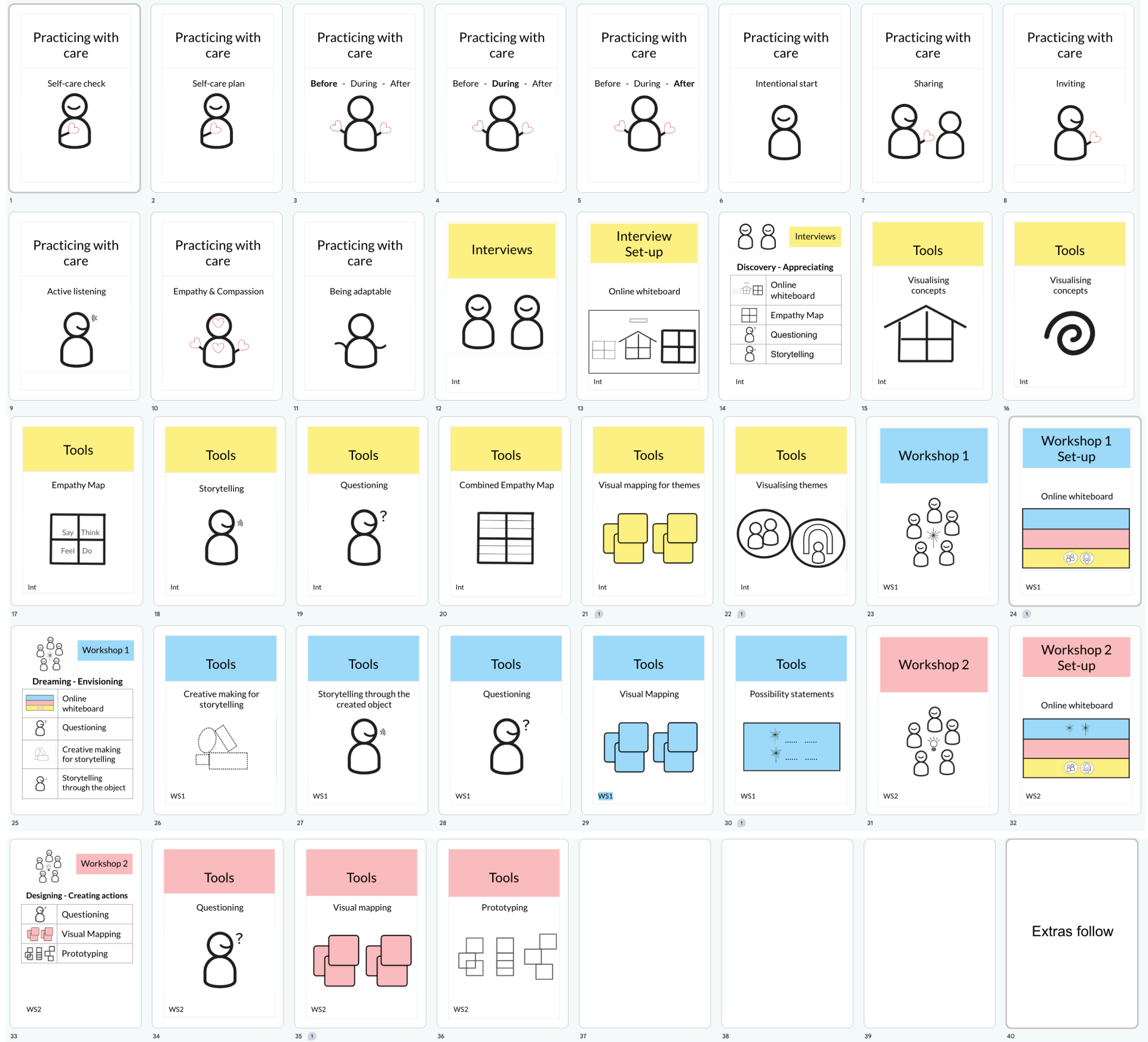


Figure 65 - Front of cards prototype

**1 Self-care check**  
Notice what you need to be present, caring & empathetic  
Practice deep listening  
Mind  
Gut/intuition  
Heart  
Adapted from: Turama Practice

**2 Self-care plan**  
Make a plan based on what you need  
e.g. sleep, movement, snacks, a drink, slow breaths - consider each of the four interrelated dimensions of well-being: physical, social, mental/emotional, spiritual

**3 Before**  
Invite participants to:  
• be curious, caring, creative, collaborative  
• agree to being recorded on the video calls  
• anonymity or acknowledgement  
• give feedback & ask questions  
Inform participants prior to each session, via email:  
• session aim, time, date, duration  
• online links to video call & whiteboard

**4 During**  
Be present & listen  
Empathise with participants' experience  
Invite engagement, encourage empathy & collaboration  
Share the intention to draw on design thinking & take a strength-based approach  
Enable participation  
Provide warm-up activities  
Provide time to think & share

**5 After**  
Care for the stories & how to represent & share findings  
Respect the shared experience  
Listen to feedback  
Ensure agreed anonymity / acknowledgement

**6 Intentional start**  
• Slow & calm  
• Start with turns to share, e.g. use a 'round' activity  
• Give time to talk & settle in, e.g. check-in activity  
• Explicitly share the workshop intentions, guidelines & activities

**7 Share your**  
• Background  
• Intentions  
• Examples to prompt thinking  
• Perspective to promote familiarity with concepts

**8 Invite people to**  
• Share by giving the option to speak or write, & time to think  
• Use the online whiteboard tools, e.g. write their name, use sticky notes  
• Warm into creative making & playfulness  
• Share feedback, e.g. what helps them connect online

**9 Listen actively**  
• As people share their experiences & perspectives  
• Show curiosity

**10 Empathy & Compassion**  
• Use empathy & invite feelings & thoughts  
• Be mindful of the participants' experience  
• Use clear communication  
• Practice compassion  
• Reassure people of what's coming up next  
• Incorporate what care looks like to the group

**11 Be adaptable**  
• Be responsive  
• Be informed by the check-in & feedback  
• Have a plan B  
• Find out what works for the group & what they need  
• Be ready, no matter who's there & what resources they have

**12 Interviews**  
Individual interviews, 60-90 min video call  
Start to build trust & empathy  
Share experiences & perspectives  
Appreciate what matters to participants

**13 Interview Set-up Online whiteboard**  
Invite the participant to write their name in a space provided, to become familiar with the tool  
Introduce your concepts using visuals, e.g. hauora  
Introduce the Empathy Map & spaces to record ideas

**14 Post-Interviews**  
Discovery - Appreciating  
• Combined Empathy Map  
• Visual Mapping  
• Visualising  
Review the video recordings of the interviews to add any additional insights for consideration.

**15 Visualise concepts**  
Decide what concepts are important to your topic  
How might you introduce them visually?  
For example, the concept of **Hauora**  
Using a conceptual model **Te Whare Tapa Whā**

**16 Visualise concepts**  
If exploring well-being in the Aotearoa - New Zealand context, this might be a helpful concept  
**Whakawhanungatanga**  
Conceptualise 5 domains of relational well-being  
Culturally located way of thinking about well-being

**17 Empathy Map**  
Four quadrants:  
Say Do Think Feel  
In their story, what did they say, think, do, feel?  
Make sense of their experiences, reveal needs, draw out insights, infer meaning

**18 Storytelling**  
Explore what the topic means to the participant  
Reveal their experiences & perspectives, how care looks & feels to them  
Appreciate what works & matters to them

**19 Questioning**  
"When has care from a colleague supported your well-being?"  
Prepare positive, solution-oriented Qs  
To prompt reflection & sharing, storytelling

**20 Combined Empathy Map**  
Make sense of participant answers  
Empathise with their perspectives & experiences  
See common & diverse needs, connections & differences

**21 Visual mapping for themes**  
Group & regroup ideas visually to find interview themes  
Identify needs & what matters  
Reveal insights into underlying values, beliefs, motivations

**22 Visualise themes**  
Visually represent interview themes  
Creative exploration e.g. using clay can help to reveal insights  
Communicate insights  
Communicate meaning  
Share with group

**23 Group Workshop 1**  
90 min video call  
Create a safe space for collaborating & empathising with different experiences & perspectives  
Envision what could be  
Imagine how the near future could ideally look & feel

**24 Workshop 1 Set-up Online whiteboard**  
Set-up the group workshop online whiteboard with 3 phases - 'discovery' (bottom, yellow), 'dream' (top, blue) & 'design' (middle, pink). These colours may be available as tangible & online sticky notes in the whiteboard.  
Invite participants into the themes discovered in the interviews through displaying your visuals.

**25 Post-Workshop 1**  
Dreaming - Envisioning  
• Visual Mapping  
• Possibility statements  
Before visual mapping, review the video recording of WS1 & add any additional insights for consideration to the online whiteboard.

**26 Creative making for storytelling**  
Provide warm-ups, e.g. scrunch paper into a ball & throw it, sketch for 30 sec.  
Making could involve tearing paper  
Making is to help thinking, rather than how it looks  
Give 2 min to make something in response to a probing question

**27 Questioning**  
"What could (the topic) ideally look or feel like?"  
Prompt thinking, sharing & collaboration  
Probing question for creative making: "What might (the topic) ideally feel like?"

**28 Storytelling through the created object**  
Give 1 min for each person to share what their object is saying, what it represents about how the near future could ideally look or feel  
After listening to each story, participants record ideas that represent the 'dream' using sticky notes

**29 Visual mapping**  
Group similar ideas  
Recognise diverse ideas  
Explore connections  
Deepen understanding of what could be  
Create themes to share  
Identify an aspect to focus on

**30 Possibility statements**  
Capture the 'dream' in two succinct emotive statements  
Evoke a collective sense of possibility to inspire ideas & future action  
Use these to provoke constructive discussion

**31 Group Workshop 2**  
90 min video call  
Create a safe space for collaborating & building on what matters  
Amplify what matters  
Plan next steps towards a specific aspect of the desired future  
Create actions

**32 Workshop 2 set-up Online whiteboard**  
Use the same online whiteboard used in workshop 1, display the possibility statements & dream themes in the top/blue section.  
Invite participants into the themes from workshop 1.

**33 Post-Workshop 2**  
Designing - Creating actions  
• Prototyping  
After the 'designing' phase of Appreciative Inquiry the 'destiny' phase involves taking action.  
Actions could be checked for alignment with the Possibility Statements.

**34 Questioning**  
"What will help us get to the dream? What do we do practically to get there?"  
Use 'What if...?' to encourage brainstorming & depth  
Use 'How might we...?' to reveal the group's collective wisdom

**35 Visual mapping**  
Invite participants to share their ideas for action on sticky notes.  
Use these to ask relevant 'how might we' questions  
Invite participants to connect ideas to show relationships, e.g. use lines or proximity

**36 Prototyping**  
Cycle: Make ideas tangible - Test to learn - Refine with feedback  
Create actions that build upon what works & matters towards what could be, in an interplay between what is appreciated (discovered) & envisioned (dreamed)  
Share to inspire action

**37**

**38**

**39**

**40**

Figure 66 - Back of cards prototype

### Pocket guide instructions and packaging

I created a two-sided instruction sheet for the pocket guide for ease of printing, which could be tri-folded (to create six pages to match the dimensions of the cards for portability (Figures 67).

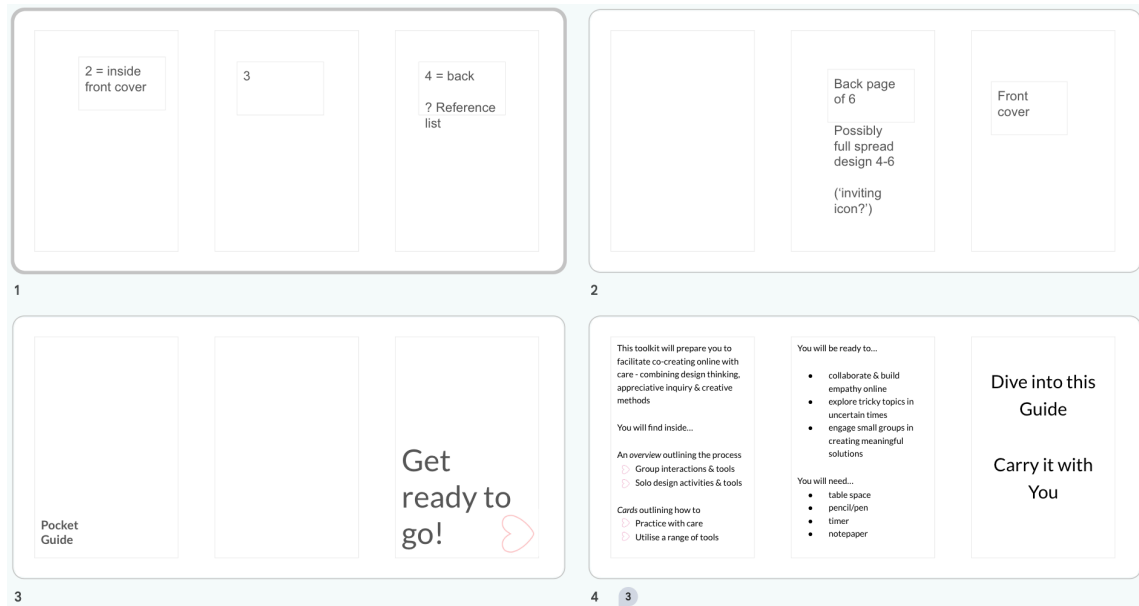


Figure 67 - Instruction sheet prototype

I explored different packaging options, with inspiration from game drawstring bags, make-up and pencil cases with zips, leather-bound journals with a button and string to fasten. I focused on how easy a 'case' would be to make and use, and how easy and comfortable it might be for a facilitator to use and carry. I decided on drawstring bags, with finished dimensions 15cm H x 11cm W (Figure 68).

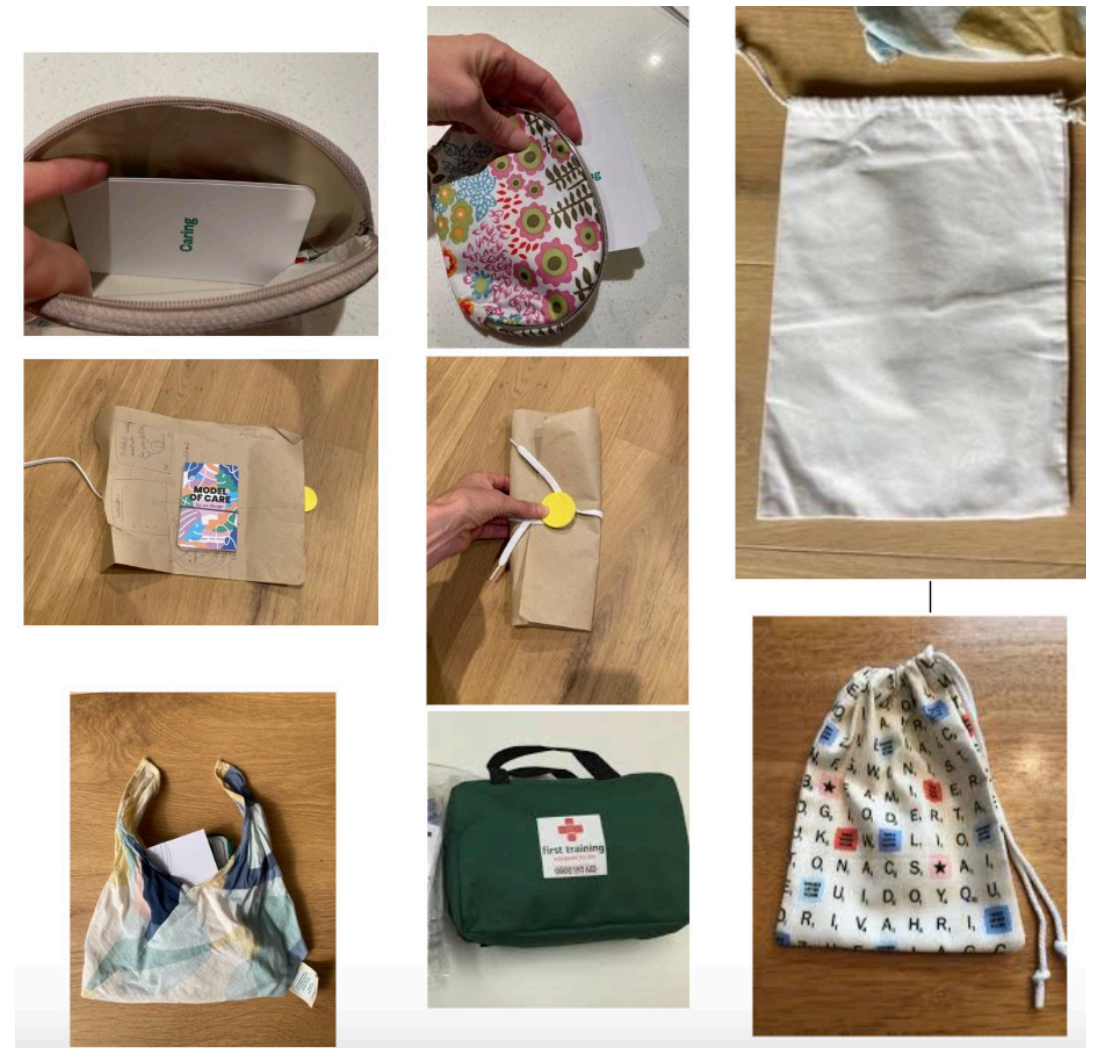
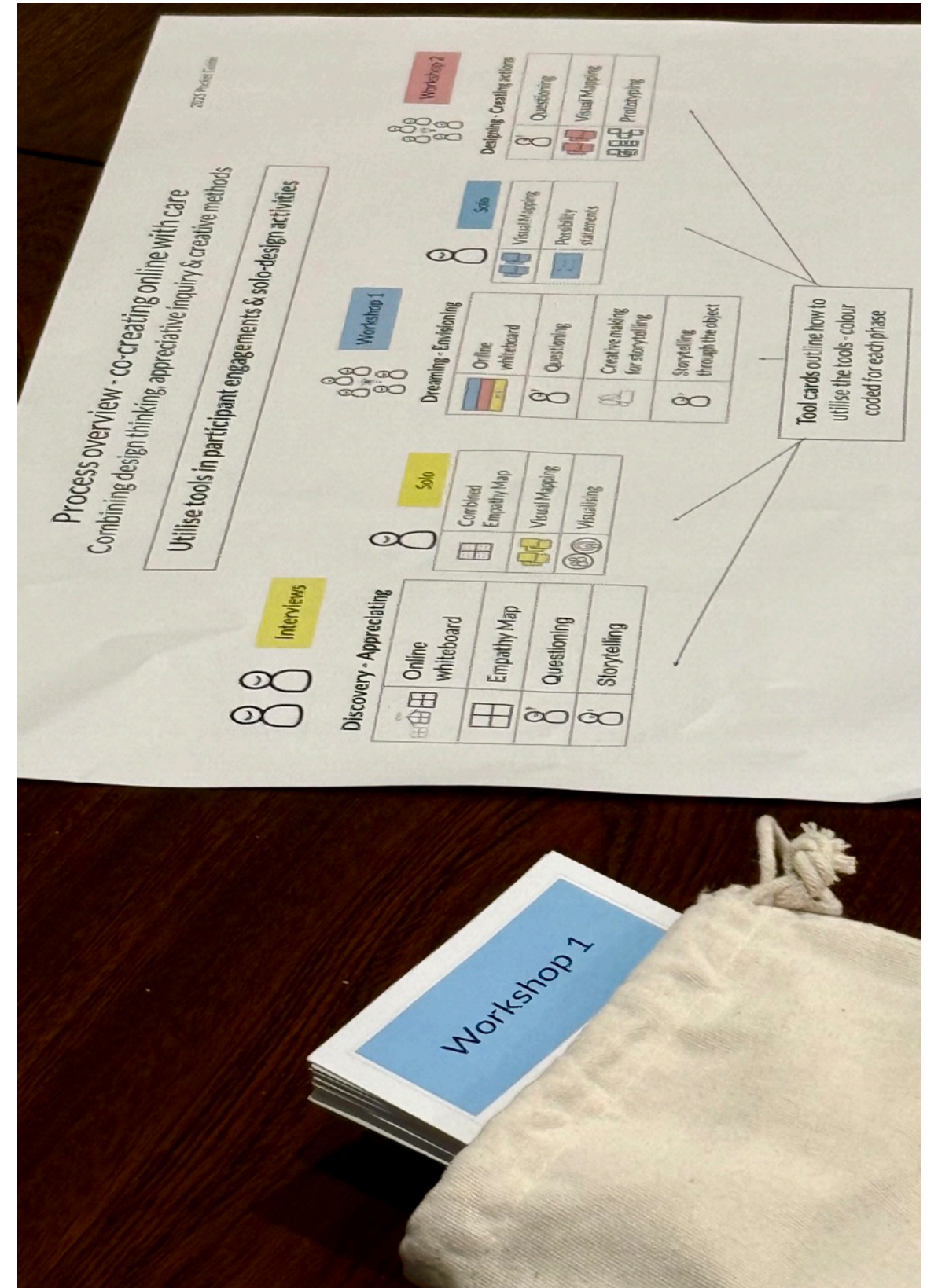
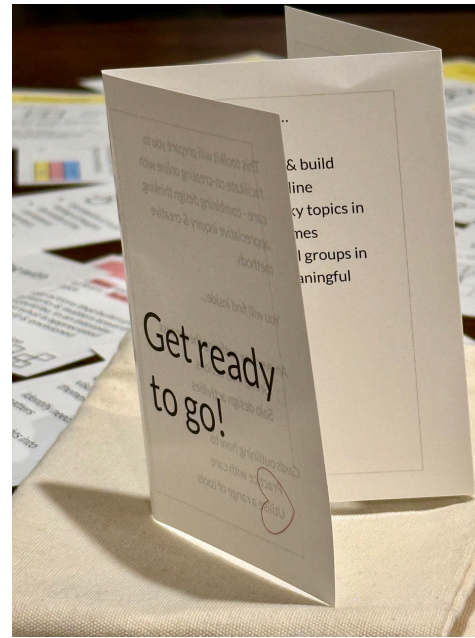
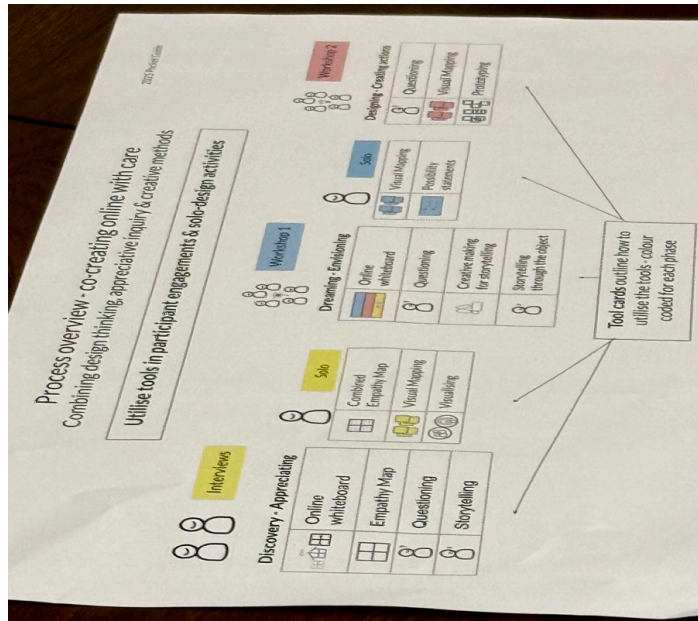


Figure 68 - Packaging exploration

Figure 69 (next page) shows the prototype pocket facilitator guide with all its elements at the time of this exegesis submission. This prototype will continue to be developed and ready to be presented in the examination.

I continued to develop this prototype in preparation for my Master of Design examination - see Appendix 12 for a portfolio of this work.

Each participant in this research was offered a complete toolkit for their use and feedback was invited.



**Storytelling**  
Explore what the topic means to the participant. Record their experiences, how care looks & feels to them. Appreciate what works & matters to them.

**Empathy Map**  
Four quadrants: Say, Do, Think, Feel. In their story, what did they say, think, do, feel? Make sense of their experiences, read needs, draw out insights, infer meaning.

**Tools**  
Visualising concepts.

**Workshop 2 set-up Online whiteboard**  
Use the same online whiteboard used in workshop 1. Display the possibility statements & draw themes in the top blue section. Invite participants into the themes from workshop 1.

**Empathy & Compassion**  
Use empathy & invite feelings & thoughts. Be mindful of the participants' experience. Use clear communication. Practice compassion. Reassure people of what's coming up next. Incorporate what care looks like to the group.

**Workshop 1 Set-up Online whiteboard**  
Set-up the group workshop online whiteboard with 3 phases - 'discovery' (bottom, yellow), 'dream' (top, blue) & 'design' (middle, pink). These colours may be available as tangible & online sticky notes in the whiteboard. Invite participants into the themes discovered in the interviews through displaying your visual.

**Post-Workshop 1**  
Dreaming - Envisioning  
Visual Mapping  
Possibility statements

**Intentional start**  
Slow & calm  
Start with turns to share, e.g. use a 'round' activity  
Give time to talk & settle in, e.g. check-in activity  
Explicitly share the workshop intentions, guidelines & activities

**Post-Workshop 2**  
Designing - Creating actions  
Prototyping

**Visualise concepts**  
After the 'designing' phase of Appreciative Inquiry the 'destiny' phase involves taking action. Actions could be checked for alignment with the Possibility Statements.

**Practicing with care**  
Self-care check  
Sharing  
Invite people to

**Visual mapping for themes**  
Group & re-group ideas visually to find interview themes. Identify needs & what matters. Reveal insights into underlying values, beliefs, motivations.

**Storytelling through the created object**  
Give 1 min for each person to share what their object is about.

Figure 69 - Prototype toolkit

# **05. Collective Wisdoms**

Here is a summary of the key findings and learnings from this research.

Underpinnings of design thinking and Appreciative Inquiry informed how I facilitated participant engagement throughout the co-creation process. Adopting a creative mindset (DT) helped me to be curious and adaptable. Principles of the Ai process (Positive, Simultaneous, Constructive, Poetic, Anticipative) encouraged me to guide participants using positive, hopeful language and to focus on appreciating what each of us brought to the interactions/process. Taking a strength-based approach seemed to facilitate building trust in each other, and the co-creation process. This invited us to build collective knowledge, discover insights, dream of possibilities, and design next steps.

*Practicing whakawhanaungatanga as part of ‘appreciative’ collaborative inquiry*

Practicing whakawhanaungatanga throughout the three Ai phases (Discovery, Dream, Design), while utilising qualitative and creative methods, contributed to creating a safe space for participants to engage in the co-creation process.

The concept of whakawhanaungatanga (building relationships) provides a way of thinking about how I engaged with participants. Although I cannot be sure of the participants’ experiences and acknowledge that whanaungatanga (connectedness) is reciprocal, the key interactions that seemed to facilitate connection with participants and engage them in the process were caring, sharing and communicating.

Building connection and trust was essential to engaging participants in empathising and collaborating, while appreciating and building on what matters/works with respect to their notions of ‘care’ and ‘care at work’.

Sharing my experiences, perspectives and background, along with being explicit about my intentions in the process and encouraging a playful approach to the creative making activity, seemed to encourage collaboration and a sense of creating together.

Connection and empathy building among the group was supported by activities that promoted listening and sharing. Multiple forms of communication (visual, verbal, text) were enabled online through video conferencing (MS Teams) and the online visual collaboration platform (Mural).

Connecting at the beginning of each session set the scene for safe and empathetic collaboration. Careful planning before each session with participants helped to intentionally create an online space for engagement. Checking-in and starting slowly prioritised whakawhanaungatanga and created space for noticing and empathising with participants.

### Using design thinking tools and processes

Visual mapping, visualising concepts, possibility statements and creative making, helped me to make sense of the ‘care at work’ findings after each participant interaction. These ‘tools’ contributed to synthesising, analysing, summarising and visually representing findings which enabled communication to the participant group in subsequent sessions. Being able to move virtual ‘sticky notes’ around on the Mural made visual mapping efficient, and enabled open and transparent data analysis, synthesis, communication and collaboration. It was easy to access the Mural between and in co-creation sessions and could be a useful tool for future co-design, through synchronous or asynchronous means. Visualising concepts (like Figure 70) for display on the Mural, helped to carry ideas to and within sessions.



Figure 70 - Practicing whakawhanaungatanga actions

Visual mapping on the Mural was an efficient and visible way to analyse and synthesise data. There are more possibilities with the empathy map tool than used in this research. When using the combined empathy map to analyse and synthesise data from the interviews, I dropped the ‘thinks’ category. I may have been able to infer insights and beliefs without it, and I may have missed an opportunity to explore and reveal them earlier, with participants in the interviews. This is something to consider for future co-design interactions.

**A system that is compassionate, considers connectedness and inherently cares for the health and well-being of the people in it.**

**Having a word to carry this notion in an Aotearoa – New Zealand context could inspire people operating at all levels of the health system to practice whakawhanaungatanga and consider how their decisions might contribute to a connected, compassionate system.**

Visualising ‘care at work’ as whakawhanaungatanga, inspired by the WCM (Carlson, et al., 2016), facilitated a way to position and make sense of the findings in this study. A range of notions of care were discovered. Participants spoke of self-care actions occurring in and outside of work and the importance of connections with family (whānau) and friends was evident in our discussions, especially as work was so uncertain at the time of this study. Participants suggested that we should not equate work with ‘whānau’. The WCM offered another layer of care and connectedness for consideration, the ‘whanaunga’ domain. We might conceptualise the collegial interactions the participants appreciated (moments of care and relationships of care), and the aspiration for local micro-culture of care as ‘whanaunga’ connections.

Figure 71 shows a way to conceptualise ‘care at work’ findings from within this project, that is, what was discovered and dreamed. In this way, we might expand the notion of ‘care at work’ and consider the well-being of healthcare professionals within the context of participants’ personal and professional lives.



Figure 71 - Care at work as whakawhanaungatanga

In the designing phase, to move towards creating a micro-culture of care at work, key ideas for action were: meeting colleagues one-on-one to come to ‘see and know’ them as individuals, to offer a range of opportunities for connection among colleagues, and to check back in with team members one-on-one, to get feedback on what helped them to feel genuinely connected, seen and known<sup>1</sup>.

Importantly, connectedness, empathy and compassion require listening and checking in with the people operating within the health<sup>2</sup> system, no matter who, no matter where, with people in diverse workplace settings. Empathy and compassion are relational dimensions that require dialogue, communication between people working together at multiple levels of the system. Figure 72 represents how I see these interactions as a transferable act of leadership, that would involve skill building (listening, empathy), relationship building, and practicing care and compassion, towards self and others at work. This could be conceptualised as whakawhanaungatanga but I am apprehensive to suggest how this might be done appropriately if removed from its cultural context, where it interconnects with tikanga and notions of mauri and wairua<sup>3</sup> for example.

1 Feedback via email from a creator of the WCM, Teah Carlson: these are highly individualistic - consider what can build culture, connection and service?

2 Feedback via email from a creator of the WCM, Teah Carlson: It can be helpful to make the distinction that you are referring to the western health system. The Waitangi Tribunal’s WAI 2575 report highlights that Aotearoa’s health system is fundamentally colonial and individualistic, privileging clinical models that separate body and mind and marginalise Māori worldviews. This is reflected across health practice, policy, and workforce structures, perpetuating inequity and institutional racism. Actively countering this requires upholding Te Tiriti o Waitangi, embedding mātauranga Māori and kaupapa Māori approaches, supporting Māori leadership and decision-making, and transforming systems to prioritise holistic, relational, and collective models of health (hauora) that restore mana motuhake and ensure genuine partnership and accountability. These are the fundamental aspects of the (WCM) model.

3 Wilson, “Relational health”

# Leadership - Practicing with Care and Compassion - Whakawhanaungatanga

Skill Building (listening & empathy), Relationship Building, Practicing Care and Compassion

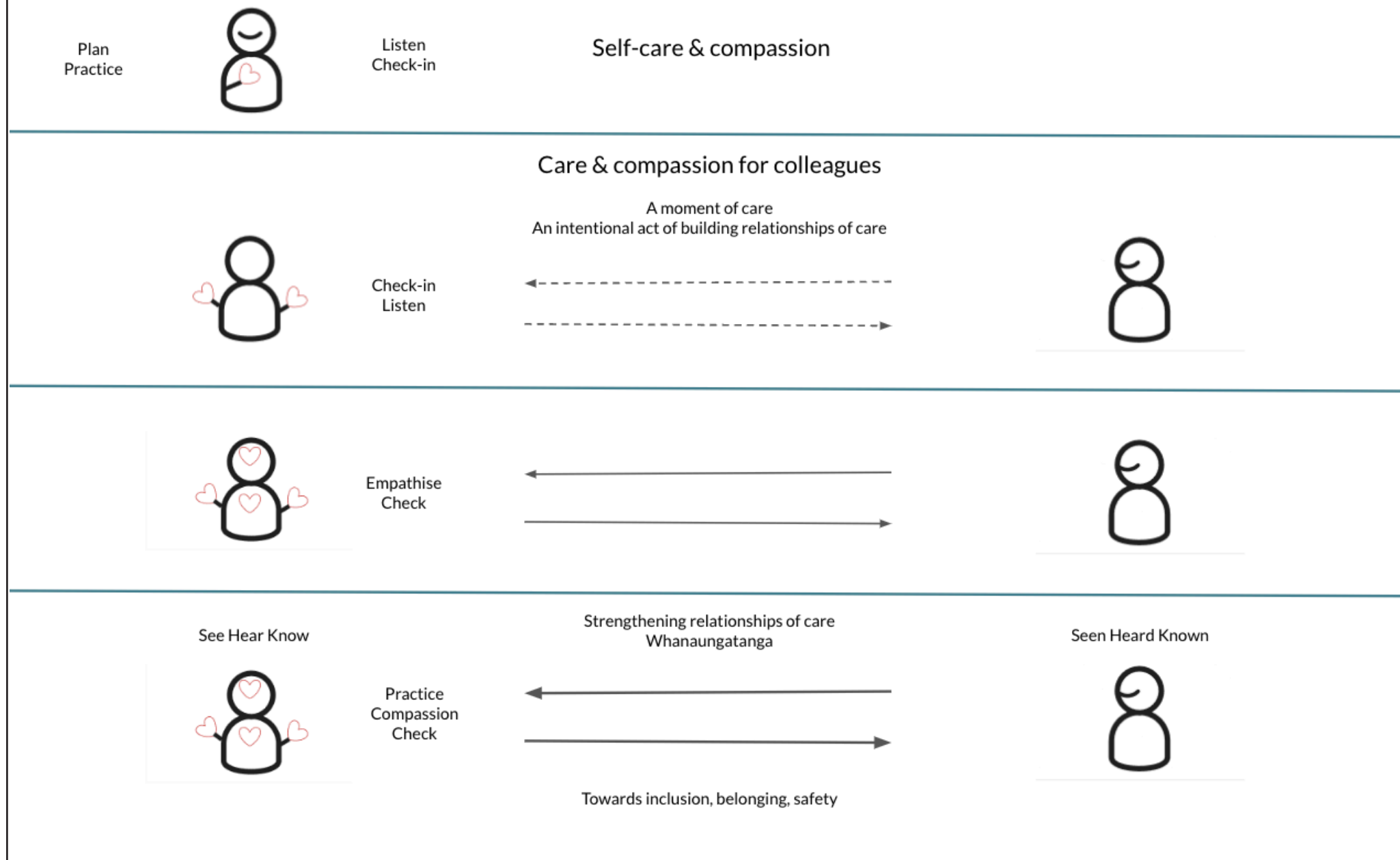


Figure 72 - Practicing care and compassion as leadership

### *Reflecting on my development as a 'fledging' (co-)designer*

Through reflection I developed more compassionate and creative ways of thinking and relating. These changes supported co-creation and connection among the group, and helped me to think, develop and communicate my ideas.

As a fledgling designer, I see a relational practice as one where I am empathetic and compassionate. I found the image in Figure 73 encapsulates how I want to be as a designer, to me 'practicing with care' is empathy in action, empathetic to people's thoughts and feelings and acting in a way that supports their well-being.

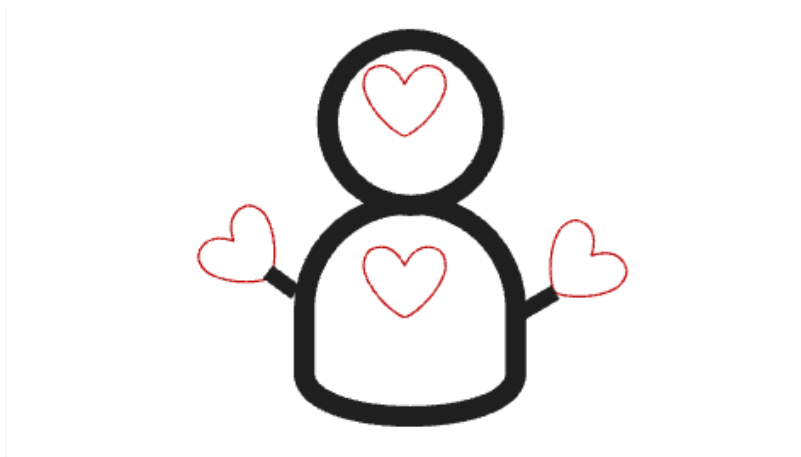


Figure 73 - Practicing with care - empathy and compassion

The WCM, informs how I see relationships, connectedness and well-being, and I feel that it helps me to centre care in my interactions. I acknowledge that I have a limited and evolving understanding of the concept of whakawhanaungatanga, and similarly, the intent and appropriate use of the WCM<sup>1</sup>.

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<sup>1</sup> I shared excerpts from this section of my exegesis with Teah Carlson, a creator of the WCM. She was happy for her responses to be included as footnotes.

I am not sure how, or if, I might share it with others in my practice. The Mātauranga embedded in the WCM is not 'my' knowledge, and I will continue to acknowledge who I learn from, and I wonder if perhaps it is not my place to share it. For that reason, I choose to use the words 'practicing with care' instead of 'practicing whakawhanaungatanga' in the facilitator's pocket guide, and to include notes around using concepts such as 'whanaungatanga' with care.

I noticed that in the participant sessions I spoke more to engage others, in thinking, making, and discussion, than to be heard. This represents a shift in my mindset. I am also mindful of the importance of language in how I frame ideas and invite possibilities and progress.

I appreciate that the co-creation process allowed time for listening, empathising, being open and checking for understanding, while also time for analysing, making sense and feeling some certainty. I appreciate how DT invites a creative mindset and Ai frames opportunities positively and provides phases as a structure or framework to progress through. This combination felt enjoyable, productive and relational.

This process provides a way through, a way to navigate uncertainty and the unknown, to 'let go', play a little and see what emerges - but, in a way that seems to generate progress. I like the security of the process and the playful way of moving that it promotes. I like to feel like I am contributing to the progress of a session, being productive without having to lead a discussion - having more questions than answers, while offering a perspective than might support progress.

In the design phase, two stages of idea generation emerged, in group workshop 2, that presented a structure I could use again, to direct or guide participants more succinctly in what to do and why. More certainty from me could foster confidence and focus in participants – yet in the workshop, participants asked questions in the moment, seemed comfortable to speak up, with a desire to understand how to contribute, and I felt reassured that the trust and safety created earlier helped us to essentially figure it out together. I am encouraged that the participants demonstrated a sense of agency and ownership in the process and I hope to facilitate that again.

Finding out that ‘creative making’ helps me to think was a revelation. A sense of play and creative exploration gave form to my ideas, enabled me to think in different ways and express my thinking to others. For example, using clay, to make sense of the participant interview themes, revealed to me how I conceptualised ‘moments of care’ as ‘a hug’. Creative exploration and visualising also supported my thinking, ideation and communication during prototyping. Sharing my clay work with my supervisors, friends and family was a practice of creative vulnerability. I was careful not to comment negatively towards my efforts, although self-deprecation felt so familiar, because I wanted to develop a positive habit that I could model with participants.

*“When working with clay in my creative exploration, I was reminded not to force an outcome, but to go with what worked, what the medium and my skills allowed.”*

Excerpt from my reflections notes

Being playful helped me to experience and trust in the emergence of ideas. I think creative exploration helped me to be conscious of my beliefs so that I could unlearn some habits and be more open to uncertainty.

When facilitating, the phrase ‘let it emerge’ reminded me to hold space for both the overall process, and the present moment.

When co-creating with people to find solutions for their situations, I am learning to resist the urge to feel like I need to have the answers.

An Appreciative Inquiry approach helped me to hold a desire to be relational and to seek answers. I know these two desires do not need to be mutually exclusive, but I notice that ‘social’ to me seems to evoke images of meandering and being frivolous perhaps, whereas I tend to think that, if I go it alone, I can get somewhere quicker and achieve the goal. Yet, I also know that this is not actually true a lot of the time - especially when dealing with ‘wicked’ problems that are by nature, ambiguous and without a defined destination.

I am learning to embody a new way of thinking and being.

When I was trying to figure something out in my head and felt stuck, I reminded myself to make something. Sketching to visualise ideas especially helped me to think more clearly and tap into creative way or new ways of seeing or understanding. For example, now, when I find myself continuing to write and re-write without gaining much clarity, I can choose to utilise creative methods to make my thinking tangible and ‘make sense’ of what I am grappling with. Essentially, ‘making’ provides an enjoyable interruption that enhances both my thinking and doing, e.g. writing. Making sense and then doing something, applying my new perspective, also provided feedback, a way to act and reflect rather than ruminating or not acting - see Figure 74. I have tried to cultivate a more playful approach, and to avoid feeling like I need to be ‘right’.

As a facilitator, I wasn’t sure if I should be inspiring participants to take steps towards creating their desired future. In the dream phase of Ai, I utilised ‘possibility statements’, a tool from Appreciative inquiry, to synthesise findings (from group workshop 1), and communicate what ‘could be’. I wondered how I could help participants to create a more clear and motivating vision of their ‘dream’, something that might evoke emotion and help them to hold and retell the story of their dream to others.

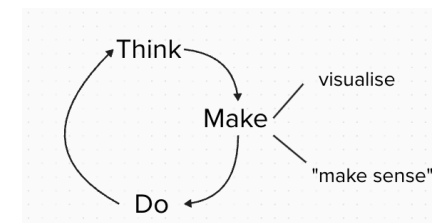


Figure 74 - Make - Think - Do

I found that I felt comfortable with this group and was able to consider what I learned about their context (e.g. uncertain), how they were feeling at this time (e.g. low capacity, tired), and what I noticed they enjoyed during the group workshops (e.g. they enjoyed making), to inform my decision-making in the session. Self-awareness and self-care action played a part in feeling prepared and ready to be empathetic, responsive and present in each session. I wondered if grieving as part of my own personal experience may have helped me to be more empathetic to their experiences.

As a ‘designer’ I want to cultivate a sense of designing ‘with’ in future co-design opportunities. I am curious to try more co-design to make sense of findings in each phase, and prototype as a group.

## **06. Discussion**

This research aimed to explore a novel approach to unpacking and empathising with notions of ‘care’, to create space for appreciating diverse ways of understanding and connecting with colleagues in caring ways, and to co-create & inspire care, connection, and well-being in diverse workplace settings.

This involved

- Exploring potentially new ways to think about & create caring connections at work as whakawhanaungatanga
- Exploring creative methods, design thinking tools & processes for building empathy & collaboration online

Overall, this project explored how to practice with care, holding a relational space to facilitate people’s engagement in the co-creation process and the moments within it. The combination of Appreciative Inquiry with creative methods, design thinking tools and processes, supported learning and co-creation through phases. Storytelling among the group – including myself as facilitator - was enhanced through creative making to think differently, visualise and communicate ideas. Acknowledging ‘whakawhanaungatanga’ as an approach to practicing design with care in an Aotearoa – New Zealand context -communicates an appreciation for Māori ways of thinking and relating and invites possibilities to create genuine, inclusive, relational spaces for connection and dialogue in co-design.

At the time this research took place, participants were experiencing significant organisational change and job uncertainty. This added a layer of complexity to the research and required a thoughtful approach and flexibility to provide safe and meaningful engagement. Facilitation grounded in whakawhanaungatanga and guided by an Appreciative Inquiry approach helped foster connection, empathy, and care among participants throughout this creative and collaborative prosocial process. Their sustained engagement across all phases of the research serves as a strong indication of the effectiveness of the methodological approach employed<sup>1</sup>.

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<sup>1</sup> Craig, Design Thinking

Mallakin et al.’s (2023) considerations for web-based co-design were relevant throughout the process: facilitation, collaboration, accessibility and equity, communication, sensemaking, tangible tools and games, and web-based research ethics.

From this research process, the beginnings of a facilitation toolkit emerged. Although outside of the scope of the current project, future research could focus on testing the finalised version of the toolkit with prospective facilitators in various organisational settings wishing to explore and co-design solutions to complex issues, such as how best to practice care in the workplace. One of the key learnings from this research was the importance of practicing and facilitating whakawhanaungatanga when working as a designer in health (complex contexts). Designers - and co-design facilitators, regardless of their background - can enact this practically through creating experiences grounded in practicing care, humility, integrity, curiosity and creativity, to promote learning together.

A key aspect of the toolkit, informed by the concept of ‘whakawhanaungatanga’, is the inclusion of ‘self-care’ and ‘deep listening’ (whakarongo), essentially recognising that facilitators are people first. Similarly, further studies into how people working in healthcare might practice ‘care at work’ as an act of leadership could extend the work by Shanafelt et al. (2023) and contribute to understanding connections between leadership and collegial well-being and collaboration<sup>2</sup>.

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<sup>2</sup> Update - It is worth considering Teah Carlson’s response to this section: *To be in leadership is first to know how to lead yourself-to invest time, joy, and presence in your heart, head, and puku (whakarongo, whakarongo, whakarongo). True listening is embodied; it means tuning in with heart, mind, and gut, cultivating a mindfulness that is attuned to the rhythms of the world around you. Grounding yourself in the taiao can be woven into this practice-for example, sitting beneath a tree, connecting through karakia or waiata, or simply being present in the environment. These acts nurture a deeper connection to self, others, and the natural world, strengthening your capacity to lead with authenticity and balance. Then in moments at work you can then check in - go back to that place of peace (the tree).*

The facilitation toolkit could be further developed to enhance experiential and emotional engagement. For example, prototyping instructions to utilise an artefact (Figure 75) provided to act as a personal, tangible reminder to practice self-care, or to invite sharing at the start of a co-design session. ‘User’ feedback on this addition to the toolkit would inform how it might be used to personalise engagement or facilitate ongoing storytelling and learning with others.



Figure 75 - Toolkit artefact ideas

Exploring ‘care at work’ using the process in this research revealed the healthcare professionals’ appreciation of connection and care in their personal and professional lives. A key finding revealed in the group was the reciprocal need to ‘see’ and be ‘seen’, to ‘know’ and be ‘known’ at work, essentially the importance of connection for care. This seems universal and transferable, a human need for connection, as shared by Shanafelt et al. (2023) and Trzeciak et al. (2017). The collective experience of ‘care’ and making sense of ‘care’ as revealed in this research speaks to ‘whakawhanaungatanga’ as a way to conceptualise care and compassion throughout the wider health system and is akin to research into team and system-wide care and compassion in healthcare.

The word ‘whakawhanaungatanga’ can encapsulate what was discovered and dreamed about care at work in this research, as a desire for a connected, compassionate healthcare system. Further research into how this concept could be understood and engaged with in culturally safe ways, could assist in creating a healthcare system that inherently cares for all its people in more equitable, accessible and inclusive ways.

While it contributes to emerging conversations in this field, this research scratches only the surface of a complex and evolving issue. Limitations of this research include a small group of participants, with limited time for co-creation, which shaped the depth and breadth of the investigation. Although the nature of healthcare work is such that availability is often an issue when wanting to engage participants in research, future studies could explore notions of care in the workplace with frontline clinical staff, given the ongoing issues this workforce faces.

Co-designing to explore and develop the role of leadership in creating micro-cultures of care in healthcare would also build on the findings of this study; and invite comparison with Mete et al., 2022 and Fox et al., 2024. Leaders in healthcare could be invited to utilise the facilitator’s toolkit to explore ‘care at work’ with their colleagues and provide feedback on the toolkit’s effectiveness and engagement.

This project adds a small but considered voice to the ongoing conversation about how care might be more consciously and creatively practised in our working lives - a space for imagining, designing, and practising more thoughtful, relational, and responsive ways of working together.

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# Appendices

(AUTECH)

11 October 2024

Ivana ~~Nakarada-Kordic~~

Faculty of Design and Creative Technologies

Dear Ivana

Re Ethics Application: **24/268 Practicing care - empathy in action among healthcare professionals**

Thank you for your responses to AUTECH's conditions.

Your ethics application has been approved for three years until 11 October 2027.

**Standard Conditions of Approval**

1. The research is to be undertaken in accordance with the [Auckland University of Technology Code of Conduct for Research](#) and as approved by AUTECH.
2. All public facing documents must have the AUTECH approval number and be of a high standard of spelling and grammar. Dates on the Information Sheet(s) and Consent Form(s) must be consistent.
3. Any amendments to the project must be approved by AUTECH prior to being implemented.
4. A progress report is due annually on the anniversary of the approval date.
5. A final report is due at the expiration of the approval period, or, upon completion of project.
6. Any serious or adverse events must be reported to AUTECH, this includes unforeseen issues that might affect continued ethical acceptability of the project.
7. AUTECH grants ethical approval only. You are responsible for obtaining management permission for access from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

The application number and title need to be referenced on all correspondence related to this project.

All forms are available online <http://www.aut.ac.nz/research/researchethics>

For any enquiries, please contact the Secretariat at [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz)  
(This is a computer-generated letter for which no signature is required)

The AUTECH Secretariat

**Auckland University of Technology Ethics Committee**

Cc: natasha.low@gmail.com

## Appendix 1

Auckland University of Technology Ethics Committee  
(AUTECH) Approval (11 October 2024)

Research in Improve- by Design for Health Masters student - approval

Penny Andrew <Penny.Andrew@tewhatuora.govt.nz>  
To: "Johanne Egan (WDHB)" <Johanne.Egan@waitematadhb.govt.nz>, "research@waitematadhb.govt.nz" <research@waitematadhb.govt.nz>  
Cc: "natasha.low@gmail.com" <natasha.low@gmail.com>

Wed, Oct 30, 2024 at 2:03 PM

Kia ora

I approve this research.

Ngā mihi

Penny

[Penny Andrew](#) (she/her)

Director

Te Whatu Ora Improve

Planning, Funding and Outcomes

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Health New Zealand | Te Whatu Ora

Application for Approval of Observational Research



WAI20252 Practicing care - empathy in action among healthcare professionals

Waitematā Contact: Johanne Egan  
Department: Te Whatu Ora Improve External CI: Natasha Low, AUT  
Project Type: Observational Research  
Duration: 21.10.24 - 30.06.25

Description: This research aims to explore a novel approach to unpacking and empathising with notions of 'care' among professionals in healthcare in a collaborative online setting to create space for appreciating diverse ways of understanding, empathising with, and connecting with colleagues in caring ways. By engaging professionals in healthcare as participants in co-design we invite their lived experience to explore the nature of what care means and how it might look and feel in a healthcare setting among colleagues.

Locality Review

The undersigned agree to the following:  
- The study protocol and methodology has merit and aligns with departmental/service area interests.  
- The local lead investigator is suitably qualified, experienced, registered and indemnified.  
- Resources, facilities and staff are available to conduct this study, including access to interpreters if requested.  
- Conducting this study will have no adverse effect on the provision of publicly funded healthcare.  
- There is a stated intent that results will be disseminated & the findings translated into evidence-based care (where appropriate).

Before this study is granted approval to commence, the Research & Knowledge Centre on behalf of Te Whatu Ora - Waitematā will check:  
- there has been the appropriate level of ethical review eg ethics committee approval if required.  
- cultural consultations have occurred or will be undertaken, as appropriate.  
- appropriate confidentiality provisions have been planned for.

Dept/Org	Role	Name (Print Clearly)	Signature	Date
Te Whatu Ora Improve	Director	Dr Penny Andrew		

Return completed form to the Research & Knowledge Centre. Alternatively, emails from approvers are acceptable as electronic sign-off. Enquires to research@waitematadhb.govt.nz

Appendix 2

Te Whatu Ora - Health New Zealand approval (30 October 2024)

<p><b>Duration: 60-90min</b>  <b>Facilitated/led by researcher</b>  <b>Online, video conference (MS Teams)</b>  <b>Video recorded</b> (set in options + transcript)</p> <p><i>Check interviewee has meeting &amp; Mural link and is confident to access.</i></p>	<p><b>Materials</b>  Image of WCM &amp; Mural workstation (invite/share link with interviewee via email &amp; suggest 2-window set-up).</p> <p>Interviewer to review ethics notes on data collection. Remember to model deep listening &amp; curiosity.</p> <p>NB: Mural – share access to edit. Turn notifications off on my laptop.</p>
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*Start recording*

*Discovery phase*

*Introduce myself, share some of my background and be prepared to describe DT / AI process*

**Introduction:** Reiterate research aim (PIS) & thank participant for being there. Remind them of video recording, workshop dates & reassure them that the intention is to: create a safe space, build empathy, collaborate, & to appreciate the ‘best of what exists’ in their life, specifically today, in regard to their experiences of 1) self-care, and 2) ‘care at work’ from colleagues, i.e. what they and others at work have done, or do, that supports their well-being. The interview is an opportunity to start building a trusting relationship supported through understanding each other's perspectives. (Discovery phase of Ai). Check they can access the slides and the Mural workstation via the link provided.

### 1. Self-care

**Say:** I will ask some questions and take notes as you talk. Feel free to seek clarification. Ask:

*What do you currently do to support your well-being? Generally in your life.*

- *Are you familiar with the Te Whare Tapa Whā model of well-being/hauora?*
- *What do you know works for you in each of the following areas?*
  - *Physical well-being*
  - *Mental-emotional well-being*
  - *Social well-being*
  - *Spiritual well-being*

*Share my experiences*

## Appendix 3

Interview Plan

**Further prompts (if needed):**

*Tell me about how you support your physical well-being, your physical body.*

*Tell me about how you support your mental state and your emotions.*

*Tell me about how you support yourself socially.*

*Tell me about how you connect to a sense of self and or something greater than yourself that supports what is termed your spiritual well-being.*

**Possible extra questions:**

*How/why do these work for you?*

*How do you know/How did you find out these actions work for you?*

Identify actions that help support your well-being - together &/or identify areas for exploration.

**2. Introduce the Whakawhanaungatanga Conceptual Model of relational well-being with aroha (WCM) (see Appendices)**

**Say:** This model offers relational ways of making sense, understanding and acting that centre relationships, connection and responsibility in narratives of hauora (well-being). We will revisit this in the workshops. Show and read through Appendix 3. If we look at the 'au' domain (App 4), does that spring to mind any other actions of self-care, especially for the spiritual dimensions of well-being?

**3. 'Care at work'**

**Say:** moving on to the second focus of the interview 'care at work'. I will take notes as you talk. Ask:

*When has care from a colleague (really) supported your well-being? (The 'best of C@W) - What's a great example of...*

- From colleagues
- i.e. what have colleagues at work done, or do, that supports your well-being?

[This sets the "Affirmative Topic" of our engagement, emphasising a positive, solutions-oriented approach to exploring what 'care at work' means to participants. It is used to reveal their experiences and how practising care might look and feel for them.]

**Say:** To summarise the key points let's create an **Empathy Map** using Mural.co, an online collaborative platform, of how you see 'care at work'. (Show the template using Mural).

**Intro** - This will visually represent your experiences and perspectives as shared in the interview. It consists of quadrants, with headings as shown below.



**Say:** I will start us off by reviewing my notes and sharing some of what I noticed so we can start to make sense of your experience/s. First, I will go through and describe each of the quadrants.

- **Say** - Here are some things I heard you say.
- **Think** - Here are some thoughts I noticed. What did you think about...?
  - Does that indicate some beliefs you have? (Unpack! Insights)
- **Do** - Here are some things I noticed that happened in your story - what you did and what your colleague did. Does that sound about right?
- **Feel** - Here are some feelings (e.g. adjectives) I noticed in your story. Feel free to add a short sentence for context next to adjectives.

"We don't need to make detailed notes on the Mural.co template, just to get an accurate sense of your experience. Let's try adding together\*. Feel free to make comments and ask questions as we go.

\* Option – I can read the notes & you scribe? - preference

Now, does that look ok?

**Inform the interviewee what happens next:**

- After all the interviews, I will review the empathy maps and interview recordings to create personas, a fictional character representing participant perspectives. These will be used in the first group workshop to establish a common ground for generative discussion.
- Workshop preparation - check if they have received the activities toolkit.
- Ask: Do you have any questions about the project? How are you feeling about the workshops?
- Prior to WS1 I will send a pdf of your Mural workstation for you to reviews – self-care, WCM, C@W
- **Auto sends video via Teams – aligning with Calendar invite in Teams**

**After the interview**

- > Download Mural pdf – format – Name – initials...
- > Download and save video and transcription to review – extend expiry on Teams until July next year

**Reflection**

- Explain concepts before
- Could link to own experiences – build relationships/connection. Emphasis I'm in it for you, your voice. Making something for you to use.



An illustration of the Whakawhanaungatanga Conceptual Model theorised by Carlson et al. (2016).

The Whakawhanaungatanga Conceptual Model (WMC) shown above presents five thematic domains of relationality and connectedness as encapsulated in the kupu (word) whakawhanaungatanga. These are listed below and summarised on the next page:

1. Whaka | whan | AU | nga | tanga: identities and personal qualities
2. Whaka | WHĀN | AU | nga | tanga: close ties and family relationships
3. Whaka | WHAN | AU | NGA | tanga: friends, mentors and wider connections
4. Whaka | WHAN | AU | NGA | TANGA: compassion and relational work
5. WHAKA | WHAN | AU | NGA | TANGA: wairua, spiritual and environmental connectedness

In an email to me on May 8, 2024, a theorist of the WMC, Teah Carlson, approved of this model being used in this project, adding that it was born from kōrero (conversations) with staff from He Kamaka Waiora (Māori health services) at four Auckland hospitals, so is a great reflection of cultural safety, te tai ao (natural environment), hauora (well-being) and aroha (love). She mentioned that she has used it in many settings, and “it really has no bounds”.

## Appendix 4

### Whakawhanaungatanga Conceptual Model (WCM)

## Summary of the five thematic domains of the Whakawhanaungatanga Conceptual Model

Drawing on Carlson's (2021) Whakawhanaungatanga Conceptual Model (WCM), the word 'whakawhanaungatanga' represents five relational dimensions of wellbeing.

In Carlson et al. (2022):

"Carlson et al. (2016) theorised that the centre of the kupu is au (a hau), signifying the self and identity: each person is the centre of their relational worlds.

By extending out from the centre of the kupu we arrive at whānau, denoting relationships unified around collective responsibility and shared vision, which may or may not involve shared whakapapa.

Moving outwards again, we arrive at whanaunga, which represents connections of shared interest and passion, including friendships, peers, leaders and activists.

The next layer is whanaungatanga, relational practices and the act of nurturing relationships.

Finally, the outside layer is whakawhanaungatanga, the collective expression of whakapapa and the acknowledgement that all living things are connected.

These five relational layers are mutually constitutive and additive, rather than discrete in the way themes are often imagined in qualitative inquiry."

References:

Carlson, Teah, Helen Moewaka Barnes, Susan Reid, and Tim McCreanor. "Whanaungatanga: A Space to Be Ourselves." *Journal of Indigenous Wellbeing* 1, no. 2 (2016): 44–59.

Carlson T. 2021. Whakawhanaungatanga: meaningful relationships. Introduction to Māori health. Auckland: Massey University. Online.

Carlson, Teah, Octavia Calder-Dawe, and Victoria Jensen-Lesatele. "You Can't Really Define It Can You? Rangatahi Perspectives on Hauora and Wellbeing." *Journal of the Royal Society of New Zealand* 52, no. 4 (August 8, 2022): 409–25. <https://doi.org/10.1080/03036758.2022.2074060>.

Interpreted from Carlson et al. (2022)'s exploration of rangatahi (youth) well-being using the WCM:

### 1. Whaka | whan | AU | nga | tanga: identities and personal qualities

The thematic domain au encompasses the most personal, intrapsychic dimensions of hauora, such as sense of self, identities and personal qualities. Au offers a way to understand the personal domain without the individualised frame characterising much Western thought about selfhood. Here, selfhood is theorised as inherently relational and intertwined with heritage and inheritance, relationships and gifts from others, and the wider sociocultural context – just as the kupu au itself is nestled within whakawhanaungatanga.

### 2. Whaka | WHĀN | AU | nga | tanga: close ties and family relationships

The thematic domain whānau encompasses close ties and relational bonds with immediate others. While often translated into English as 'family', our mobilisation of the concept of whānau is more capacious than this, invoking a sense of collective, shared responsibilities and a common vision (with or without shared whakapapa and genealogical ties).

### 3. Whaka | WHAN | AU | NGA | tanga: friends, mentors and wider connections

The next layer of wellbeing concerns strong connections beyond the whānau, to friends, mentors and role models.

### 4. Whaka | WHAN | AU | NGA | TANGA: compassion and relational work

Building on the relational worlds of whānau and whanaunga, the thematic domain of whanaungatanga captures the actions of a full heart: the sense of purpose and wellbeing derived from supporting and caring for their communities and close others.

### 5. WHAKA | WHAN | AU | NGA | TANGA: wairua, spiritual and environmental connectedness

The final analytic domain, whakawhanaungatanga, includes belonging and relationality in its broadest and most inclusive sense, encompassing wairua, religion and connections to the natural world. E.g. values from religion and culture. E.g. connection with nature.

## Appendix 5

### Empathy Map Template

Care at work		Question
Your experience & perspective.		<ul style="list-style-type: none"><li>• When did care from a colleague really support your well-being?</li><li>• What's a great example of care at work?</li></ul>
SAY <i>Write here</i>	THINK <i>Write here</i>	Notes
DO <i>Write here</i>	FEEL <i>Write here</i>	

Empathy map template used in Mural to explore participants' 'care at work' stories in the interviews

Representative questions I asked during the interviews as part of the process of empathy mapping to identify needs and reveal insights from the participants' experiences and perspectives

*Note for future co-design: The statements after each question could be used when engaging participants in co-analysis of an empathy map, and/or when sharing specific (e.g. quotes) back with participants to illustrate themes.*

- **Say** - What are some quotes and defining words they said? / Here are some things I heard you say
- **Think** - What did they think? What can be inferred about their thoughts/beliefs? / Here are some thoughts I noticed. What did you think about...? Does that indicate some beliefs you have?
- **Do** - What actions and behaviours did they take and how? / Here are some things I noticed that happened in your story - what you did and what your colleague did. Does that sound about right?
- **Feel** - What feelings did they have? Their emotional state. Often represented as an adjective plus a short sentence for context. / Here are some feelings (e.g. adjectives) I noticed in your story. Feel free to add a short sentence for context next to adjectives.

Your experience & perspective.

SAY Write here	THINK Write here
DO Write here	FEEL Write here

## Appendix 6

Representative Questions Used as Part of Empathy Mapping

A version of reflective thematic analysis supported by visual and creative sense-making

In this research, this involved:

1. **Reviewing** rough **notes** taken during each interview, '**coding**' them and sorting them into categories on a table with the headings: Words, Feelings, Values, Actions (WFVA); while also posing questions and creating **visual representations** of ideas
2. Listening to the **interview recordings**, taking more detailed notes, noticing ('coding for') WFVA and adding to the table from step 1.
3. **Reviewing the Empathy Map** (Say Think Feel Do) created with each participant during their interview. Asking questions of the empathy map to analyse the data, identify needs and reveal insights (see Appendix \*\* for representative questions I asked of each empathy map)
4. **Returning to the data gathered and analysed from each individual interview** (from steps 1-3) to identify key quotes from each interview and 2-5 key themes to represent each interview
5. **Repeating** steps 1-4 for each of the four interviews
6. Making a **Combined Empathy Map** to see connections and differences visually, using a combination of interview notes (from steps 1-2), code/categories (from step 2), and individual Empathy Maps (from step 3). Creating 8-12 themes and representing each on 'sticky notes'.
7. **Identifying 2-4 key ideas/concepts as themes** across the interviews, trying to visually represent each theme and identifying quotes (evidence) to illustrate each theme.
8. Taking time away to play around with the themes, arranging 'sticky notes' in different ways to group and create bigger themes (**visual mapping**). Testing if the resulting themes represented all four interviews. Noticing similarities between interviews and testing for reasons why, i.e. insights.
9. Using **clay** to represent the themes, to make sense of relationships between and in themes.
10. **Reframing** the themes/ideas as human needs and modes of interaction, with descriptive characteristics and visual representations
11. **Repeating** step 8.
12. The themes were supplemented by **mind maps** in the subsequent workshop (1) to allow participants to be more fully immersed in the data and to provide feedback.

## Appendix 7

Reflective Thematic Analysis

## Workshop 1 of 2 - Activities and guiding script

<p><b>Duration:</b> 60-90min  <b>Facilitated/led by researcher</b>  <b>Mode:</b> Online, video conferencing (MS Teams)  <b>Video recorded</b></p> <p><i>Check all know how to set-up screens, access &amp; have toolkit, e.g. in Interview.</i></p>	<p><b>Materials</b>            Activities toolkit* with participants (sent earlier).</p> <p>Links to Mural workstation (invite participants to the Sketchpad). Sketchpad set up with two Ai phase headings: <i>Discover &amp; Dream</i>.</p>
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1. **Icebreakers (5 min)** - Please share in the chat your name, where you are coming from today? Open and explain the research activity toolkit received. One at a time, participants to show the character notebook they have (which is unique to their toolkit) and share one thing they do for self-care and why (identified in Interview).

**Playdoh warm-up – make a ball, snake, snail, square – squash it.**

2. **Introduction (2 min):** Establish group guidelines & intention for WSs. Remind them of video recording and workshop 2 date. Reassure them that the **intention is to create a safe space, collaborate, appreciate and build on what works.**
  - a. Intention in Mural
  - b. Warm-up activity in Mural – find your book character image and drag it to the empathy/compassion icon.

Say (wording important): see Intention in Mural (guided there, by E/C icon)

*'Care' doesn't always mean the same thing. How someone receives 'care' can vary from person to person. I think empathy helps us to find out what 'care' means for someone.*

3. **What is empathy? (5 min)**  
 Refer to icon/visual and say: Empathy is said to be "the ability to recognise and share the mental states of others" I have also seen it described as having 3 dimensions: cognitive, Emotive & action – involving Head Heart & Hands:
  1. HEAD - Cognitive empathy - the ability to **understand someone else's perspective** and what they might be thinking and feeling. (It's the thinking part of empathy, and as the name suggests, it happens on a cognitive level.)
  2. HEART - Emotive empathy - it is **feeling with** someone. It goes beyond just the cognitive and is not above or apart from them, but together *with* them. You stand shoulder-to-shoulder with that other person and feel with them.
  3. HANDS - Empathic-action - the doing part of empathy. It goes beyond simply understanding others and sharing their feelings: it moves us to **take action**, to help however we can. This is essentially practicing compassion. (That comes in many forms, depending on the situation, ranging from direct help, to asking how you can help to just sitting in silence with them and not "doing" anything, which is often exactly what that person needs us to "do." - Brene Brown).

4. **Say:** (Reiterate) - This first Workshop aims to build empathy, connection, trust, mutual understanding and appreciation of the 'greatness that exists'. We will be using the Mural/Sketchpad to make notes today under the two headings: Discover and Dream.

5. **DISCOVER: Themes intro (1 min).** Share on screen and

## Appendix 8

### Workshops Plan

Say: I'll share the themes (as visuals and mind map/quotes etc.) I discovered from reviewing your interviews and EMap we created together.

We will use these for generative discussion about 'care at work', & to appreciate 'what's working well'.

By appreciating these ideas, reviewing the quotes we can collaboratively identify needs and insights associated with 'care at work' currently. We may draw out nuance and meaning from the experiences and aim to develop a deep, shared understanding and empathy about C@W (HEAD)

Activity – What have you been thinking about C@W since the interview? And in response to the themes,

(From this, meaningful opportunities for change can emerge and inform the design process. Don't worry, I will guide us through the process, and remember we are exploring this together to learn.)

6. **DISCOVER: activity (5-10 min)** (discuss and add to collaborative document)

Say: Let's use the Mural.co 'sketchpad' tool to record what we notice. We are *Discovering* what works currently.

**Look to what we currently experience as 'care at work' - the best stuff.**

7. **DISCOVER: Review and Recap (5-10 min)**

Do we have a feel for, understanding of, needs met by C@W?.. how it might look/feel for people working in healthcare? Say: Does this lead us to add any more Needs, Insights or Wonderings? If so, let's add it to the Mural

8. **DREAM: Creative/making activity: storytelling through participant-created artefacts - Intro (2 min)**

2 min to think and make something with playdoh that represent your thoughts – feel free to use paper and pen to sketch ideas, then we'll have a turn each to share and discuss and make notes on Mural sticky notes.

[Background: This aims to provoke the imagination of new ways of practising care for colleagues at work and to engender emotional engagement and reflexivity. Dream phase of Ai. Linking now to Emotive empathy.]

Say: Ok, let's leave that for now and try a creative activity to help us move into the next phase, **dreaming**. You get to use any of the materials provided in your toolkits and I will give you a question to prompt your thinking and creativity. The point of this activity is to create something that helps you to share. don't worry about the quality of what you make. You are invited to make in any way you like.

*How do you imagine it could be? If there was a culture of care among colleagues?*  
- in future teams and beyond, broadly in healthcare as a workplace.

Prompt Q: **What might care (from colleagues) at work ideally feel like?**

Say (wording important):

You will have 5 min. Afterwards, you'll have the chance to share verbally what you've made with the group. Any questions? .... (Answer/clarify Q).

I'll let you know when there is 20 sec left. Give it a go!

10. **DREAM: Making (5 min)** (timed by facilitator, with verbal signal at "20 sec to go").

11. **DREAM: Sharing in the group (10-15 min)**

[Background: The creation acts as a probe intended to enhance dialogue and invite participants to be involved in the exploration of the concept of 'care at work' and to start envisaging a future reality (Dream phase of Ai).]

Say: You'll have 1 min each to share, I'll time it and then we can make notes of what we notice – the feelings shared by the speaker & your own thoughts and feelings. If you agree, I'd like to take screenshots of your creation later.

To listen deeply, notice your own thoughts and feelings. This may include some gut reactions or wonderings. This is 'deep listening' - listen with your head, heart and gut.

- each person presents their creation and shares for 1 min -

12. **DREAM: Group discussion: giving shape to the Dream (20-25 min)**

[Background: Visual mapping in the form of **affinity diagrams** - to group together similar ideas, items, statements, or data. This incorporates different perspectives in a collaborative effort to deepen understanding of the participant perspectives and enhance inclusion and ownership of the insights. - in the workshop we will do a high level version of this]

Say: Now, let's take a look at the Sketchpad: **Needs and Insights** notes, and take a few minutes to record any new needs or insights in the 'How it could be' section. Use the **thoughts and feeling** notes. (3-5 min)

Say: Now, let's take turns to speak to the needs and insights we have identified and start to shape some themes – notice what's common and also what's diverse.

Sticky notes

Ask:

- *What is common and diverse in the thoughts and feelings we have identified?*
- *Have we come to realise any new needs or insights?*

**Important points**

- Value the discussion and do not rush. If needed, the researcher will review the video recording of the workshop and bring any additional draft statements to workshop 2 for consideration and further discussion.
- If this Dream phase needs to continue into Workshop 2, that's better than rushing on. We can finish with either themes or 'provocative propositions' / 'possibility statements'.

15. **Ending** – Review intentions and ask for feedback. Thanks for coming. See you in workshop 2. Next session we'll move into the Design (or continue Dream and then into Design), you may like to bring to workshop 2 the Ai steps diagram and your pen and paper for making notes? Confirm workshop date and time.

[Record Workshop 1 outcomes: Needs, Insights, Themes / 'provocative propositions' / 'possibility statements']

## Workshop 2 of 2 - Activities and guiding script

<b>Duration:</b> 60-90min <b>Facilitated/led by researcher</b> <b>Mode:</b> Online, video conferencing (Teams) <b>Video recorded</b>  <b>Check all participants:</b> <i>know how to set-up screens, can access Zoom/have meeting link &amp; remember to bring their toolkit.</i>	<b>Materials</b> Activities toolkit* with participants (sent earlier).  Links to Mural workstation (invite participants to the Sketchpad) - continued from WS1  Outcomes from workshop 1 – on Mural.
--	---

Prior – reminders. 1 week, 1 day, any tech questions?

[Background: Workshop 2 intends to inspire participants to co-create ideas - specifically for, as is the **aim**, a process/toolkit for exploring and inspiring care, connection with colleagues at work – diverse settings. This Design phase in Ai is about co-creating actions to realise the desired future, bridging 'what is' and 'what might be' (which is the Discover & Dream phases in Ai, **Whakaea**). This is in an iterative process, informed by the workshop 1 outcomes.]

### 1. Introduction (1 min)

Reiterate group guidelines established in workshop 1.

Say: Thanks again for being here. Today we will move from what 'care at work' *could be* to by making a plan. Towards / building on what already works!

Encourage sharing – diverse perspectives

[Background: To start the design, participants will be asked to identify what short-term and long-term actions they could do, for building empathy and practicing 'care' at work with their colleagues.]

**Start** – In Mural – revisit START HERE & intention (we will...).

ASK – How? What did you love from last time for connection and to feel safe? - Feedback

### 2. Connection activity - your takeaways (10 min)

Ask: What are your personal takeaways so far, what have you thought about in regards to what you could do in a) the short-term or b) the long-term?

Quick-fire – jot in the chat. Do the actions link DISCOVERY to DREAM? How? Short or long term? - Sharing -

### 3. DESIGN phase

#### 4. Let's get specific (refining for feasibility & impact)

Take notes on the Sketchpad in a new DESIGN section

**Ask: What action do you need to take to make it happen?**

Ask: What is doable, meaningful actions? [check for feasibility/impact]. Ask: What's efficient and why?

Ask: How do we create more of what's great already? Ask: Where do we start? And what's next?

**5. If time** - Any feedback/thoughts/wonderings about how to successfully facilitate online collaboration & empathy building? These could be considerations for your future workplace collaborations online.

**6. Ending** - thank you. With the object in your toolkit, I'd like you to think of 1-3 words that remind you of your intention to contribute to care, connection and well-being at work. Link the words to your object as a reminder.



## Participant Information Sheet

Kia ora, I'm Natasha, a Master of Design student at AUT University.

I am interested in using co-design to promote care, connection, well-being and collaboration among professionals working in the context of healthcare. I would like to invite you to be a research participant in this design research. This research forms the basis of my master's exegesis which is a requirement of the Master of Design qualification.

### Date Information Sheet Produced:

11 October 2024

### Project Title

Practicing care: empathy in action among healthcare professionals

### What is the purpose of this research?

This research aims to explore a novel approach to unpacking and empathising with notions of 'care' to create a space for appreciating diverse ways of understanding, empathising with, and connecting with colleagues in caring ways. This will inform the design of a process/toolkit for co-creating and promoting care, connection and well-being in diverse workplace settings.

This includes:

- Exploring potentially new ways to think about and create caring connections at work as whanaungatanga.
- Explore design thinking tools and processes for empathy building and collaboration online.

The findings of this research may be used for academic publications and presentations.

### How was I identified and why am I being invited to participate in this research?

You have been invited to take part in this design research project as a potential leader in systems change through being a member of the Improve team, within the National Service Improvement and Innovation directorate at Te Whatu Ora Waitematā - Health New Zealand. However, the number of participants will be limited to five to support effective collaboration online.

### How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

A consent form is required before you take part in the design research. This should be signed and returned electronically via email to the researcher Natasha Low. This acts as confirmation that you would like to participate in the research.

### What will happen in this research?

You will be invited to participate in one 60-90 min individual online interview with Natasha and two 60-90 min group (3-5 participants) online co-design workshops. You will receive a toolkit to use in the interview and workshops. In the interview you will be guided through activities to help you express your notions of 'self-care' and 'care at work', introduced to a conceptual model of whakawhanaungatanga, and we will visually represent what you share. In the workshops we will explore design thinking tools to build empathy and connection (Workshop 1) and enable the co-creation of a process or toolkit to explore and inspire care and connection among colleagues in your diverse workplace settings (Workshop 2). Interviews and workshops will be video-recorded, and notes will be taken during them.

### What are the discomforts and risks, and should any occur, how will they be alleviated?

There is minimal discomfort or risk anticipated with this design research. However, should you experience any discomfort, you may withdraw at any point during the research project.

## Appendix 9

### Participant Information Sheet

**What are the benefits?**

As a research participant, you will have the opportunity to learn about and practice co-design in an online setting. There is also the chance for you to appreciate diverse ways of understanding, empathising and connecting with colleagues. Finally, you will be part of a collaborative effort to promote care, connection and well-being in our healthcare system. I, the researcher, will benefit from this research by using the insights, learnings, and design outcomes to complete my qualification. The wider healthcare community may benefit from this research contributing to more inclusive ways of promoting well-being, care and connection, particularly in online settings.

**How will my privacy be protected?**

A consent form is required to be signed to participate in this design research. On the consent form you can indicate if you would like your name and/or photos of anything you create in the project to be included and acknowledged in any publications and presentations. Alternatively, pseudonyms can be used. Data collected in the sessions and subsequently synthesised will be stored on the AUT Server and then deleted after six years. Limited confidentiality only may be offered as participants are drawn from a small pool and will be known to each other.

**What are the costs of participating in this research?**

There are no costs associated with participating in this research, except a time commitment of three to four and a half hours across the interview and two workshops.

**What opportunity do I have to consider this invitation?**

You will have two weeks from the date of this invitation to consider whether to participate in this research.

Interviews and workshops will be planned to suit the researcher and participants.

1. Interview - October - December
2. Workshop 1 - December - February
3. Workshop 2 - February - March

**What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Ivana Nakarada-Kordic, [ivana.nk@aut.ac.nz](mailto:ivana.nk@aut.ac.nz), 09 921 9999 ext. 28399

Concerns regarding the conduct of the research should be notified to the Executive Secretary of ATEC, [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz), (+649) 921 9999 ext. 6038.

**Whom do I contact for further information about this research?**

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

**Researcher Contact Details:**

Natasha Low

[natasha.low@gmail.com](mailto:natasha.low@gmail.com)

**Project Supervisors Contact Details:**

Ivana Nakarada-Kordic

[ivana.nk@aut.ac.nz](mailto:ivana.nk@aut.ac.nz)

Johanne Egan

[johanne.egan@aut.ac.nz](mailto:johanne.egan@aut.ac.nz)

*Approved by the Auckland University of Technology Ethics Committee on 11<sup>th</sup> October 2024  
AUTEK Reference number 24/268*

## Consent Form

**Project title:** *Practicing care: empathy in action among healthcare professionals*

**Project Supervisor:** *Ivana Nakarada-Kordic and Johanne Egan*

**Researcher:** *Natasha Low*

- I have read and understood the information provided about this research project in the Information Sheet dated 30 August 2024.
- I have had an opportunity to ask questions and to have them answered.
- I understand that the interview and workshops will be video-recorded, and notes will be taken during them.
- I agree to keep the information in our workshop discussions confidential to the group.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, I understand that data I share in the workshops will not be able to be removed following data analysis.
- I would like the following needs or information to be considered in the research (e.g., particular access needs, personal circumstances, cultural background, etc.)  
.....
- I permit the researcher/designer to use photographs/stills of any artefacts I create, alone or in conjunction with any wording, for academic purposes. I acknowledge that these will not be published outside of this project without my written permission (please tick one): Yes  No
- I would like to be acknowledged by name as a co-contributor to this research in any future publications and presentations (please tick one): Yes  No
- I would like photos of artefacts I create in the project to be acknowledged with my name (please tick one): Yes  No
- I wish to receive a copy of the process/toolkit we co-create via email (please tick one): Yes  No
- I wish to receive a link to the thesis that results from this research via email (please tick one): Yes  No
- I agree to take part in this research.

Participant's signature: .....

Participant's name: .....

Participant's contact email: .....

Participant's email to receive the process/toolkit and/or link to the thesis (option to provide an alternative email):  
.....

Participant's postal address to send the research activity toolkit to:  
.....

Date: .....

*Note: The Participant should retain a copy of this form. Please sign and return via email to [natasha.low@gmail.com](mailto:natasha.low@gmail.com)*

*Approved by the Auckland University of Technology Ethics Committee on 11 October 2024, | AUTEK Reference number 24/268*

# Appendix 10

## Participant Consent Form





## Appendix 12

Portfolio of Facilitation Toolkit - Final Prototype

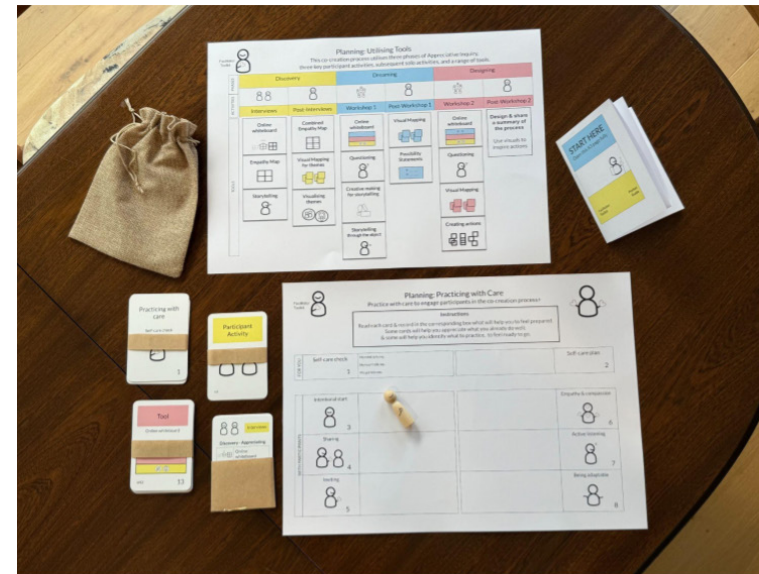




The **Facilitator Toolkit** is intended to prepare a facilitator/s weeks before facilitating a co-creation (creative collaboration & inquiry) online with a small group.

It introduces facilitators to the co-creation process & guides them to reflect & plan, to be ready to work with a group of participants.

The wooden mascot can be held & carried through the journey as a reminder to practice with care throughout the co-creation process.



## Contents

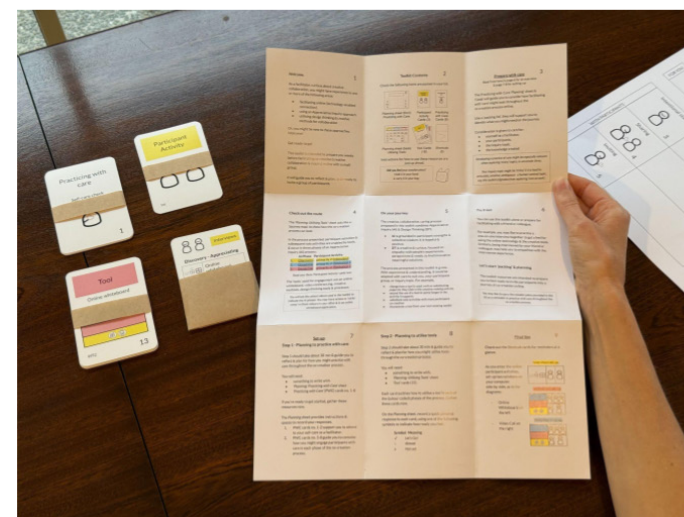
The toolkit includes:

- An Introduction booklet
- A Planning sheet to prepare for Practicing with Care (front) & Utilising Tools (back)
- A set of cards (32) bound in their four categories
- A wooden piece
- A drawstring bag



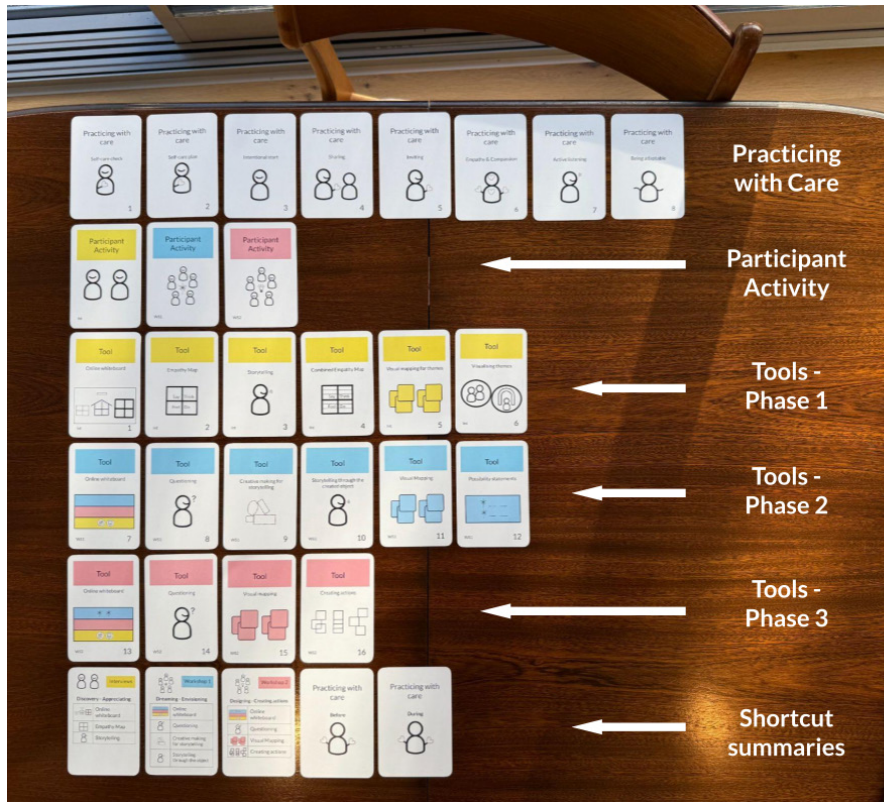
Activity Sheet

The toolkit is designed to be portable. Items come in a drawstring bag which is wrapped in an activity sheet that invites facilitators into a creative activity from the get go.



As the **Introduction booklet** is unfolded the facilitator/s are presented with information on the co-creation process & guided to prepare with care (pp 1-6) & set-up (pp 7-8) for facilitation.

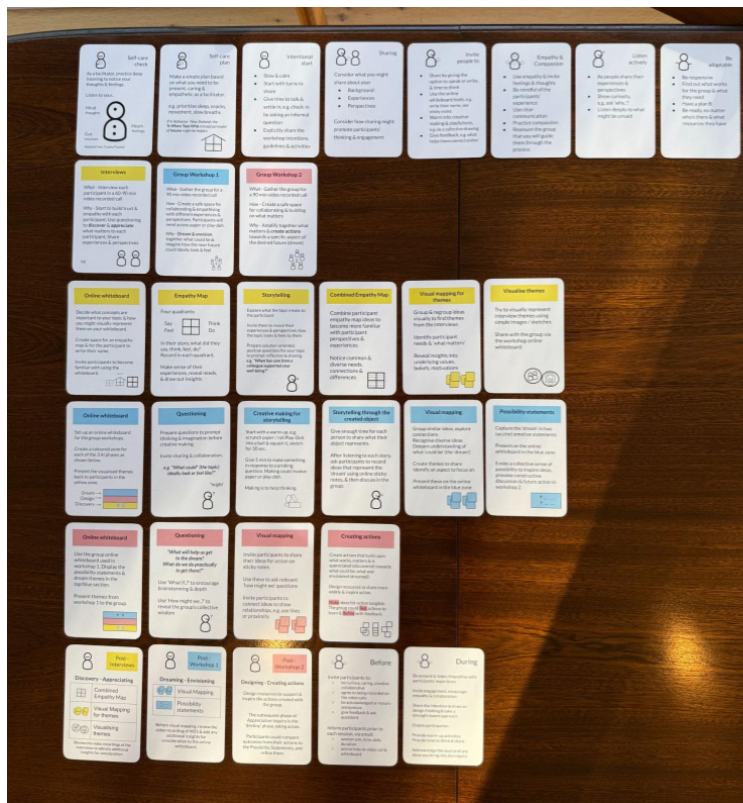
Final Tips (p 9) & links for further information are also provided (on the back).



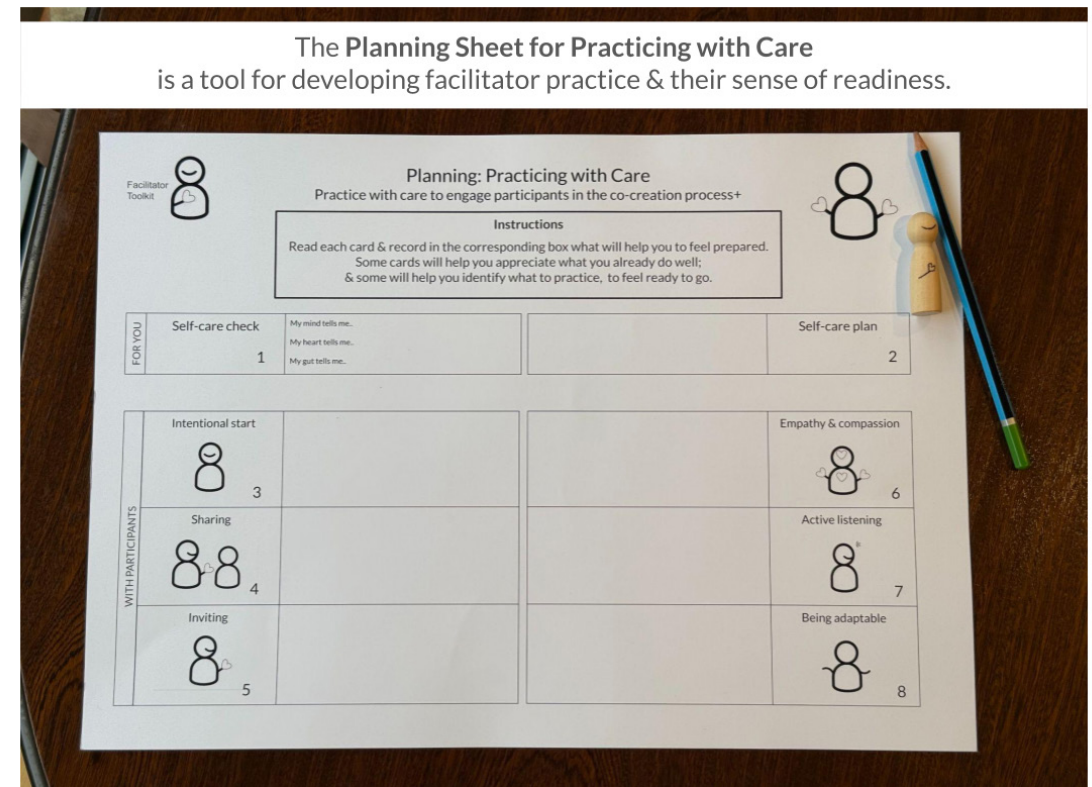
The Set of Cards includes categories.



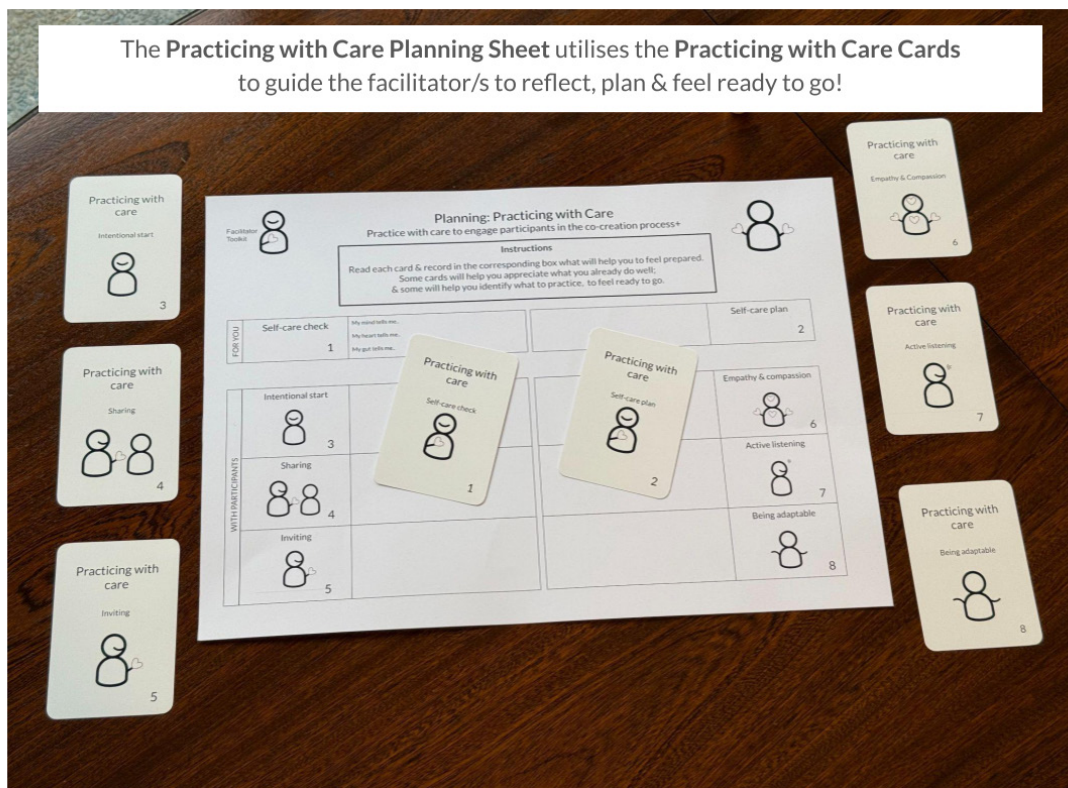
The three Participant Activity Cards are the first to be introduced. This outlines the key participant activity utilised in each of the three phases of the co-creation process.



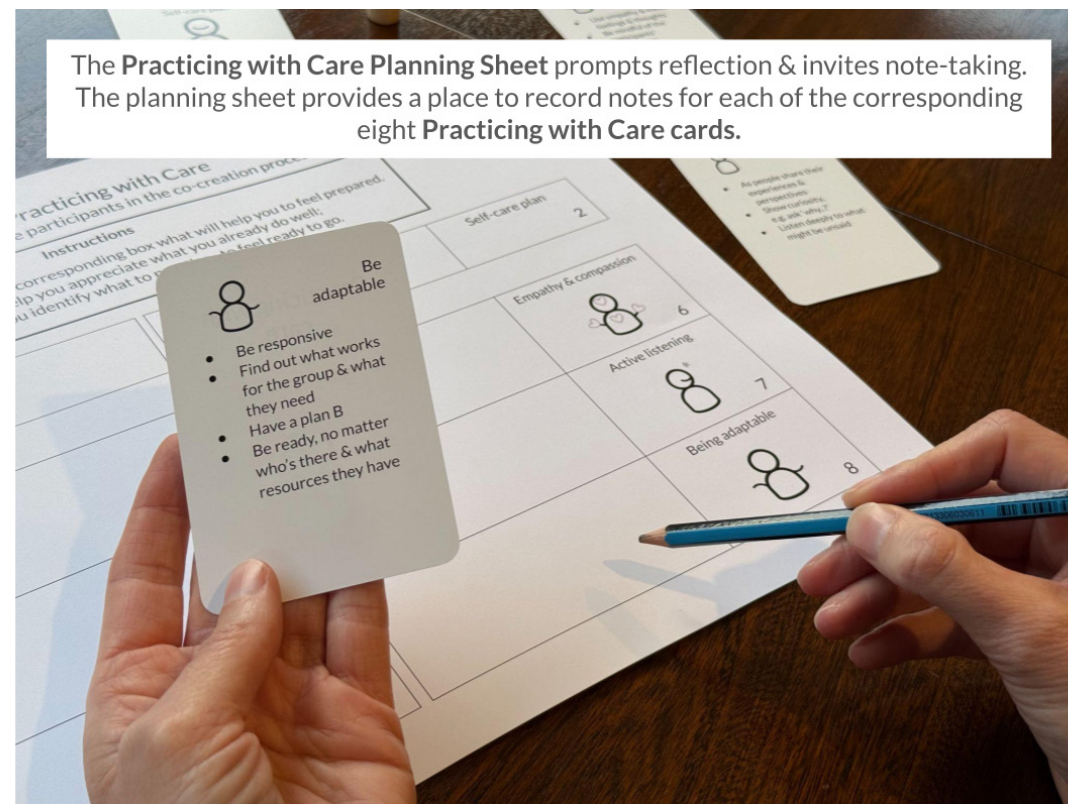
The back of each card provides guidance to inform & prepare the facilitator/s to practice in the co-creation process.



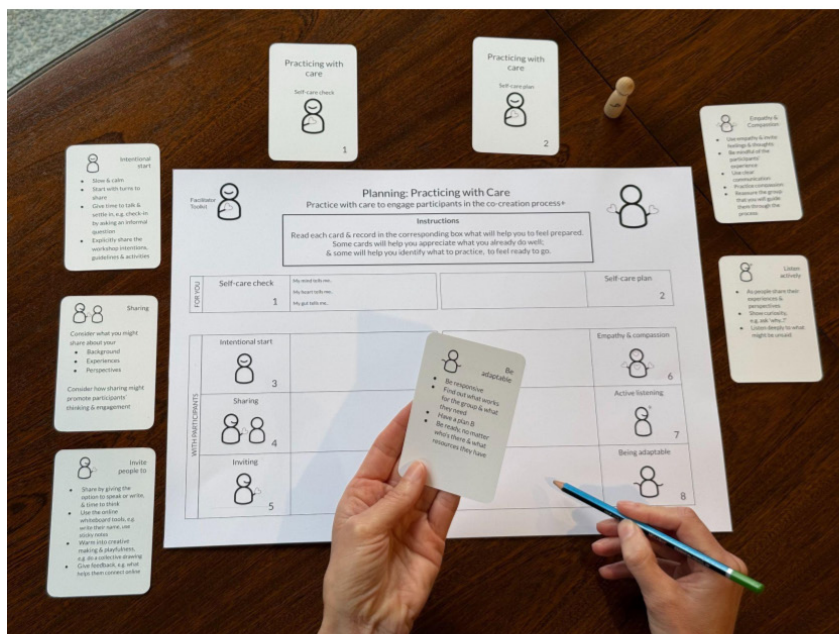
The Practicing with Care Planning Sheet utilises the Practicing with Care Cards to guide the facilitator/s to reflect, plan & feel ready to go!



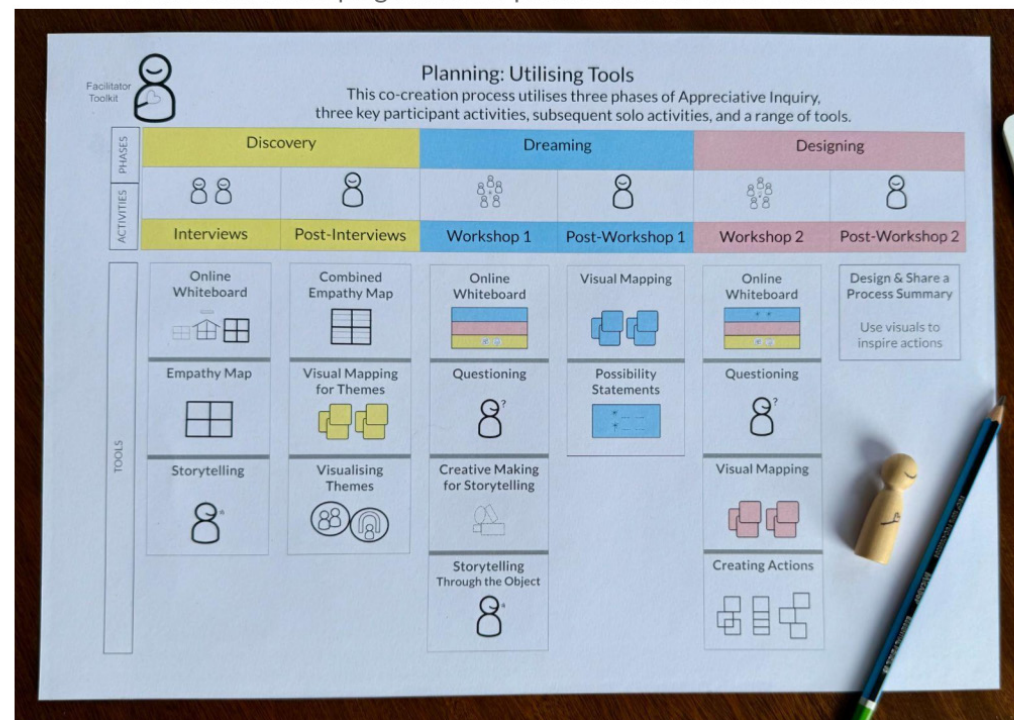
The Practicing with Care Planning Sheet prompts reflection & invites note-taking. The planning sheet provides a place to record notes for each of the corresponding eight Practicing with Care cards.

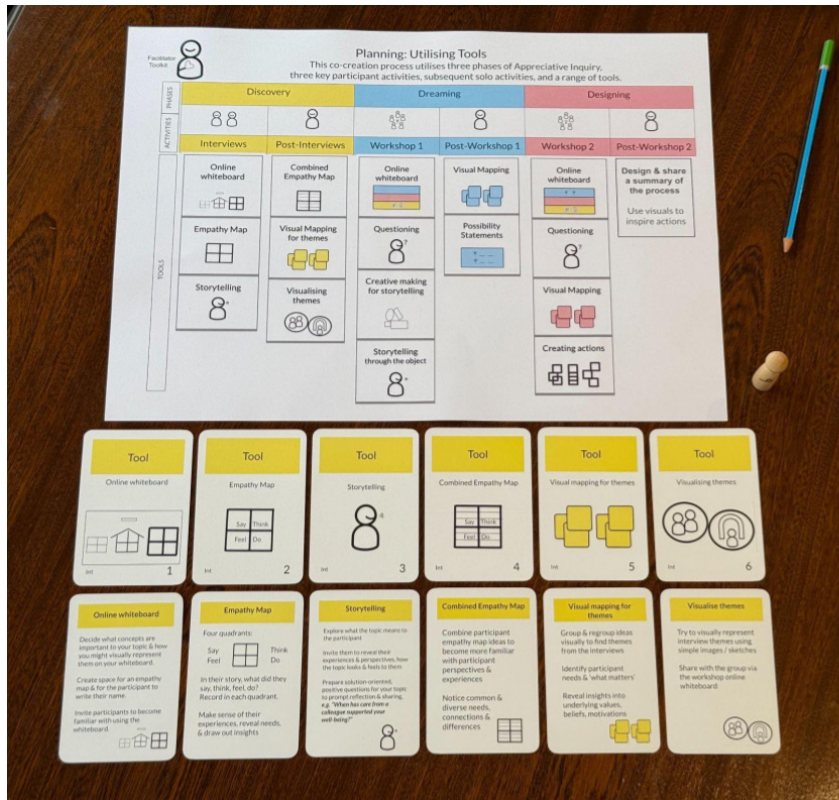


The Planning Sheet for Utilising Tools is a tool for developing facilitator practice & their sense of readiness.



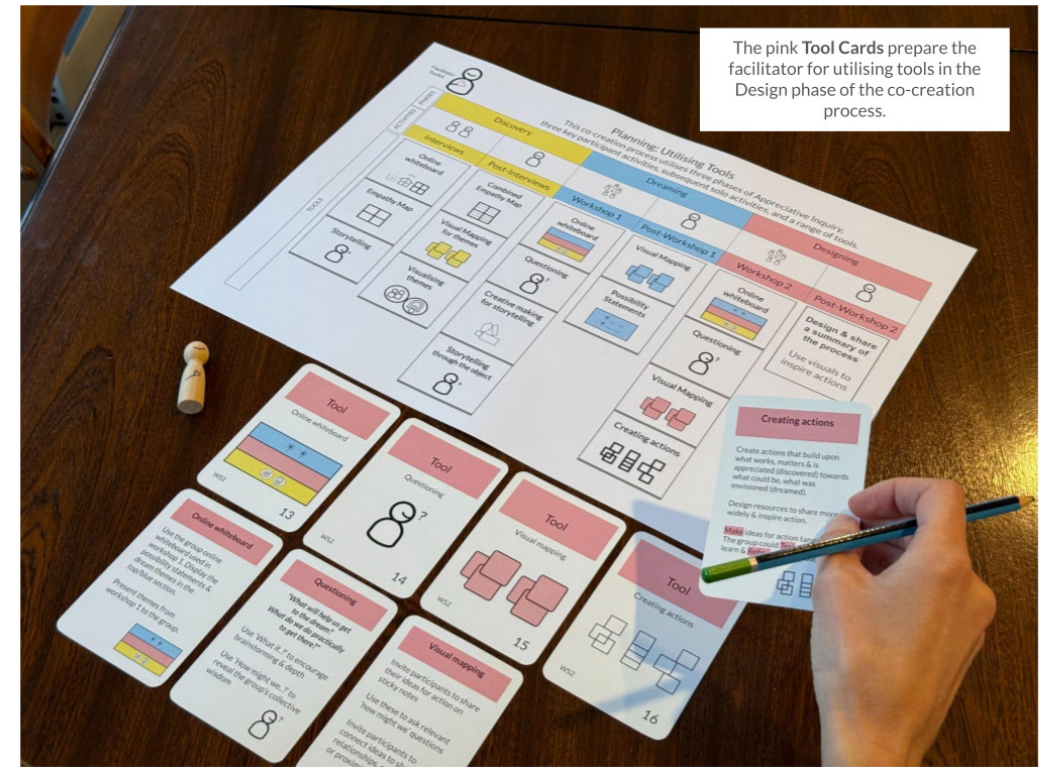
There are eight Practicing with Care Cards: no. 1-2 support facilitator self-care, & no. 3-8 guide the facilitator/s to consider how they might engage participants with care in each phase of the co-creation process.





The Utilising Tools Planning Sheet is supported by the Tool Cards for each of the three colour coded phases in the co-creation process.

Tool Cards no. 1-6 (yellow) outline how to utilise the tools in the Discovery phase of the co-creation process.



The pink Tool Cards prepare the facilitator for utilising tools in the Design phase of the co-creation process.



Each Tool Card prompts reflection & invites the facilitator/s to record a quick personal response to each card, to indicate their sense of readiness.

The blue Tool Cards correspond to the Dream phase of the co-creation process.

