Edinburgh Napier UNIVERSITY

Leadership in Compassionate Care

Leadership in Compassionate Care Programme

Final Report

June 2012

NHS Lothian

Edinburgh Napier University
and NHS Lothian

Enhancing Patient Care by promoting compassionate practice

Final Report, June 2012

Leadership in Compassionate Care Programme Team

Top row – left to right: Billie Morrow; Ria Tocher; Simon Pullin; Dr. Belinda Dewar; Melanie Hornett.
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The Leadership in Compassionate Care Programme Team would like to acknowledge that the programme was funded by a very generous donation from Dr Ann Gloag, Non Executive Director, Stagecoach Group plc.

Dedication

This report is dedicated to Simon Pullin. Simon was a Senior Nurse on the Leadership in Compassionate Care Programme from its commencement in December 2007 until his death in July 2011. The Leadership in Compassionate Care Programme Team would like to acknowledge his special contribution to this work and dedicate this report to him.

About the Authors

Liz Adamson

Liz Adamson is a Teaching Fellow and Lecturer within the School of Nursing Midwifery and Social Care at Edinburgh Napier University. Her role involves teaching, assessing and supporting undergraduate adult nursing students. She is responsible for the progression of 150 students through the undergraduate programme. She leads a SCQF level 9 blended learning module that uses simulation to teach recognition of acute illness and deterioration. She teaches international post graduate clinical research associates at MSc. Level and Health Assessment to undergraduate students in Singapore. She maintains close links with clinical practice and supports students on placement. Her research interests include application within practice of learning through simulation and compassionate care.

Dr. Belinda Dewar

Belinda is a nurse, educator and researcher and has been working with nurses in older people care settings over the last 20 years. She held a Senior Research Fellow position where her remit was to involve older people and care staff in a meaningful way to enhance care through action research. She has expertise in user involvement, and action learning and has been asked to contribute to this body of knowledge both nationally and internationally. She is committed not only to improving care services for service users but also to supporting staff in the health care sector to enhance their working lives.

She held a position of nurse consultant and worked with Scottish Government and other key stakeholders to promote a positive care culture across care homes in Scotland. She is currently a Senior Nurse in the Leadership in Compassionate Care Programme based at NHS Lothian and Edinburgh Napier University where she is working with a team of people to embed compassionate caring practices both in the wards and in the university curriculum. She recently completed her doctoral studies where she developed a model for compassionate caring. She is committed to approaches to research that empower others to be critical of their practice and develop change in partnership with patients and their families. Future aspirations include being able to work collaboratively with other leaders in the field of compassionate relationship-centred care to develop meaningful frameworks for practice.

Dr Jayne Donaldson

Jayne is the Head of School of Nursing and Midwifery and Social Care, Edinburgh Napier University. Jayne has responsibility for the strategic development and operational functioning of the school. Jayne believes that it is essential that the school responds to international and national healthcare demands, and produces students who are fit for purpose and fit for practice. She values the contribution the school has to the development of learning, teaching and assessment methods, and research, employed within global healthcare. Jayne has worked within Higher Education in Scotland since 1998, and completed her PhD study in 2003. Jayne's teaching and research interests include compassionate care, simulation, acute adult nursing care, use of systematic reviews within research and wound care. She has extensive experience in the enhancement of students' competence, mentorship and practice placement standards.

Mandy Gentleman

Mandy completed my Registered Mental Health nurse training in Edinburgh in 1987 and then after working in England for a year decided to do her Registered Nurse training which was completed in 1989. Mandy spend some time working in Clinical Neurosciences, Western General Hospital in Edinburgh before going to work in Australia for two years. Following her return to the United Kingdom mandy returned to practice in Clinical Neurosciences and worked predominately in Advanced Practitioner roles which focused on improving patient services for people with neurological conditions.

Mandy's most recent post was that of Clinical Nurse Specialist in a national Acquired Brain Injury Neurobehavioural Service, based in Edinburgh. One of the main remits of this unique post involved reviewing and evaluating the Service with the aim of improving the experiences of the patients and their families who came into contact with the Service.

Prof. Morag A. Gray

Morag Gray is a Professor Emeritus of Edinburgh Napier University. In her last role, Associate Dean (Academic Development) she was responsible for all curriculum development across two Schools (Life, Sport & Social Sciences; Nursing, Midwifery & Social Care) making up the Faculty of Health, Life and Social Sciences at Edinburgh Napier University. She is passionate about making the student experience an enjoyable and life-changing one. She completed her PhD in 1997 and since then she has written many successful grant funded proposals; undertaken a wide range of externally funded research projects, and been commissioned to write systematic literature reviews. Her research interests lie in mainly qualitative methods. In terms of publications, Morag has had 30 articles peer-reviewed journals; 7 book chapters; 12 research reports for funding bodies and 2 textbooks published. She chaired the Leadership in Compassionate Care Programme Evaluation Board.

Dr. Dorothy Horsburgh

Dr Dorothy Horsburgh is a Lecturer within the School of Nursing, Midwifery and Social Care, teaching students at undergraduate and postgraduate levels. Dorothy has research interests in care of people who have enduring conditions and has link lecturer responsibilities in respiratory, dermatology, rheumatology and stroke/cardiac rehabilitation units.

Linda King

Linda King is a Lecturer within the School of Nursing, Midwifery and Social Care, teaching students at undergraduate and postgraduate levels. Linda has interests in ageing, dementia, compassionate care and leadership with link lecturer responsibilities in medicine of older people, acute stroke and care home settings.

In 2008 she completed her MSc dissertation exploring how undergraduate nursing students conceptualise and learn about compassionate care and proposed a number of recommendations for education and practice. She maintains strong links with clinical practice and is committed to improving care through respect and dignity

Jenny Kalorkoti

Jenny was a Senior Nurse Leadership in Compassionate Care programme, working with the Department of Clinical Neurosciences at the Western General Hospital for 2 years until Oct 2011. Currently still on secondment doing patient experience work within Cancer Services until April 2012. Qualifications: MSc in Palliative Care, Diploma in Cancer Care, Registered General Nurse, B.A in Social Administration.Relevant work experience: In her previous role as a Senior Charge Nurse in Oncology Jenny's focus was the development of a strong team committed to providing excellent care within a supportive and learning culture.

Juliet MacArthur

Juliet MacArthur is Lead Practitioner in NHS Lothian where she has responsibility to develop research capacity amongst nurses and midwives. She leads a collaborative research framework with the three universities in Edinburgh that includes developing clinical academic research careers and creating 'research clusters' of clinicians and academics to take forward applied research programmes. She is also a part-time PhD student at Edinburgh Napier University where she is undertaking a longitudinal qualitative study to examine the impact of Beacon Strand of Leadership in Compassionate Care Programme on the wider NHS organisation. This is using Pawson and Tilley's (1997) 'Realistic Evaluation' approach, which examines the relationship between the context and processes of the Programme and how these have affected the outcomes. Juliet has been involved alongside the Programme since its very early days, and has interviewed most of the key stakeholders on a number of occasions. She aims to complete her thesis in 2012.

Pawson, R., & Tilley N. (1997) Realistic Evaluation. Sage Publications Ltd: London.

Mairi Maclean

Mairi worked in the NHS for 20; her posts included Ward Manager, Training and Development Manager and Senior Manager. She has worked independently for 13 years and during this time she has kept close links with the NHS and public sector work. She is now an Executive Coach and leadership facilitator and has worked with a range of organisations in the UK and abroad. She works with people and their organisations and specialises in areas such as emotional intelligence, managing conflict, group facilitation and strategic development. She became involved with the Compassionate Care Project after contributing to the initiative, 'Leading into the Future'. She believes in supporting staff to optimise their effectiveness at work by developing healthy relationships with colleagues and patients alike, and to be resilient through times of change.

Gill McCrossan

Gill has over 20 years' experience in the field of health care, predominantly working as a senior nurse in Critical Care. This combined with Accident and Emergency experience, Air Ambulance and practicing within Unscheduled Care service delivery/redesign results in specific interests particularly in the field of patient assessment, professional judgement and decision making.

In 2004 Gill gained a Lecturer position at Edinburgh Napier University where she uses her extensive clinical background to contribute to the students learning experience. To achieve relevance and currency in her teaching she maintains close links with clinical practice and is a member of various forums linked directly to the NHS and Service User initiatives (e.g. LANMAC, Voices Scotland, ENU Service User and Carer Liaison Group, NHS24 Clinical Education and Practice Development Group).

Research activity includes a Cochrane systematic review on 'Metered dose inhalers versus nebulizers for aerosol bronchodilator delivery for adult patients receiving mechanical ventilation in critical care units' which attracted CSO funding and CSMEN funded research on 'The development, implementation and evaluation of online video in clinical skills education for undergraduate student nurses'.

Iain McIntosh

Iain McIntosh has been Deputy Dean since Jan 2009, and previously Head of the School of Nursing, Midwifery and Social Care at Edinburgh Napier University, Iain has been involved in healthcare education in Scotland for around 25 years. He is committed to education that supports the best possible patient experience; he is passionate about promoting a role for higher education for healthcare that is relevant, responsive and challenging. His central role in the development of the Leadership in Compassionate Care Programme with NHS Lothian provides clear evidence of this commitment. Iain is a member of the Executive Committee of the Council of Deans of Health. He is currently chair of the NMC Key Stakeholder Advisory Group as part of the Review of Pre-registration Nursing Education and co-convenor of the SGHD (now NES) Delivery Group on Recruitment and Retention. He was until recently chair of NES's Nursing and Midwifery Professional Advisory Group.

Janis Ross

Janis Ross is a Lecturer in the School of Nursing, Midwifery and Social Care, teaching students at undergraduate and postgraduate level. Janis is also an Academic Conduct Officer and a School Disability Contact. Her research interests relate to learning, teaching and assessment and enhancing the Personal Development Teacher Role. She has link lecturer responsibilities in a range of community and hospital settings.

Simon Pullin

Simon's nursing career started in London in 1981. His clinical career has been focused on the care of older people. Simon worked as a clinical manager and subsequently a matron for Older People at Royal Free Hospital working with staff to create new working practices for nutrition, falls assessment, stroke and multidisciplinary working. Simon left London in 2007 to take up a position as a Senior Nurse with the Leadership in Compassionate Care Programme. Simon completed an MSc in clinical service delivery in 2004 and Post Graduate Certificate in Higher Education in 2010. Sadly Simon died in July 2011 and the team wish to highlight his important role and contributions.

Sue Sloan

Sue has a background in Community Nursing, having worked as a District Nurse for many years in West Lothian. Sue's career changed direction following her participation on the RCN Clinical Leadership Programme in 2001-2002. She was initially seconded as Leadership Facilitator and was fortunate to enjoy further secondments before successfully becoming Lead Practitioner Clinical Leadership, NHS Lothian in 2007. Sue is passionate about leadership development, feels privileged to work with staff and teams across the workforce, and be part of their leadership journeys- enabling, encouraging, inspiring, challenging; to enhance their leadership skills, which ultimately impacts positively on patient care and team working.

Fiona Smith

Fiona has worked in nurse education since 2003, and as a Lecturer in Acute and High Dependency Nursing, she has a key role in the development and delivery of acute and high dependency nursing modules within the undergraduate programme. Fiona has a keen interest in the use of simulation in nurse education and is involved in the development and implementation of modules utilising this teaching method to both undergraduate and post graduate students.

Her background is in surgical and critical care nursing (both national and international experience) and strong links with practice remain, both clinically and theoretically, with her involvement with the Foundation in Critical Care Course.

Recent research publications include a Cochrane Systematic review on the 'Debridement of Surgical Wounds' and an investigation into student nurses' knowledge retention following a blood transfusion teaching programme (Journal of Nurse Education in Practice) and evaluation of the Physician's Assistant Anaesthesia Programme. Current research includes a Cochrane systematic review of Nebulisers versus MDIs in adult ventilated patients in critical care, research into learning styles and simulation. Published work includes 'Student nurses knowledge retention in relation to safe blood transfusion practice'.

Dr. Stephen D. M. Smith

Stephen trained as a general and mental health nurse and for 15 years has worked in palliative care. This has involved clinical, research and managerial experience within the voluntary hospice sector as well as working in the NHS as a Clinical Nurse Specialist. Stephen was the Chair of NHS Lothian's Palliative Care Managed Clinical Network and worked with NHS Quality Improvement Scotland in the development of national standards for palliative care. Stephen completed a BSc in Nursing Studies at Queen Margaret University in 1997, a Masters Degree in Cancer Nursing at the University of Glasgow in 2000 and a PhD at Queen Margaret University in 2009. Stephen lead and co-ordinated the West Lothian Dementia Palliative Care Project, a three year action research project. This work formed the basis of Stephen's PhD study. He is currently Lead Nurse / Senior Lecturer for Edinburgh Napier University and NHS Lothian's Leadership in Compassionate Care Programme, a three year action research study utilising relationship centred care and appreciative inquiry approaches.

Ria Tocher

Ria Tocher has been working as a registered nurse in NHS Lothian since 1976, specialising in the care of older people. Ria is a registered practice educator and has developed and taught on a range of clinical topics. As Clinical Development Nurse for 12 continuing care wards Ria was committed to integrating practice development into practice, and to improving the patient, relative and staff experience in NHS continuing care. In 2007 she was seconded to the Leadership in Compassionate Care project were she felt privilege to be involved in working with staff to uncover and unpick what it was they did to make care compassionate. Having returned to her post in older people services Ria is enthusiastic to share her learning and continue to work with staff in pushing the boundaries in order to deliver a consistently high standard of care to older people and their loved ones.

Anne Waugh

Anne is a Senior Teaching Fellow in the School of Nursing, Midwifery and Social Care with some 20 years of experience in nursing education. She led the Programme within the School from its inception until the appointment of the Lead Nurse in August 2007. Anne has remained involved in the programme through action learning sets, study days for newly qualified nurses and is leading two of the curriculum action research projects (stories and demonstrating compassion during recruitment and selection). Her teaching includes aspects of life sciences applied to nursing and postgraduate students undertaking teaching qualifications. Anne has published several textbooks for nursing students including Ross and Wilson: Anatomy and Physiology in Health and Illness, which has been translated into Japanese, Korean, French and Dutch.

Chapter 1

1 Background to the development of the Leadership in Compassionate Care Programme

1.1 Introduction

This report reflects the initiation, planning, running and the important outcomes emerging from the Leadership in Compassionate Care Programme. The team worked in close partnership across the School of Nursing, Midwifery and Social Care, Edinburgh Napier University and NHS Lothian. This report also shares the highlights, challenges and solutions to embed compassionate care education and nursing practice.

The report is presented in four main sections reflecting each of the programme strands.

The report has multiple authors, reflecting the broad, interconnected nature of the LCCP and the wide range of staff involved. Each author was requested to write a section of the report that had particular relevance to their contribution. Authors had two opportunities to review the full report and suggest changes and amendments prior to publication. The LCCP team would like to acknowledge and thank Professor Morag Gray for her contribution in pulling together this report and ensuring consistency in presentation and style.

1.2 Background

The Leadership in Compassionate Care Programme was initiated in response to a growing awareness that some of the things most important to patients had been lost within practice and were not always made explicit within pre-registration nursing and midwifery education programmes. At this time a growing emphasis on the caring dimension of healthcare could be seen within emerging policy (DoH 2001 a, b, DoH 2005, SEHD 2006a, SEHD 2006b; Scottish Government 2010; Lown et al. 2011).

A group of nursing academics and staff from the Development Office at Edinburgh Napier University recognised this and, with the possibility of funding from a prospective benefactor, began to consider which groups of healthcare professionals and areas of practice would benefit most from private investment. The aim was to make the greatest impact and influence on healthcare provision with the resources available, and to ensure that compassion was woven into the ethos of caring within Lothian.

A unique feature of this programme which was vital to its success, was the forging of a strong partnership between Edinburgh Napier University and NHS Lothian with support and involvement from the highest level in both organisations. Individuals holding key positions within NHS Lothian, including Professor Heather Tierney Moore, Executive Director of Nursing, Carol Crowther, Chief Nurse, Fiona Cook as a representative from Continuing Professional and Practice Development and Alison MacDonald, Clinical Service Development Manager were invited to join the programme development team and a broad aim was identified. We would like to acknowledge and thank all of these staff for their significant contribution at the early stage of the programme.

1.3 Aim of the Leadership in Compassionate Care Programme (LCCP)

The aim of the Leadership in Compassionate Care Programme is: 'To embed compassionate care as an integral aspect of all nursing practice and education in NHS Lothian and beyond'

1.4 Creation of four stranded programme plan

Bimonthly meetings were held during which the meaning of compassionate care was explored and debated, and many of the operational challenges associated with the programme were addressed.

One example was that the Senior Nurses in Compassionate Care were to be employed by NHS Lothian while the Lead Project Nurse would be employed by the University. Therefore an important part of the programme development team's work was to establish support for the Senior Nurses within practice.

A project plan with four strands that could impact on a nurse's potential career trajectory emerged:

1 **Establishing Beacon Wards** that would showcase excellence in compassionate care

2 **Facilitating the development of leadership skills**. This strand would offer leadership development opportunities to key individuals.

3 **The undergraduate curricula**. A priority was to influence education through embedding relationship -centred compassionate practice in the nursing and midwifery programmes.

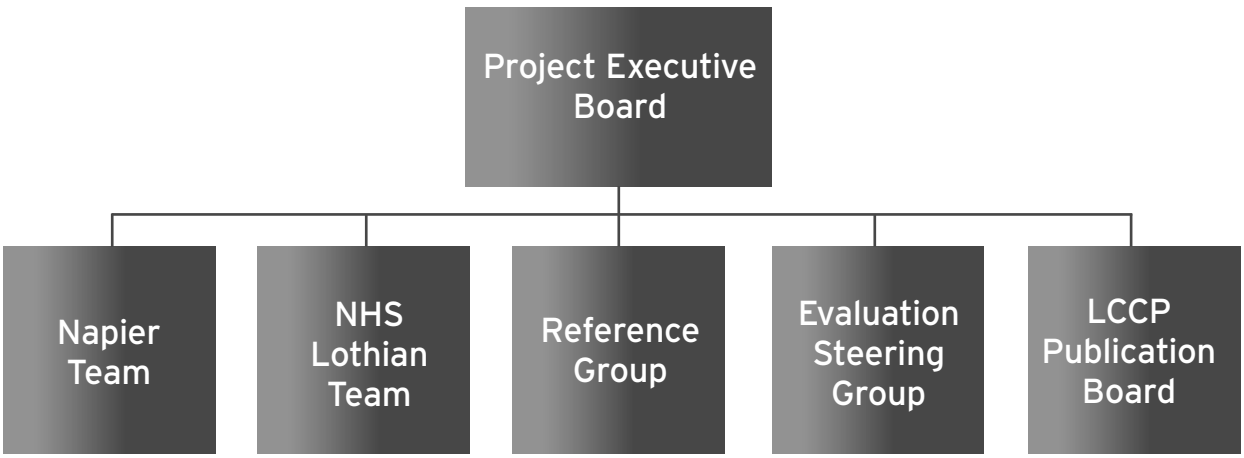
4 **Supporting newly qualified nurses.** This strand aimed to provide on-going support for all NHS Lothian newly qualified nurses during their first year in practice through a series of study days.

A number of focussed approaches were planned to ensure that Edinburgh Napier students and alumni, and other NHS practitioners would integrate principles of compassionate relationship-centred care into their daily practice. The plan not only provided a useful guide for the team as the programme evolved but also an effective tool to assist in communicating the programme vision to others.

It was considered vital that programme development information reached all prospective stakeholders and means of dissemination included road-shows, newsletters, email and face-to-face dialogue within both University and NHS settings. The Leadership in Companionate Care website was established at this time. This raised awareness at different levels within education and practice about the programme and how the aims might be realised in practice.

1. 5 Management of the programme

Once the programme development team had established the LCCP, a number of groups were developed to support and oversee the management of the programme. These groups included the Project Executive Board, Evaluation Steering Group and the Reference Group. A brief description of each group is given below and a chart identifying lines of responsibility is included below. Throughout the LCCP a range of staff involved in delivering the programme were research active, their research activity related to their specific contribution.



NAPIER UNIVERSITY and NHS LOTHIAN

LEADERSHIP IN COMPASSIONATE CARE PROGRAMME

PROJECT EXECUTIVE BOARD

PROJECT BOARD REMIT

Project Board Membership

Chair – Head of School	Iain MacIntosh
NHS Lothian Nurse Director	Heather Tierney-Moore
Director of Development	Karen Cairney
Lead Nurse in Compassionate Care tba	(Chair of the Project Team)
Senior Lecturer	Anne Waugh
Chief Nurse Quality and Professional Standards	Carol Crowther
Member of the Evaluation Team	Norrie/Morag Gray
Ex OfficieDean – Faculty of Health, Life and Social Sciences	Morag Prowse

In Attendance

Secretary to the Project Board	Susan Muirhead

Remit

- To oversee the implementation and ongoing management of the Leadership in Compassionate Care Project.
- Through the Lead Nurse, ensure that the project is delivered in accordance with the Project Plan – on time and within budget.
- Through the Chair and Director of Development, ensure that the Principal and Donor receive regular progress reports and updates, as outlined in the Project Plan.
- To oversee the appointment of all staff funded by the project.
- To oversee the formation, remit and ongoing activity of the Project Team.
- To oversee the planning process.
- To oversee and agree the communication strategy associated with the project.
- To carry out such other functions that may be required

Frequency of meetings

Meetings of the Project Board will be set initially on a quarterly basis, and may be increased or decreased depending on progress/project requirements.

Reporting requirements

The Principal and Donor will receive a report following each meeting.Every six months these reports will be presented in person.

April 2007

Project Evaluation Steering Group

Terms of reference

Purpose:

To develop, direct and manage the evaluation process of the Leadership in Compassionate Care Project.

Remit:

1 To develop and implement a research proposal that will evaluate the Leadership in Compassionate Care Project.

2 To complete the NHS and Napier University ethical approval processes relevant to this research, namely the National Research Ethics Service (NRES) and the Ethics Committee within Napier University.

3 To address and manage the evaluation process, in accordance with identified ethical principles, and within the local research governance framework.

4 To identify and utilise, a relevant research and evidence base within the evaluation process.

5 To manage the evaluation process in accordance with the stages and activities of the project.

6 To ensure key stakeholders participate in the evaluation process, key stakeholders identified as patients, clients and families, Napier students, various staff from Napier University and NHS Lothian

7 To engage and co-ordinate participation of staff from Napier University and NHS Lothian in the evaluation processes and provide a quarterly report to Project Executive Board.

8 To co-ordinate timely and appropriate feedback of evaluation activity to project participants.

9 To disseminate the outcomes of the evaluation, within NHS Lothian, nationally and internationally.

Membership:

Professor Morag Gray (Chair and Principal Investigator)

Professor Morag Prowse

Dr Jayne Donaldson

Juliet MacArthur

Stephen Smith

Frequency of meetings: Four times a year during the life of the project.

Responsibility and reporting line: To Leadership in Compassionate Care Project Executive Board (PEB). A member of the evaluation team will be present and provide a report at the PEB meetings.

Minutes of meetings: Copies of minutes will be sent to members of the evaluation group and to agreed group of participating members of staff within Napier and NHS Lothian.

Co-options: The group will actively engage staff from Napier and NHS Lothian to participate in the evaluation process. No specific co-opted individuals identified at present.

(270907)

Leadership in Compassionate Care Reference Group

Aims of reference group

In order to enhance the quality, breadth and impact of the project, knowledge, expertise and advice will be drawn from a range of lay people and professionals.

The project will actively engage with the views of service users, partnership representatives and relevant professionals.

Outcome

The activity and outcomes of the project will be influenced and enhanced by engagement with, and advice from a range of lay people and professionals.

Ways of working

To work in a flexible manner dependent upon the needs and direction of the project
The reference group will meet twice a year.
Prior to each meeting, papers will be circulated updating members of project activity and provision of an agenda.

At various time periods during the life of the project, individual members of the group would be invited to provide advice in regards to specific aspects of the project, dependent upon their expertise and the needs of the project.

Membership

Patient/public representatives
A carer representative
Partnership Representative
Hospital Chaplaincy
NHS Education for Scotland
Dementia Services Development Centre
Scottish Government
Medical
Royal College of Nursing
NHS Quality Improvement Scotland
Nurse Consultant for Older People,
Care Commission
Head of School of Nursing Midwifery and Social Care Napier University
Stephen Smith, Lead Nurse Leadership in Compassionate Care Project
Senior Nurse, Leadership in Compassionate Care Project

Leadership in Compassionate Care Programme

Edinburgh Napier University & NHS Lothian

Publication Board

Aims of Board

- To ensure the key messages of the project are communicated at every appropriate opportunity.
- To encourage both a proactive and reactive approach to publication
- To provide support to any Edinburgh Napier Staff, NHS Lothian staff and project participants who wish to publish material about the programme. This could involve for example a discussion of where to publish and editing comments.
- To co-ordinate the activities agreed within the publication strategy.
- To ensure all publications reflect the University and NHS Lothian's current position on the programmes knowledge transfer activities.
- To ensure articles or written information being published are written to an appropriate standard and quality and accurately reflect the work of the programme and the key messages.

Members of the Publication Board

- Professor Morag Gray, Associate Dean (Academic Development), Faculty of Health and Life Sciences, Edinburgh Napier University (Convenor of the Board)
- Dr Jayne Donaldson Head of School, School of Nursing Midwifery and Social Care, Edinburgh Napier University
- Stephen Smith Lead Nurse, Leadership in Compassionate Care Programme, Edinburgh Napier University

Remit of the Publication Board

- To encourage and support potential authors to publish their work about the Leadership in Compassionate Care Programme.
- All material related to the Leadership in Compassionate Care Programme to be published will be reviewed by the Board prior to publication.

- Proactive publications: potential authors will provide Board members with a period of two weeks to review material prior to publication deadline.
- Reactive publications: Board members will be contacted to discuss reactive opportunities for writing about the programme. Deadlines for review of written material will be negotiated dependant upon individual circumstances.
- The members of the Board will meet three times a year to plan strategic publication opportunities but will also operate in a virtual manner and review written material via electronic means.
- The members of the Board will liaise and seek advice, as necessary, with those responsible for Knowledge Transfer Activities in the University.
- All three Board Members will undertake the above activities jointly however in the case of holidays or absence those present and available will undertake these responsibilities.

Responsibilities of potential authors

All Edinburgh Napier University, NHS Lothian and programme participants from other organisations who aim to publish material in relation to the Leadership in Compassionate Care Programme are required to comply with the above guidance.

Written by Stephen Smith

Final copy 240609

1.6 Funding

Private funding enabled the appointment of five full time programme staff, the Lead Nurse and four Senior Nurses in Compassionate Care. The programme development team were involved in devising the job descriptions and interviewing applicants for these key posts.

1.7 Selecting Beacon Wards

A large part of the programme development team's time was invested in devising the process for selecting the Beacon Wards. It was agreed that a portfolio of evidence would be compiled to demonstrate achievement of key criteria which related to the following areas:

- The caring environment: initiatives demonstrating holistic and person-centred care;
- Evidence of collaborative and effective team working: good ward communication and efficient team organisation and use of resources;
- Evidence of staff development: e.g. evidence of mentorship training and provision of preceptorship for newly qualified nurses.

All clinical areas were invited to present a portfolio to showcase their practice, with support and guidance provided by the programme development team. This enabled staff to reflect on their 'caring practices' and highlighted many patient-centred initiatives. The portfolios were reviewed by team members from education and practice including the Director of Nursing. Following short-listing and visits by senior staff from education and practice, four Beacon Wards were selected in August 2007. A Senior Nurse was assigned to each ward where they would observe practice, capture key elements of compassionate care and work with staff to build on this.

1.8 The Goals of Beacon Wards

The goals of the Beacon Wards included the following:

- Developing an understanding of compassionate care from the perspectives of patients, families and healthcare staff;
- Developing key principles of compassionate nursing practice;
- Test out and evaluate interventions that enhance compassionate care
- Developing best practice statements for compassionate care;
- Providing undergraduate nursing students on placement within the Beacon wards exposure to programme developments;
- Ensuring sharing of programme developments so that best practice could be rolled out across NHS Lothian;
- Feeding back learning from the Beacon Wards into the undergraduate programmes.

1.9 Key Learning points: Establishing the LCCP

Key Learning Points:

- The relationship between practice and higher education was extremely valuable and also unique. The different challenges and constraints faced by the two organisations became apparent; nevertheless an ability to work together and to progress when both partners share a common goal was a good lesson to learn;
- Sharing the vision of embedding compassionate care in practice and education was an important and on-going part of the work;
- Seeing the examples of compassionate care demonstrated within the Beacon Ward portfolios was encouraging for those who were privileged to read them. However it was also very special to see the pride and enthusiasm and the common aim within clinical teams as they shared and celebrated their excellent work.

In summary, the planning and development stages of the Leadership in Compassionate Care Programme were vital to the realisation of the programme vision. This was facilitated by the unique working partnership between education and practice.

The impact of the programme vision had the potential to transform practice in several important ways and it was hoped that the findings from The Leadership in Compassionate Care Programme would impact positively on healthcare practice nationally and internationally.

1.10 Theoretical Approaches adopted in the Programme

The focus of this research was to work collaboratively with those who have experience of care and care giving on the wards, and to explore ways of developing and promoting a culture of relationship centred compassionate care. A research approach that embraced collaboration, empowerment and promoted change through an intervention was important.

1.11 Selecting an appropriate research methodology

A further consideration in the selection of appropriate methodology was the fact that the first round of selected wards for this study had already been awarded Beacon status for excellence in compassionate care giving, so a methodological approach that was not only empowering, but one that deliberately focused on positive caring practices was appropriate. With this in mind, an Action Research approach using Appreciative Inquiry and Relationship Centred Care was chosen; involving patients, their families, staff and students in the learning was key to generating new knowledge and identifying ways to further promote compassionate, Relationship Centred Care in hospital.

A further point, worthy of consideration in the selection of appropriate methodology, is the topic of the study itself, compassionate care, as this influenced the choice of the research approach adopted.

Inherent in the concept of compassionate care are principles that take into consideration the perspectives of others, emotional engagement, working collaboratively through relationships and understanding the behaviours of others (von Dietze and Orb 2000; Firth Cozens and Cornwell 2009; Dewar, Pullin and Tocher 2011).

The Leadership in Compassionate Care Programme (LCCP) thus followed three key theoretical principles in the design and conduct of this research, namely Action Research, Relationship Centred Care and Appreciative Inquiry. Each of these theoretical principles will be considered below.

1.12 Action Research (AR)

Action Research has been described as 'the study of social situations carried out by those involved in that situation in order to improve, both their practice and the quality of their understanding' (Winter & Munn-Giddings 2001: 8). It aims to bring about social change through action, developing and improving practice, and at the same time generating and testing practice based theory

(Binnie and Titchen 1999; Winter 2003; Coghlan 2010). Action Research emphasises the production of knowledge and action directly useful to practice and the empowerment of people at a deeper level through the process of constructing and using their own knowledge. This was important in the LCCP since one of the outcomes was to develop strategies that enhance compassionate caring that practitioners themselves had ownership of and were able to develop.

The AR approach also encourages engagement, not only with development and implementation activities but also the process of research (Boog 2003; Reed 2005; Meyer 2006; McNiff and Whitehead 2011). A key outcome of Action Research is to achieve sustainable change through the development of practitioners and practice simultaneously (Grundy, 1982; Walsh et al. 2008).

The main features of Action Research include:

- Its participatory nature (whereby researchers and participants work together in directing the course of the change and the accompanying research);
- Its democratic impulse (whereby participants are seen as equals in the process and are empowered to change contexts in which they work together);
- Its contribution to social science and social change (the knowledge it produces is argued to be of a different kind and more meaningful to practice (Meyer 1999; Coghlan and Brannick 2001; Hockley and Froggatt 2006; Soh et al. 2011).

In order for these three elements to be realised in the everyday practice of the inquiry the quality of the relationship between the researcher and the participants is seen to be crucial (Heron and Reason 1997; Bradbury & Lichtenstein 2000; Williamson and Prosser 2002; Gerrish and Lacey2010). In the LCCP we were acutely aware of the importance of establishing strong relationships in all sites. A significant period of time was thus built in at the start of work in each site to enable the development of relationships between researcher and participants. In addition research methods that aimed to work with and for people rather than on people were selected.

In addition, Action Research requires reflexivity by the researchers so that all aspects of the process of inquiry, including the role and actions of the investigator are examined (Heron, 1996; Heron and Reason 2001; Stronach et al. 2007; Rallis and Rossman 2010; Bishop and Shepherd 2011). These reflections form a key part of the analysis of the research, thus making transparent developing understandings and decision making in the research process. The senior nurses kept reflective notes about process issues and were supported at team meetings to explore challenges and celebrations related to these issues. These reflections formed part of the overall analysis.

Given that the primary aim of Action Research is to develop *'genuinely well informed action in real time social life'* (Reason and Torbert 2001: 5) the emphasis in this study was on:

- attaining practical knowledge and working towards outcomes which are useful in daily life and work;
- contributing to an enhanced experience of care for patients, their families and staff.

Emphasis throughout this study was thus focused on working with and for practitioners to help them to develop ownership of activities, develop their own understanding of the situation and to challenge for themselves taken for granted assumptions about practice and context. In relation to patients and families the emphasis when working with and for them was to help them to develop their own understanding of the situation and to encourage them to contribute to developing action if appropriate.

In keeping with an Action Research methodology work in the field needs to be dynamic, responding to the specific contexts where the programme takes place (Coghlan & Brannick 2005; Koch and Kralik 2006; Whitehead and McNiff 2006).

It was not therefore possible to identify at the start of the programme what the action cycles would be, but rather these were informed by the exploratory work and the context.

1.13 Appreciative Inquiry (AI)

A criticism of Action Research (AR) is said to be its problem solving focus (Reed 2007; Kowalski 2008; Blumenthal 2011). By focusing on problems this can create a sense of limitation rather than possibility in project and / or work that promotes change (Gergen 1994; Seligman, 1992; Koch and Kralik 2006; Whitehead and McNiff 2006).

Problem solving approaches to change have shown mixed results and there is a lack of evidence to support sustainability of change over time (Stange et al. 2003; Pena 2010). There is some evidence to suggest that approaches that focus on strengths and the positive elements of individuals and the organisation results in effective and sustainable change (Cooperrider and Srivastva 1987; Cooperrider et al. 2003; Cooperrider et al. 2008; Vittrup and Davey 2010). One of these approaches is appreciative inquiry (AI). The purpose of AI is 'to generate knowledge within social systems and to use this knowledge to promote democratic dialogue that leads to congruence between values and practices' (Kavanagh et al. 2008: 43). It is an approach to research that focuses on exploring with people what is valuable in what they do and how this can be built on rather than focusing on problems (Cooperrider et al. 2003; 2008).

Cooperider & Srivastva (1987) argue that there are four principles important for Appreciative Inquiry: the inquiry begins with appreciation, and is applicable, provocative and collaborative. The basic process of Appreciative Inquiry is to begin with a grounded observation of the "best of what is" (discovery phase), then through visioning and debate collaboratively articulate "what might be" (dream phase), working together to develop "what could be"(design phase) and collectively experimenting with "what can be"(destiny phase) (Moore, 2008). In the design phase, cycles of change are developed and are then implemented in the destiny phase. AI and AR thus both aspire to the same goals – that is to work towards emancipatory transformation (Reason & Bradbury 2001; Boog 2003; Grant & Humphries 2006; Smith et al. 2010).

Appreciative Inquiry links to action research in that both approaches emphasise a collaborative and participatory nature that seeks to inform change for the future and takes particular cognisance of the contexts in which people work.

Both approaches work on the understanding that the organisational context can shape the action and change and that the development of supportive relationships between the researcher and the participants is crucial. The value of exploring the process in the inquiry as well as the outcome is central to both approaches.

Although Appreciative Inquiry has been used extensively in organisational development there is increasing evidence that AI as an approach is being used as a change methodology in nursing (Reed et al. 2002; Carter et al. 2007) but as yet its effectiveness has not been systematically examined and presented. There continues to be a lack of published research evaluating appreciative inquiry across all disciplines (Van der Haar & Hosking 2004; Reed, 2010).

Within this study the Senior Nurses acted as action researchers with an appreciative stance. Thus in working with staff, patients and families to understand compassionate care in the wards, they worked with practitioners to systematically discover the best of what is and what has been, to take another look at and try to comprehend what is happening by actively being curious, understanding and affirming different points of view (Dewar & Mackay 2010). Questions that focused on what was working and how can we develop these aspects, rather than, what are the problems were important. Furthermore it is important to note that problems or negative comments were not ignored, but rather the response to this was about considering possibilities rather than dwelling on the problem.

1.14 Relationship Centred Care

A relationship centred approach to care was developed in the United States of America in 1994 by Tresolini and the Pew-Fetzer Task Force (Tresolini & Pew-Fetzer Task Force 1994). It arose as a result of concerns about the growing numbers of people with chronic conditions

and how modern healthcare, focused on cure, disease orientated and sub-speciality models of care, cope with this situation. The results of this modern form of health care delivery can result in fragmented and episodic care that doesn't acknowledge the wholeness of the person's experience (Clark, 1996).

The following extract states the vision of Relationship Centred Care from the perspective of the Pew-Fetzer Task Force:

'In order to promote a more holistic vision of healthcare, the task force focussed both on the social, economic, environmental, cultural and political contexts of care, and on the subjective and inter-subjective experience of illness, and the relationships that unfold between practitioners, patients, families and the wider community. They argued that these interactions lie at the heart of relationship centred care and are the foundations of any therapeutic or healing activity' (Nolan et al. 2006: 123).

From the statement above relationships are seen as crucial in the provision of care (Pew Fetzer et al. 1994; Nolan et al. 2006). Relationship Centred Care therefore is a way in which healthcare settings value, act on and sustain relationships that form the context and basis of care. It is for this reason that relationship centred care was identified as a key approach within the programme (Smith et al. 2010).

Research about care that is based on relational principles is increasingly being advocated in the literature (Wasserman & McNamee, 2010). In particular these authors draw our attentio to the importance of dialogue not just from the perspective of the patient, but one that really values the contribution of patients, staff and families.

What this meant in this study was that data generation, analysis and actions were examined and debated through a relational lens. For example, in the context of data generation, perspectives were gathered from staff, patients and families and similarly in analysis, generation of a theme from one data source was examined in the context of other key stakeholders to check relevance and meaning.

Adopting a research approach that built on the principles of Action Research, Appreciative Inquiry and Relationship Centred Care was appropriate for this study in that it helped practitioners to be part of the research process, to develop practice that was meaningful to patients, staff and families, to consider taken for granted assumptions about care, and to understand and celebrate and further develop practice that was already working well.

That said, the positive, participatory and emergent approach was an unfamiliar way of working for many practitioners who were surprised by the fact that: a) the focus was not on developing aspects of care that were problematic and; b) that they were invited to play a lead role in the direction of the programme. Practitioners, were on the whole, pleased that the focus was not just on what the patient and family valued but what they themselves saw as important and recognition that this was considered as part of the development process.

Chapter 2:

Programme Strand 1: Beacon Wards

2 Introduction

The first programme strand involved the establishment of the Beacon Wards. As mentioned earlier in the introduction to Chapter 1, considerable effort and attention was focused on this critical area of development within the programme. It was considered that the establishment of the Beacon Wards would become the shining light of inspiration driving the Leadership in Compassionate Care Programme to succeed in achieving its goals.

2.1 Executive summary

Aim
Establish excellence in compassionate care practice within NHS Lothian wards (Beacon Wards, Development Sites and Development Units)
Team: Dr. Belinda Dewar; Billie Morrow; Mandy Gentleman; Melanie Hornett; Jenny Kalorkoti; Juliet MacArthur; Iain McIntosh; Simon Pullin; Scott Taylor; Dr. Stephen Smith; Ria Tocher

Strand 1: Establishing NHS centres of excellence in Compassionate Care (Beacon Wards, Development Sites, Development Units)

This strand involved three phases:

Phase 1: The Beacon Strand of the Leadership in Compassionate Care Programme (LCCP) aimed to establish NHS Lothian centres of excellence in compassionate care.

A robust selection process was devised. In total, eighteen wards submitted a portfolio, six wards were shortlisted and following assessment visits to these wards from senior staff from NHS Lothian and Edinburgh Napier University, four wards were chosen to become Beacon Wards[1]. Those wards that were unsuccessful in their application were invited to select staff from their area to join the Leadership strand of the LCCP.

The purpose of this work was to understand what compassionate care looked like and develop key indicators and processes which identify and enable compassionate care to happen. The aim was to systematically discover the best of what is and what has been.

We wanted to focus on what is working, rather than what the problems were. Four senior nurses worked with selected wards within NHS Lothian. These wards worked alongside the Senior Nurses for 9 months and 2 – 3 days a week to:

Explore what was happening with regards to compassionate care;

- Role model compassionate care;
- Work with staff to identify development opportunities in delivering compassionate care;
- Support staff to implement change;
- Support staff in their development and learning beyond beacon ward.

Phase 2: Four development sites[2] were identified through a more streamlined yet robust process to test out the methods and processes understood from the Beacon phase and assisted staff to develop their relationship centred, compassionate care practice. The remit of this phase was to:

- Explore what is already understood from the beacon wards and look for this in the development sites;
- Search for further evidence of compassionate care and how it is delivered within the development sites;
- Enable the ward team to identify and try out ways of working that enhance compassionate, person – centred care;
- Role model compassionate care;
- Support staff to implement sustainable change;
- Support staff to share their learning and development with other practitioners.

Phase 3: The aim of this phase was for the LCCP team to work with as many ward areas as possible to identify and develop strategies that would facilitate sustaining this theme over-time post the completion of the LCCP. The team worked with wards that were grouped together as part of a service and had the same line manager. In total throughout the 3 years of the programme 28 clinical areas were involved in the programme.

The work of this entire strand was underpinned by adherence to ethical considerations and

appropriate permissions obtained. Three theoretical concepts were followed during this strand; relationship centred care, a participatory action research approach nd appreciative inquiry.

To develop a shared purpose and vision, a Beliefs and Value Clarification practice development method was used. This created an early opportunity for the Senior Nurses to develop relationships with ward staff. Consistent with the Appreciative Inquiry approach, staff were able to envision their aspirations for the future, 319 staff participated in these sessions. The Royal College of Nursing's Dignity resources were also used as a resource in focus groups, enabling staff to explore issues of dignity and care, this involved 46 participants and 7 focus groups.

Formal and informal observation processes were used in order to uncover aspects of compassionate care and these were shared and reviewed with staff. In the initial stages of participation in the programme, staff found it difficult to articulate aspects of compassionate care, observation was helpful in uncovering compassion in the seemingly 'ordinary' elements of care. Fifty two episodes of formal observation were undertaken,

In addition, image work [photographs] were used as a quick and flexible tool to facilitate staff exploring their understanding of compassionate care and providing feedback about a range of issues, 269 staff participated in this. An output example is the use of a digital photo frame, relevant images were selected to form a background to a series of statements about positive care practices. This process linked images and words, the purpose was to make the positive care practice visually striking and more memorable. The positive care practices were used in this format to provide a basis for discussions with staff about compassionate care and reinforce positive ways of working. Images were also incorporated into feedback cards, these posed the questions: what have we got right for you in the ward, and what would help to make your experience better? These cards provided an opportunity for quick feedback from patients, relatives and staff and provided further evidence supporting positive care practices and identifying areas for development.

The use of Emotional Touchpoints was a particularly significant development in the LCCP. The process of using emotional touchpoints as a way of hearing the voices of patients, families and staff and the learning arising from these stories directly influenced change on the wards in the form of a range of action projects. The changes not only focused on practical solutions but provided a platform for discussing some of the more complex cultural and contextual aspects that contribute to the delivery of compassionate care. Seventy eight patients, forty nine relatives and one hundred and seven staff participated in this activity.

To support the Charge Nurses who were leading the programme in Beacon Wards action learning sets were employed. The inclusion of the process of action learning helped participants to explore challenges to developing compassionate caring practice in their areas. Action learning continued to be utilised as part of the leadership programme (strand 2) and staff from Development Wards and Units also participated in this process.

A principle of real time feedback was adopted throughout the processes identified above. This involved making a deliberate attempt to feed back information to staff as soon as practicable after the data was collected. A range of feedback mechanisms were employed to make evidence accessible to ward staff giving consideration for example to large multidisciplinary teams and the shift patterns. Feedback took the form of group discussions, sharing information at handover sessions, meetings and information placed on ward notice boards and in folders.

In response to the data collected and in partnership with staff a wide range of local action projects were identified, undertaken and reviewed. An iterative and collaborative process between the LCCP team and staff was essential, where possible patients and relatives were involved in these developments. Examples of action projects include:

- Developing information for visitors in response to a relative's story about the anxieties of visiting a hospital patient during the night.
- Establishing relatives rounds and relative clinics in response to evidence identifying a need for more effective communication and emotional support.

- Implementing monthly sessions where staff share positive caring stories from practice.
- Implementing the offer of toast rounds/snack rounds in the early evening for ward patients.
- Learning more about patients and staff as people through implementation of a framework of questions integrated into the patient admission or staff recruitment processTowards the end of the programme, 'exit interviews' were undertaken with staff and these facilitated gaining in-depth feedback including both positive and negative comments. These data gave an opportunity to identify areas for further development, take another look at practice, generated new ways of working/thinking and reinforced staff's' awareness of their ability to bring about change. Overall, staff were able to consider progress rather than seeing this as an end point. One hundred and forty staff participated in exit interviews.

During the three phases of working with Beacon Wards, Development Wards and Development Units, a continuous and iterative process of data analysis was undertaken by the team. A framework identifying key themes and sub themes in regard to the provision of compassionate care were developed. Six key themes were developed and these provide the focus for future practice development activity and investigation. The six key themes were;

Caring conversations : Discussing, sharing, debating and learning how care is provided, amongst staff, patients and relatives and the way in which we talk about caring practice

Flexible, person centred risk taking: Making and justifying decisions about care in respect of context and working creatively with patient choice, staff experience and best practice.

Feedback: Staff, patients and families giving and receiving specific feedback about their experience of care

Knowing you, knowing me: Developing mutual relationships and knowing the persons priorities, to enable negotiation in the way things are done

Involving, valuing and transparency: Creating an environment throughout the organisation where staff, patients and families actively influence and participate in the way things are done

Creating spaces that work, the environment: considering the wider environment and where necessary be flexible and adapt the environment to provide compassionate care

Key Learning Points:

Organisational

- Creation of dedicated opportunities for staff to have caring conversations, sharing perspectives about care and discussing practice. This needs encouragement and facilitation at local and organisational levels.
- Linking, aligning and integrating compassionate care activities to other organisational processes, targets, and quality initiatives would be imperative.
- The necessity of senior management support – e.g. local action groups, led and supported by senior staff, focused on quality improvement and taking forward compassionate action projects. Managers being proactive in their support, e.g. doing weekly 'walk- abouts' in the ward area, and asking staff about the outcomes of initiatives such as the implementation of relative rounds.
- Reflective forums such as action learning greatly enhanced staff's ability to learn from practice, take forward change and develop transformational leadership skills. (However due to service pressures, very few staff were able to continue with action learning following completion of the Leadership strand of the LCCP also few staff accessed clinical supervision).
- Committed senior staff in both organisations who are actively involved in supporting development of compassionate care and who have the authority to support changes to practice.
- Leadership programme – in particular the opportunity this brings to increase and maintain capacity for leadership in compassionate care across the organisation.

- Patients and families involved in shaping service development and inform pre-registration curriculum delivery.
- Treating staff and students with dignity and respect as well as patients and families.

Interpersonal Communication at all levels

- Emotional support for senior nurses and staff involved in taking forward compassionate care developments
- In using a relationship centred model this valued not just the perspectives and experiences of patients but of families and staff and students. Staff felt their voices were also heard.
- Recognition between staff of the complexity of this work and the emotional investment required. One manager stated that this was the hardest initiative she had ever been involved in taking forward.
- Working alongside people in their practice (both clinical and educational) helped to role model, question practices, and feedback about the less obvious or easy to articulate dimensions of compassionate care.

Processes used in LCCP

- Methods used within the programme (such as Emotional Touchpoints and observation) helped to get at the heart of what people felt and provided a powerful lever for development and learning. Staff needed skilled facilitation in order to take this forward.
- Appreciative inquiry – supported people to examine and learn about what worked well rather than focusing on problems.
- Action research helped staff to collaborate with the team, take forward and evaluate changes that were relevant to local practice and context.
- Opportunities to reflect, when staff were able to devote time to learning lessons from the experience of others this worked well.

2.2 Literature Review

In this section, the literature related to compassionate care will be explored under a number of salient headings.

2.2.1 What is Compassionate Care within in-patient hospital settings?

Definitions of compassion are linked to the notion of suffering, and emphasise the role of the healthcare professional in the recognition, acknowledgement and response to that suffering (von Dietze and Orb 2000; Nussbaum 2003; Schantz 2007; Schulz et al. 2007). McHolm (2004) proposes that compassion contributes to establishing trust and therapeutic relationships with patients, on the basis that it is an emotion that allows the caregiver to enter into the world of the patient, become aware of his/her suffering and take action to ease it. Youngson (2008:2) defines compassion simply as *'the humane quality of understanding suffering in others and wanting to do something about it'*.

What compassion looks like in practice is increasingly debated, along with the question of whether it can be measured. Proctor (2007) proposes that demonstrating compassion includes listening, protecting dignity, anticipating anxieties, and acting to prevent or minimise these. As well as focussing on response to suffering, many commentaries on compassion centre on what Perry (2009) describes as the 'essential ordinary' that demonstrate to patients that they matter. This component is recognised in the English *NHS Constitution* where compassion has been defined as a core NHS value and is regarded as being with the patient and being proactive to address 'the little things':

'Compassion: We respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for those we serve and work alongside. We do not wait to be asked, because we care'

(Department of Health 2010: 12)

Compassion is fundamentally linked to the concept of caring, which is seen as a central component of nursing practice. Finfgeld-Connett (2008) emphasises the fact that caring is a process strongly influenced by the context in which it takes place and is founded

on interpersonal sensitivity and intimate relationships. The nature of the work environment is viewed as highly influential to its delivery, along with the nurse's expertise, maturity and moral foundations. Effective caring is recognised as enhancing mental well-being among nurses and patients, and improvements in patients' physical well-being.

2.2.2 Why do we need compassion?

Whilst there is a great deal to celebrate about the provision of healthcare in the UK, over the last few years there has been an increasing perception that the caring dimension has been lost within an organisational culture that has become focused on targets, financial constraints, reduction in length of stay, increased acuity and technical competence (Department of Health 2005; Burdett Trust for Nursing 2006; London Network 2007; Help the Aged 2008; Healthcare Commission 2009; Patients Association 2009). Alongside this has been a perception within the nursing profession that nurses have 'lost their way' (Maben & Griffiths 2008). On the basis of her own experience, Corbin (2008) posed the question 'Is caring a lost art in nursing?', and called for a dialogue that goes beyond defining what is meant by caring and gets at the heart of what nursing is today and where it wants to be in the future.

The findings of the inquiry into care at the Mid Staffordshire NHS Foundation Trust (Healthcare Commission 2009) pointed to nursing shortcomings related to hygiene, provision of medication, nutrition and hydration, use of equipment, and compassion, empathy and communication. Much of the focus of concern has been on the care of older people. The Patients Association (2010) continue to highlight examples of poor care reported to their helpline, most recently in their report *Listen to patients, Speak up for change*, a collection of 17 firsthand accounts of hospital care of older patients from across the NHS.

A notable outcome of these concerns has been the prominence of UK-wide campaigns, guidelines and initiatives led by Government, professional and statutory bodies and voluntary organisations focusing on caring practices (Department of Health 2007; Help the Aged 2007; Royal College of Nursing 2008; Kings Fund 2009; NMC 2010). During the course of 2007 and 2008, the word compassion became explicitly linked to this ove all agenda. The Chief Nurse for England, Professor Dame Christine Beasley, implored nurse leaders to establish a 'social movement for compassion' and challenged nurse directors to reintroduce into their executive roles the qualities of compassion and caring (Proctor 2007). In the *Nurses in Society* report, Rafferty (2008: 4) argued that the profession needed to be underpinned by a:

'... reinvigorated sense of service, one which is responsive to what patients want from nurses: empathy, compassion, keeping them informed, doing the right things at the right time, being with and available to patients and their loved ones'.

Professional concern has been mirrored by political attention including a proposal to introduce a 'compassion index', which the media linked to measuring the degree to which nurses smile (Guardian 2008). The notion of compassion becoming another health service metric did not go unchallenged (Smith 2008; Bradshaw 2009; Mooney 2009) and prompted debate (Dreaper 2008a and 2008b) that placed the term compassion firmly within the political and media arenas. Niall Dickson, the Chief Executive of the King's Fund, went as far as to suggest *'If we can't get compassion into our healthcare, the system is failing. It's as fundamental as that'* (Dickson 2008).

Compassion emerged within a wider debate on the challenges to the UK health and social care systems when the NHS Confederation (2008:1) published a briefing posing two questions:

- Has compassion in healthcare become the missing dimension of healthcare reform?
- Is compassionate care fundamentally at odds with modern healthcare?

The author of the briefing was Robin Youngson a UK-trained anaesthetist working in New Zealand, who as a result of personal experience had founded a national 'Centre for Compassion

in Healthcare'. What has emerged is the lack of precise definition or specific understanding of the meaning of compassion or how to measure it, if indeed that is an ambition.

Sanghavi (2006) suggests that although compassionate care itself cannot be quantified meaningfully, the consequences of such care can be measured in the form of prospectively tracking satisfaction, health knowledge, and health outcomes in terms that are understandable to patients.

Some of the evidence used to inform this debate is drawn from large-scale patient experience surveys and formal complaints, which tend to present a contrasting picture. In Scotland the in-patient survey conducted in 2010 as part of the *Better Together Programme* (Scottish Government 2010a) indicated that overall the majority of patients involved were satisfied with their experience of the NHS. Some 87% of the 30,880 respondents were positive about staff. In contrast, however, the most common causes of formal complaints about the NHS (after those relating to clinical treatments) are about staff attitudes, communication and information to patients. With regard to nursing most complaints focus on fundamental elements of nursing care: nutrition, privacy and dignity, and communication (Healthcare Commission 2008).

In their review paper for the *Point of Care Programme,* Goodrich and Cornwell (2008) analysed a range of evidence that points to clinical, business, and moral reasons for focussing on and improving patients' experience in in-patient hospital settings.

- Clinical – evidence relates to the negative relationship between poor experience (anxiety, fear, failures in communication) and recovery and the self-management of long-term conditions;
- Business – the increasing role that patient choice and expectation relates to the reputation of hospitals;
- Moral – the need to protect vulnerable people, with a particular focus on frail older people, and those with a learning disability.

What is clear from the literature is the increasing recognition of emotional labour associated with nursing (Smith 1992, Hunter & Smith 2007; Gray 2009; Gray and Smith 2009), and that there are consequences and costs associated with caring work (Sabo 2006; Gray and Smith 2009). The concept of compassion fatigue has been recognised as a form of physical, social and spiritual exhaustion that can cause a decline in desire, ability and energy to feel and care for others (McHolm 2006: Coetzee & Klopper 2010).

Focussing on the needs and experience of staff is recognised as an important component of healthcare delivery (Firth-Cozens & Cornwell 2009), particularly as Cornwell (2010) indicates there is research evidence that links staff engagement with enhanced patient outcomes and experience.

Those investigating NHS hospitals where patients have suffered very poor care have identified remote management, failure to involve staff in decision making, a culture of bullying, low staff morale including a reluctance to raise concerns (Healthcare Commission 2009).

2.2.3 What is the evidence for research, policy and practice?

Research

What is clear from the literature is that whilst there is a growing call for compassionate care, to date, there has been a lack of empirical studies that point to interventions and approaches that will enhance its delivery. There have been a number of studies aiming to define the characteristics of compassionate healthcare professionals. In a phenomenological study, Graber and Mitcham (2004) identified the specific actions, interventions and interpersonal relationships demonstrated by 'compassionate healthcare clinicians'. They linked compassionate care to 'individual motivation and wisdom' and argued that, given the demanding environment where most health professionals work, to be consistently compassionate individuals must possess 'considerable tact, self-control and other inner resources'.

The Schwartz Centre undertook a study across 54 hospitals in 21 US States to investigate the question 'what makes for a compassionate patient-caregiver relationship?' (Sanghavi 2006). The study identified that there were three key components to this relationship:

- *Communication* – style (non-verbal, tone and cadence of speech and showing emotions) and content (imparting facts clearing, conveying competence and providing prompt feedback);
- *Common ground* – the nature of the caregiver-patient partnership and how this could be influenced by the approach of the professional;
- *Respect for individuality* – ways of working that included 'small acts of kindness', telling the patient's stories and shared decision-making.

Policy

Government responses to concerns about the care of older people raised by organisations such as Help the Aged (1999) were responded to by each UK Health Department with individual strategies (DoH 2001a, b; Scottish Executive 2001; Welsh Assembly 2006). The Royal College of Nursing (RCN) published a strategy for the nursing care of older people (Ford & Waddington 2004) followed by its high profile *Dignity Campaign* (RCN 2008).

The Nursing and Midwifery Council's recent *Guidance for the Care of Older People* (NMC 2010) is designed to be used by employers to measure performance.

In England, Lord Darzi's *NHS Next Stage Review: High Quality Care for All* (Department of Health 2008a) set out a vision for the NHS with 'quality at its heart'. It included a commitment to establish the NHS Constitution, with its core values including respect, dignity and compassion. This has been followed with a range of initiatives and directives centred on improving the patient experience led by the NHS Institute for Innovation and Improvement.

The Scottish Government (2007) demonstrated a wider commitment to improving patient experience in *Better Health, Better Care*, including advocating that NHS Scotland 'should deliver patient-centred care which is respectful, compassionate and responsive to individual patient preferences, needs and values'. The *Better Together – Patient Experience Programme* was established to encourage and empower patients, carers and health care staff in Scotland to work together in partnership to provide patient-centred care and improve NHS services for the benefit of all. Providing safe, effective care that enhances patients' experiences of services is at the forefront of the NHS Scotland *Healthcare Quality Strategy* (Scottish Government 2010b). A central tenant of this strategy is the recognition that patients want 'caring and compassionate staff and services'.

Practice

In the last 5 years there have been a number of projects across the UK that aimed to develop practice responses to enhance care delivery. These include:

- The development of a *Person-Centred Nursing Framework* (McCormack and McCance 2006) in Northern Ireland, leading to the formulation and testing of a Caring Dimension Inventory/Nursing Dimensions Inventory as an instrument that can be used as an indicator of person-centred practice within acute hospital settings (McCance, Slater, McCormack 2009; McCormack and McCance 2010; McCance et al. 2011; McCormack 2011).
- *Confidence in Caring,* which was a national project conducted in four acute hospital settings in England (Department of Health 2008a) that led to the publication of a framework for best practice directed at individuals and teams. It involved patients, relatives and staff and aimed to help nurses meet the challenges of caring in the current context.
- The UK-wide Royal College of Nursing (RCN) Campaign *Dignity: at the heart of everything we do,* which has led to the publication of a range of resource to support local practice development initiatives (Baillie, Gallagher and Wainright 2008; RCN 2010).
- In 2008 the Department of Health launched its *Dignity in Care Campaign* including the appointment of Sir Michael Parkinson as

- *National Dignity Ambassador* (Parkinson 2010). The campaign has led to over 23,000 people in England and Wales joining the campaign as Dignity Champions who have access to a wide range of resources to support local initiatives (Dignity in Care Network 2010).
- *Dignity in Care Project,* which is a joint venture between City University, Royal Free Hampstead NHS Trust and Barnet and Chase Farm Hospitals NHS Trust London, involves a programme of research to promote and sustain dignity of care in acute settings (Nicholson et al. 2010a; 2010b; 2010c). It has led to the publication of a range of tools that support nurses in delivering dignified care (Dignity in Care Project 2010).
- The *Point of Care Programme* led by the King's Fund (Goodrich and Cornwell 2008; Firth-Cozens & Cornwell 2009) involves working with patients and their families, staff and hospital boards to research, test and share new approaches to improving patients' experience. It includes evaluations of practical initiatives such as the introduction of 'Hospital Pathways' and Schwartz Center Rounds®, which are monthly, one-hour session for staff from all disciplines to discuss difficult emotional and social issues arising from patient care.

A number of these projects will contribute to the emerging evidence base interventions that enhance compassionate care in general hospitals.

2.2.4 What has worked well?

In their review paper focussing on enabling compassionate care in acute hospital settings, Firth-Cozens and Cornwell (2009) identified four inter-related elements: teaching compassion; dealing with staff stress and burnout; effective team work; and the organisation of hospital care. Although there is a lack of evidence specifically linking compassionate interventions to specific outcomes there is a growing awareness of the significance of creating work environments that support staff to deliver compassionate care.

Enabling staff to feel and be compassionate towards patients requires action on multiple levels, ranging from individual practitioner, team and unit. It also includes the overarching ethos of how an organisation works, which suggests that in order for compassionate care to be delivered within an organisation, the organisation itself needs to be compassionate (Firth-Cozens and Cornwell 2010). These concepts are well established and were first recognised in 1959 by Menzies Lyth in her examination of social systems in hospitals, and again by Revans (1964) who demonstrated the link between nurses' morale in hospitals and impact on patient care. There have been numerous subsequent studies linking work environment and nursing leadership with patient satisfaction and outcomes. Such studies emphasise the role of the charge nurse in determining how staff work and feel about their work (Smith 1992; Wong & Cummings 2007; Cummings et al. 2010).

Good teamwork is recognised as enhancing the quality of team members' interactions and also improving the quality of the care delivered to patients (Firth-Cozens & Cornwell 2009). In regard to government policy, the Department of Health in England recognised that care for staff within healthcare organisations is critical and should take many forms and at different levels. This includes physical care, for example quick response to staff injury, and proactive supportive interventions in regard to mental health problems and stress experienced by staff (Boorman 2009).

Relationships are viewed as being fundamental to teamwork, leadership and care delivery. The concept of relationship-centred care (Tresolini 1994) recognises that the nature and quality of relationships are central to health care and the broader health care delivery system. Attention to the relationships between professionals, patients and relatives has been the focus of considerable research in gerontology (Nolan et al. 2004) and led to the development of the Senses Framework (Nolan et al. 2006). Focus on relationships based on the six Senses have been linked to 'enriched' environments of care, and have also been demonstrated to be significant for student nurses (Brown et al. 2008a, b; Andrew et al. 2011).

Teaching compassion focuses on interpersonal aspects of care and can involve simulation and role-play using patient stories (Firth-Cozens & Cornwell 2009). Modelling compassionate behaviours to other members of staff,

patients and relatives is seen as an important responsibility for staff in senior positions, and is especially relevant when students are present and observing the practice of others. Studies of effective role models illustrate that important qualities include compassion, honesty and the importance of the relationship with the patient (Paice, Heard & Moss 2002; Bluff and Holloway 2008) as well as clinical competence.

Regular feedback is essential so that staff know what it is they do well, what is valued and receive recognition when they have provided compassionate care. Areas of good practice need to be highlighted so that the staff have an opportunity to know when their delivery of care has been good as well as the times when things have gone wrong. It is suggested that adopting this approach may help reduce stress and increase the overall morale of staff working within an organisation (Firth-Cozens & Cornwell 2009).

2.2.5 What were the challenges?

Goodrich and Cornwell (2008) emphasise the fact that improving patient experience is not just about individual acts and commitments. Whilst individuals can make a difference, there is also a need to focus on organisational systems and processes – including competing strategic priorities, the day-to-day reality of clinical activity in any location, present workload, decision-making and emotional challenges. Davidson and Williams (2009) suggest that issues inhibiting compassion in everyday nursing practice can be professional, cultural or personal. Challenges to delivering compassionate care can arise when staff develop inappropriate or ineffective coping mechanisms in response to such work pressures, alongside their exposure to fellow human beings suffering and distress (Cornwell & Goodrich 2009; Coetzee & Klopper 2010). It has been suggested that the present day organisation of the NHS has inadvertently increased such pressures through the introduction of targets, which demand shorter patient admissions. Youngson (2008) cites shorter admission times as one of challenges in delivering compassionate care as there is less time for staff to develop relationship with patients and the build-up of trust whereby patients feel able to discuss their concerns.

2.2.6 Conclusions and future direction

There can be no doubt that over the last few years compassion has become embedded in the lexicon of the NHS, as well receiving attention from the nursing profession, press and public. Patients' experience of healthcare is increasingly recognised as vital dimension to service delivery. In some quarters the need to be compassionate towards staff is also acknowledged as key. What is needed to support this agenda is research to determine what constitutes compassionate care and how it can be recognised and assessed appropriately. In addition it is important to examine the team and organisational influences that contribute to compassionate care and determine how these can be strengthened in the everyday reality of healthcare delivery.

2.3 Description of Scope

Phase 1 – Beacon wards[1]

The Beacon Strand of the Leadership in Compassionate Care Programme (LCCP) aimed to establish NHS Lothian centres of excellence in compassionate care. The purpose of this work was to understand what compassionate care looked like and develop key indicators and processes which identify and enable compassionate care to happen. The aim was to systematically discover the best of what is and what has been. We wanted to focus on what is working, rather than what the problems were. Four senior nurses worked with preselected wards within NHS Lothian. The Senior Nurses worked alongside these wards for 9 months and 2 – 3 days a week to:

- Explore what was happening with regards to compassionate care;
- Role model compassionate care;
- Work with staff to identify development opportunities in delivering compassionate care;
- Support staff to implement change;
- Support staff in their development and learning beyond beacon ward.

To explore and understand this, senior nurses worked with the ward teams using a range of practice development methods:

- Patient, relative and staff stories including emotional touchpoints;
- Observation (formal and informal);

Beliefs and values clarification;

Imagery;

RCN dignity DVD;

Evaluation using exit interviews.

The Beacon Wards were acute medicine for older people, older people with enduring mental health conditions, respiratory and stroke care.

Phase 2 – Development sites

Following on from the Beacon wards the LCCP team worked with four wards as development sites, these wards were where the team helped to test out the methods and processes understood from the beacon phase and assisted staff to develop their relationship centred, compassionate care practice. Senior Nurses worked with these sites for 2/3 days per week for a period of 8 months. The remit of this phase was to:

- Explore what is already understood from the beacon wards and look for this in the development sites;
- Search for further evidence of compassionate care and how it is delivered within the development sites;
- Enable the ward team to identify and try out ways of working that enhance compassionate, person – centred care;
- Role model compassionate care;
- Support staff to implement sustainable change;
- Support staff to share their learning and development with other practitioners.

The four development sites were rehabilitation in mental health, older peoples and palliative care, combined assessment area and a national unit for neuro-rehabilitation of brain injury.

Phase 3 – Development units

In the third phase, the LCC programme aimed to work with as many ward areas as possible. With this in mind, the focus was on groups of inpatient areas, where each group is supported by the same line manager. These comprised of 3 areas within maternity services across two sites, 3 discharge lounges and a medical day care area across three sites, 3 surgical wards, 5 inpatient community services across three sites and Clinical Neurology 3 areas on one site. Senior Nurses worked in these areas 2/3 days per week for 8 months.

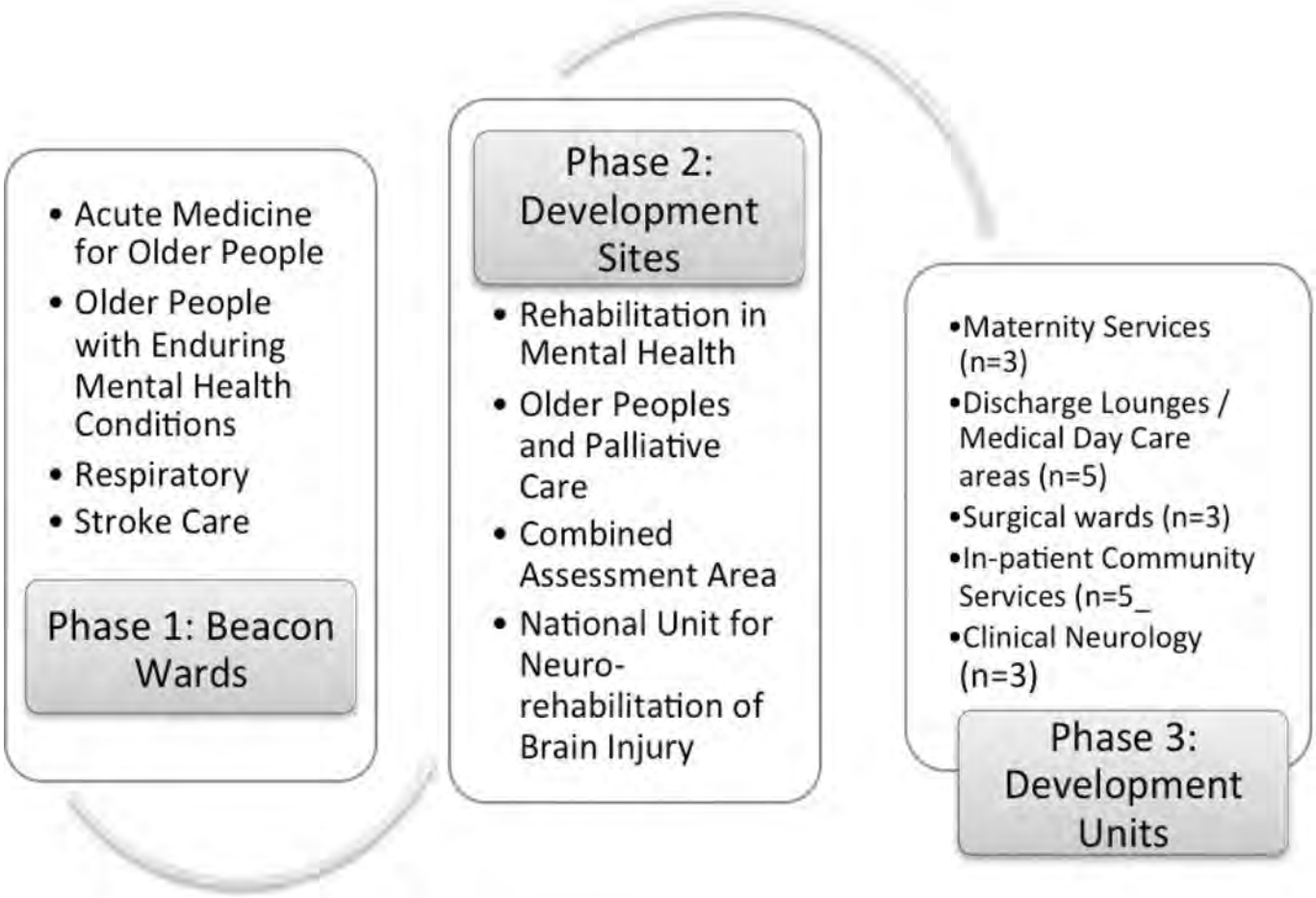


Figure 1: Phased approach to the involvement of clinical areas in the Beacon Strand

In total throughout the 3 years of the programme 28 clinical areas have been involved in the programme and undertaken processes that work to help explore practice (see Figure 1 above). The majority of wards have remained connected throughout this time with regular visits from the senior nurses and opportunities for other staff to undertake the leadership course.

2.4 Selection processes within the three phases

Beacon Wards

In the first phase of the Leadership in Compassionate Care Programme and prior to the LCCP team being recruited, wards in NHS Lothian were invited to apply to become Beacon Wards in compassionate care. The development of a portfolio was required to be submitted by staff from wards who wished to be considered for Beacon Ward status. The portfolio asked for specific and detailed information that included evidence of the way staff were managed, practice development initiatives, audit activity, team working processes, and systems of communication with patients and families. Feedback from patients and relatives about their experiences was encouraged.

In total, eighteen wards submitted a portfolio, six wards were shortlisted and following assessment visits to these wards from senior staff from NHS Lothian and Edinburgh Napier University, four wards were chosen to become Beacon Wards. Those wards that were unsuccessful in their application were invited to select staff from their area to join the Leadership strand of the LCCP.

Development Sites

In the second phase where we aimed to identify development sites, experience and understanding gained from the first phase of selection were used to modify the process. The purpose was to make the process quicker and, whilst gaining

valuable information about each area, streamline the information, taking into consideration the availability of practitioners' time to complete a portfolio. In the first instance, applications took the form of submitting a short abstract from the charge nurse of the area. This included a description of compassionate care, what developments in practice had been undertaken and the learning from this along with future plans for development and change. The potential development sites were then considered on the explicit evidence of these abstracts. The abstracts were reviewed by senior staff from Edinburgh Napier University and NHS Lothian.

Key questions and evidence were sought under the following broad headings (See Appendix 1):

- Caring environment
- Ward/team management
- Staff management – support and communication for and within the team

Areas that were shortlisted were then asked to submit further and more detailed evidence and information in the form of a portfolio. The shortlisted sites were then visited by a team from NHS Lothian and Edinburgh Napier University to determine the selection of the Development Sites.

In total 15 wards submitted an abstract, 12 wards then went on to submit a portfolio, eight wards were visited during a two day period and four wards were selected. Those wards that were unsuccessful in their application were invited to select staff from their area to join the Leadership strand of the LCCP.

Development Units

In the third phase an options paper was produced to consider the most appropriate way forward to select Development Units. A decision was made by the Programme Executive Board to commence an open application process but seek to work with a group of wards / areas that form a unit (e.g. managed by the same Nurse Manager, provide a specific service across NHS Lothian in different sites, designated by a care pathway).

Key benefits of adopting a 'unit' approach and working with a group of wards would be to facilitate stronger team-work; positive competition; active support; real time sharing and implementation of developments in regard to more wards / areas and increased numbers of staff within a group of wards than had been achieved with Beacon wards and development Sites. Line managers put forward their units for consideration to become development units through submitting notes of interest.

There were some notes of interest from single areas which were invited to be integrated into a unit. For example a nomination from Maternity services Triage and Assessment Area would join a broader maternity unit application.

The notes of interest were then considered by Programme Executive Board and four units were selected. The reason for this selection related to the nature of the area, whether we had worked in the area before, practical considerations in terms of changing roles and responsibilities within the senior nurse team. All areas that had submitted notes of interest were invited to remain connected with the programme by nominating participants to engage in the leadership strand of the programme.

2.5 Ethical considerations and data generation processes

This section will present information about the consideration given to ethical and data generation processes.

Consent Processes for Beacon Strand

The act of gaining consent from participants was a continuous process rather than a one off event. The steps in the process included giving of verbal and written information, the explanation of risks and benefits and having repeated discussions with those involved at appropriate moments in time to ascertain that individuals continued to be content to participate.

Several events were held at the beginning of the programme to raise awareness and invite applications from wards to participate. Ward staff deciding to make an application were in fact starting to engage in the consent process.

Informed consent needs to be voluntary and based upon adequate knowledge and understanding (Beauchamp & Childress 2009), therefore all participants received an information sheet detailing the purpose of the research study; an indication of why they were being invited to take part, emphasising the voluntary nature of participation; an explanation of what will be involved if they choose to participate; an assurance that their involvement will be kept anonymous (by use of pseudonym) and confidential if they wished; and patients or relatives were reassured that their participation or non‐participation would not affect the care they receive. The use of patient stories in NHS Lothian contained participant information and details of an independent third party that could be contacted for further information and advice prior to agreeing to participate (See Appendix 2).

Challenges of the consent process were:

- Providing anonymity for the Beacon/ Development wards involved in the programme was difficult. There was publicity across NHS Lothian which provided easily identifiable information about the Beacon Wards, some wards were also specialist in their area and this further emphasised this challenge. It was important to emphasise to all participants how their contribution would be used and shared and continually agree a consent process.
- It was difficult to predict every future circumstance in which data might be shared. One senior nurse gave the example of quotes from a story being used on the side of a bus as an example of a patient/relative/staff experience of care, which helped participants to think more broadly about what they were signing up to.
- When situations arose for data to be used specifically out with NHS Lothian and Edinburgh Napier University and in a way we had not originally considered, we made further contact where possible with the participants and revisited the consent process. For example when a national newspaper wanted to incorporate a relative's experiences in an article, we went back to the relative and discussed this with them and gained their consent. In these situations the programme team liaised with the communications departments of NHS Lothian and Edinburgh Napier University.
- For those participants who were unable to understand or sign consent forms methods and principles of process consent were followed (Dewing 2002). This involved close collaboration with patient, family and the multi-disciplinary team and ensuring all were comfortable with any level of involvement before this progressed.
- It was not always possible to allow a 24 hour period from providing information to gaining consent. Depending on the circumstance of the patient and their ward situation, we would try and maximise the time given to consider participation. This was particularly the case in areas where patients moved quickly through the service, for example Combined Assessment Area. It was important to emphasise, in these situations where participants did not have 24 hours to consider participation, they did not have to participate in the research.
- Senior nurses found it challenging at times to get feedback from the participants in terms of changes and amendments to the interview transcripts. Participants would consent and share their experience of care, including signing a consent form. A transcript of the interview would be sent to them to check that they were happy with the content and some did not respond.
- Senior Nurses would contact participants on a maximum of two occasions to ask for this feedback. If they did not respond the data would not be used.
- Latterly in the programme, focus groups were held with patients whereby an alternative consent arrangement was made. Participants consented in the usual manner ahead of participating in the group, however greater emphasis was placed on ensuring consent in the moment and during the focus group. There was less opportunity to make contact with these participants following the focus group as they were being discharged home. Due to the numbers of participants taking part in these specific groups it was not feasible for staff to contact and do a final checking out of the focus group report with the participants once home. Participants were encouraged to make contact should they wish to highlight something

or change the content of their contribution. Importantly this process was flagged up ahead of the focus group.

- Further work is required to make accessibility to the consent process more universal. Specifically simplifying and shortening the information and consent forms in order that they can easily be read by people for example who feel generally unwell, have difficulty with concentration and reading ability.

Repeated checking with participants ensured that the process used to gain informed consent was continuous and robust, and not a tick box exercise. All those who participated had the right to withdraw at any time without affecting their rights.

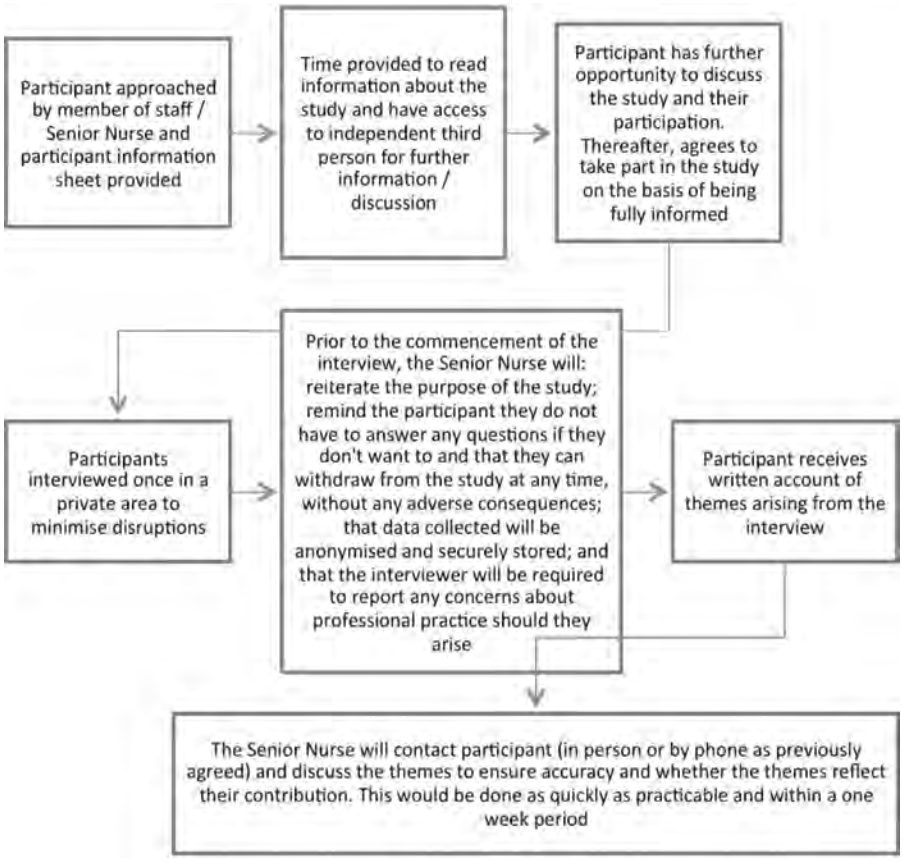
Only those persons who gave their consent were included in the programme. A flow chart of the sequence of events can be found in Diagram 1 below.

Diagram 1: Sequence of events in obtaining consent

Key Learning Points: Obtaining Consent

Consent

- Taking consent has been an on-going process with each individual although this has been easier to achieve with staff given their accessibility during the research process;
- The key points when this happens are: prior to collecting the data; on participants' review of the data; and on sharing the data out with NHS Lothian and Edinburgh Napier University. For example when a national newspaper wanted to do a feature on compassion, and asked for a contribution, participants were approached to consent specifically. Within these situations the communications departments of both organisations were involved;
- For those participants who were unable to understand or sign consent forms methods and principles of process consent were followed (Dewing 2002; RCN 2009). This process was adopted for patients, relatives and staff. This involved close collaboration with patient, family and multi-disciplinary team;



- Further work is required to make accessibility to the consent process more universal;
- It has not always been possible to allow a 24 hour period from providing information to gaining consent. Depending on the circumstance we would try and maximise the time given for participants reflection;
- Due to the nature of action research the way in which data are used cannot always be determined in advance and researchers have to be constantly asking if we have consent from participants to use their data in changing circumstances.

2.6 Data Collection Methods

Appendix 25 contains information regarding numbers of data collection activities in regard to participating sites; Beacon Wards, Development Sites and Development Units. For example in total, 78 patients, 49 relatives and 107 staff participated in providing stories during the LCCP, a total of 234 stories.

2.6.1 Beliefs and Values Clarification

A belief is defined as "an acceptance that something exists or is true, especially one without proof" (Concise Oxford Dictionary 2011) for example, "I believe that all politicians are corrupt", however, a value is defined as "the regard that something is held to deserve; the importance, worth, or usefulness of something" (Concise Oxford Dictionary 2011) for example, "I value my freedom". What you believe in, and what you value influences your attitudes, which shape your behaviour in the workplace. Ultimately these factors influence the workplace culture and how things are done.

We are not always conscious of our beliefs, values and attitudes and therefore may not be aware of the reason why we behave in certain ways. A Beliefs and Values Clarification exercise is a practice development method which can be used to identify and develop a common shared purpose and vision in a number of different scenarios (Warfield & Manley 1990; Manley 1992). The Values Clarification exercise can also be a useful starting point when introducing cultural change and by making clear our individual beliefs and values this process can help to work towards creating a shared vision. The development of a common vision is often seen as the starting point to making the vision become a reality in the work place; the method is aligned to transformational leadership approaches (Manley 1997). This style of leadership is supported by the work currently being implemented on a national level in Scotland by NHS Education for Scotland and The Scottish Government in projects such as Leading Better Care and Releasing Time to Care (2011).

2.6.2 Process

A Beliefs and Values Clarification exercise would always start with a stem to assist in identifying the main purpose, for example, "I/We believe the ultimate purpose of X is …." This would then be followed on by another stem identifying how that purpose would be achieved and so on. In the context of The Leadership in Compassionate Care Programme senior nurses working in the Beacon and Development Sites/Units have undertaken a number of Beliefs and Values Clarification Exercises in the areas to explore what staff value in their workplace.

Questions such as:

"As a member of staff working here I value …."

"As a patient here I would value…."

"As a relative here I would value…."

This was a useful exercise to do at the start of working in each of the areas as it enabled staff to explore their own and others beliefs and values and come to some shared understanding in relation to the workplace culture and how practice and culture is influenced by beliefs and values.

The sessions allowed for the identification of common values and beliefs and identified the areas of common ground and agreement about the nature and purpose of what the team was trying to achieve.

The values clarification exercise works best when done in small groups, ideally no less than 4 people which allows for a mutual sharing of ideas that a common vision will develop.

There needs to be a degree of flexibility when working in the clinical areas as it can be difficult to get a group of staff together in terms of availability of staff and time and therefore requires careful planning to ensure that all the staff are able to contribute. In some instances, images have been used to provide an alternative way to stimulate ideas and suggestions. Undertaking these groups provided an opportunity to be inclusive of the widest range of participants, including patients and members of the multidisciplinary team.

Participants in one of the sites made the following comments when articulating what they valued as a member of staff:

- Feeling respected for my contribution
- Feeling welcomed
- Other staff having a clear idea of what my role is here
- Openness
- When everyone's opinion is valued
- When everyone feels involved
- My colleagues to work along with me
- Going home at the end of a shift and feeling you have done your very best
- Respect and understanding from top to bottom
- To really understand one another – so if you are having a bad day people will support you
- Developing friendships and relationships
- Feeling that people care about you here

2.6.3 Outcomes

- Created opportunity early on for the Senior Nurses to develop relationships with staff but also further develop relationships between staff on the ward;
- Used to start the process of hearing specific examples from practice and as a method to help people to challenge whether what they said in their beliefs and values matched what took place in practice;
- The groups helped people to envision their aspirations for the future which is consistent with an Appreciative Inquiry approach;
- In one area of Mental Health Rehabilitation practice this exercise resulted in patients saying how much they valued and enjoyed talking, and being with staff. This inspired the setting up of 'Talking Groups' with staff and patients attending, these are now embedded into the practice of this area and run twice weekly.
- Researchers found data from Beliefs and Values clarification to be less powerful as evidence for the development of a framework for Compassionate Care, the data provided fewer specific practice examples, rather than for example, specific data generated from patient stories.

Key Learning Points: Belief and Values Clarification

- Created opportunity early on to develop relationships with and between participants;
- Used to start the process of hearing specific examples from practice and as a method to help people to challenge whether what they said in their beliefs and values matched what happened in practice;
- Created a space to share perspectives and talk about practice;
- Offered the opportunity to be inclusive of a wide range of participants; members of the staff team and patients
- Process required time (bringing groups together);
- Helped people to envision their aspirations for the future which is consistent with appreciative inquiry;
- Researchers found data from Beliefs and Values clarification to be less powerful as evidence for the development of, and understanding of compassionate care.

2.6.4 Image Work

Image work in the context of the LCCP refers to using photographs as a tool when working with individuals or groups within the Beacon Ward strand and other strands of the programme. The literature refers to this process as 'Photo elicitation' (Brand and McMurray 2009; Lorenz

2011). For example, when working with staff to explore their understanding of compassionate care, a number of varied photos were laid out on a table and staff asked to select an image that summed up what compassionate care meant to them. They were then asked to share the reasons for selecting their image (usually the facilitator would also participate in this process). The photos used commonly depict images such as people, landscapes, close ups, abstracts, animals and everyday objects.

Initially staff were often curious about the use of images but when they began to explain what an image meant to them in regard to compassionate care, the level of thought and engagement was often deep, surprising and varied. It is necessary to identify that potential scepticism in the process appeared to focus on the activity being possibly trivial or flippant in respect of discussions around NHS care.

The images have been used with patients, either individuals or with groups, for example using the question; 'Could you choose an image that sums up what it feels like to be here?' Images used in this way can elicit brief stories about their experience, this can be a useful approach when working with those whose level of cognitive function prevents them using methods that demand that they read or write.

How do photographs make a difference to the quality of the information shared? Using photographs engages the whole group quite quickly; sharing together helps begin the open dialogue whether it is about caring or leadership or how they feel being a member of staff, patient or relative. The image seems to help the individual connect with thoughts they may not have voiced before and articulate them clearly.

Loeffler (2004) reviewing the literature on this subject states, 'Harper (2002) advocates the use of photo elicitation because images evoke deeper elements of human experiences than words alone.' As with many of the data collection activities undertaken in this programme, this process created a space to think about and share practices.

The outputs from sessions with staff using images were included within reports and were fed back to staff. They were also put on notice boards within wards, for example the image with a statement next to it.

This provided a focus for feeding back information but also generated further discussion amongst staff, but also patients and relatives if notice boards were accessible to them.

Although in the literature, studies often involve participants first taking the photos from which they then select images and go on to explore their meaning, nevertheless there is strong evidence that the data obtained when using photos in interviews has a richness (Oliffe and Bottorff 2007; Thompson et al. 2008; Storli and Lind 2009; Lorenz 2011). Samuels (2004: 1529) found in a study working with monks that:

'Unlike word-only interviews ... photo-elicited interviews resulted in a greater interest to take part in the study as well as enabling me (researcher) to establish a rapport with the monks much more quickly.... photo-elicited interviews resulted in much more detailed data and I believe, more meaningful to the interviewees.... it also had more of an emotional flavour'.

Examples of image work, quotes from staff about compassionate care

I think compassionate care is about an effective and caring team approach to care. In that team I would now include the patient and family – I might not have thought this before.

Compassionate care can be hard and uncomfortable for some people. People need help to get there.

2.6.5 Images and positive care practices

Images were also used in the LCCP to strengthen the visual impact of displaying positive care practices that staff wanted to share and uphold in their area (See page 61). Using a digital photo frame, relevant images were selected and formed a background to the statements therefore linking images and words. The purpose was to make the positive care practice visually striking and more memorable. The positive care practices were used in this format to provide a basis for discussions with staff about compassionate care.

Images have been used throughout the programme to provide a visual impact to material and enhance engagement with participants, for example feedback sheets for use with patients and relatives included the pictures of a rose and a dog (see Illustration 1 below).

Key Learning Points: Image Work

- Created a space to share perspectives and talk about practice
- Quick and flexible process that engaged participants at a meaningful level;
- Some participants were sceptical about the process because it was unfamiliar and potentially appeared trivial or flippant;
- Possible therapeutic benefits in mental health settings.

2.6.6 Feedback Sheets

A method used within the programme to elicit specific feedback from all those involved in giving and receiving care, has been the use of feedback sheets. These have been used previously in settings in the format of comments cards or suggestion cards. The limitations of these specific ways of seeking feedback include:

- There can be challenges engaging people to provide this form of feedback
- They relate primarily to feedback from patients and families not necessarily other visiting staff and students who can provide valuable feedback from a different perspective
- They can lack detail

A specific form was developed and systems put in place to ensure a more proactive and specific approach to seeking feedback from all groups of people who were involved in giving and receiving care. People who had used the service, for example patients, family members but also other staff members e.g. visiting staff or students, were asked to fill out the feedback form as illustrated below.

What have we got right for you on the ward?

Share with us what helped you to have a good experience:

Thank you for your feedback,

Charge Nurse,
Ward XXX

What would help to make your experience better?

What would help to make your experience better?

Help us to understand how to make your experience better:

Thank you for your feedback,

Charge Nurse,
Ward XXX

Illustration 1: Examples of Images used throughout the programme to provide a visual impact to material and enhance engagement with participants

The questions stated on the feedback sheet invited people to share balanced feedback, specifically stating things that worked well and things that needed to be developed. The wording also specifically focused on future solutions as opposed to the problem experienced.

Senior Nurses supported staff to use this method in a range of different ways including:

- Members of staff asked to give out a specified number of feedback sheets to patients they were caring for at some point during their shift and to share these with other staff at the end of the shift.
- The ward clerk/other staff member handing these out just prior to patients being discharged
- Visiting staff asked to complete a feedback sheet at the end of their shift
- Inclusion of these forms in ward information booklets, student placement booklets
- Giving out forms to seek feedback about specific events such as mealtimes, relative rounds, following specific learning event

The feedback sheets have been particularly useful in areas where there is high throughput of patients or clients such as:

- Combined Assessment Area
- Triage and assessment area in Midwifery services
- Discharge Lounges

Staff focused immediately on the feedback and planned changes following discussion with colleagues or alternatively have developed a system where a number of feedback sheets have been issued over a period of time and comments have been analysed to develop common themes, which in turn have informed development of the service. For example, in the midwifery unit a common theme was the concern about waiting times in triage and assessment and the value of the positive welcome that women received on attendance to the unit. Similarly in one area where this method of using feedback sheets was used specifically with bank staff over a period of time, key themes that emerged included: lack of understanding about the specialty which then resulted in the development of an information booklet for visiting staff that was subsequently shared with the wider organisation. Staff developed a range of strategies to share the feedback sheets with others.

This has included displaying these on ward notice boards, collecting event specific feedback sheets to use as evidence for audit purposes, and selecting and displaying specific quotes in a range of visible locations, for example, at the front of off duty folders, coffee cupboard doors or on paper tablecloths on tables used at handover meetings.

The feedback sheets have proved to be a quick and useful method to capture contextually relevant feedback, in the moment, for a range of staff, patients and families. However, staff have found that people often needed some prompting and encouragement to be specific in what they write.

Key Learning Points: Feedback forms

- Quick and easy to understand;
- Achievable within a busy patient area;
- Contextually relevant;
- Language evolved to be future focused and about solutions. For example from ‘what … problem’ to ‘what could have done differently’;
- Helped people to be more focused;
- It was found to be more relevant and meaningful if staff encouraged people to give specific examples;
- Could be used with all groups e.g. staff, students, patients, Doctors etc. consistent with relationship-centred approaches to care;
- As with the collection of stories (see next section) this provided balanced feedback, not just focusing on complaints.

2.6.7 Stories: Emotional Touchpoints

Staff, patient and family stories using emotional touchpoints were carried out to understand experiences of giving and receiving care. A variety a methods have been used in research to learn about patients experience in hospital, an example being discovery interviews (Murphy et al. 2005; Bridges & Nicholson 2008; Bridges et al. 2008; Dawood and Gallini 2010). This has been in response to a move away from asking patients if something is good or bad (Coyle & Williams 2001; Schmidt 2003). We know that it can be difficult for service users to feel free to express openly about how they feel about a particular situation, particularly if this has been a negative experience. This can be due to a number of reasons including, low expectations about the service and fear of reprisal (Coyle & Williams 2001).

Researchers have recognised the limitations of asking patients what they need or want. People do not necessarily know what they need. It is through telling their story about their experience that these needs can become apparent (Guaspari 1999; Petersson et al. 2009). Stories are especially appropriate in articulating the human side of the nurse patient interaction because stories are said to be the juncture where facts and feelings meet (Van Manen 1997; Petersson et al. 2009).

The story method of using emotional touchpoints (ET), first developed by Bate and Roberts (2007), focuses on emotion by asking participants to think about key points in their 'journey'/experience and to select from a range of emotional words, those that best describe how they felt about an experience (Bate & Roberts, 2007). Key touchpoints might include, coming into hospital, mealtimes, working a as member of the team, or talking to the nurses. Emotional words included a range of positive and negative phrases such as belittled, proud, satisfied, frustrated, surprised and valued. The method, thus, helps the interviewer and interviewee to directly focus on the emotion related to the different points (touchpoints) in the experience. For a fuller account of this method and its use in this programme please see Dewar et al. (2010).

The participants in the LCCP were invited to discuss their experiences of being in hospital or working in the unit. They were asked to consent to this through a formal process whereby they were given written and verbal information about the process and reasonable time to consider whether they would like to take part. The story was conducted in a private room on the ward and lasted from 20 minutes to an hour. Each senior nurse led the session with another member of staff from the ward/unit. This provided staff with important opportunities to learn how to conduct the process but also demonstrated the principle of working in partnership with staff, rather than excluding them from the process of evaluation of the service they provided. In general, staff required a level of on-going support to feel confident to use this process. Taking a story like this requires multiple skills and staff have reported a need to build up confidence with the process. To begin it can be useful for staff to take stories from students as this provides a potentially safer forum from which to build experience.

The touchpoints were laid out on a table (see Illustration 2 below) and the participant/storyteller was invited to select, from these touchpoints, those that they would like to talk about. They were also asked if there were other key moments that they would like to discuss. One relative, for example wanted to talk about her experiences of being on the ward at night, and this was therefore added as a touchpoint. It was important that the storyteller decided what was significant and provided the focus for the story. Taking each touchpoint in turn the storyteller was then asked to describe what happened and select from the emotional words those that best sum up their experience. There were blank cards that could be used if the patient used an emotional word that is not in the pre prepared collection of emotional words.

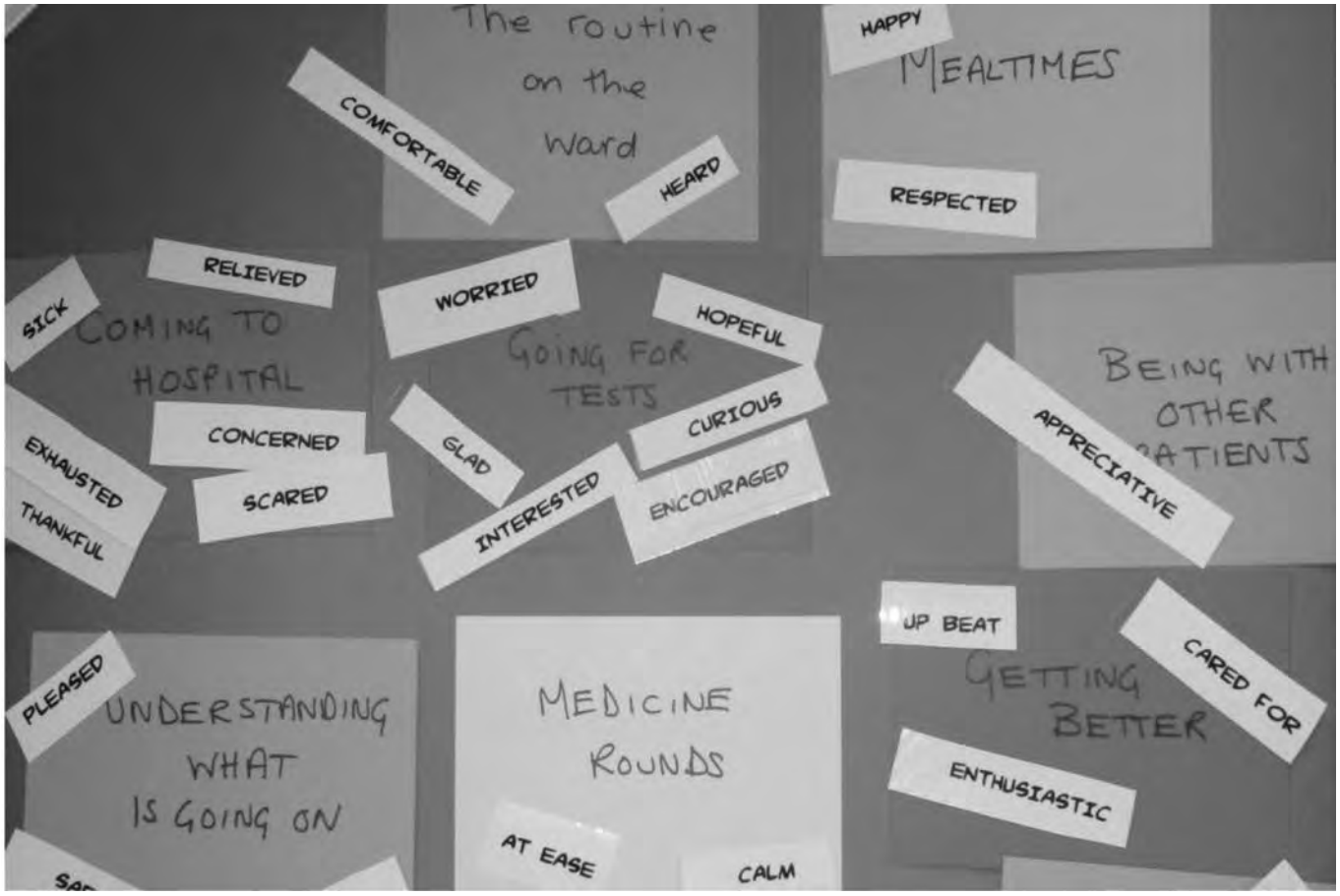


Illustration 2: Use of Emotional Touchpoints

The participant/storyteller was then invited to say why they felt this way. If appropriate they were also asked to discuss how things could have been done differently, particularly if the emotion identified was a negative one.

Notes were taken from the interview and the story, in typed form, and fed back to the storytellers within 24 hours. Although some changes were made to the stories at the storytellers request, all of the storytellers agreed their stories could be used for further learning and development both within and out-with the organisation.

The process of using emotional touchpoints as a way of hearing the voices of patients and families was a significant development in the LCCP. Learning arising from these stories directly influenced change on the wards. The changes not only focused on practical solutions but provided a platform for discussing some of the more complex cultural and contextual aspects that contribute to the delivery of compassionate care. In addition hearing the positive, special and often invisible aspects of practice that this process has enabled patients and families to articulate, had a significant influence on staff and enabled them to more clearly articulate, the compassionate caring acts they carry out and value. Examples of some of the quotes from stories and resultant action or developments in thinking are detailed in Appendix 3.

From working with this method, key benefits identified by patients, families and staff included:

- Participant / storyteller has some control over the direction the discussion takes
- Helps the participant / storyteller to go beyond bland statements of –' that was good'
- Seeks feedback that is based on the person's unique emotional response to a situation
- Method does not directly focus on blaming the service but rather helping to find ways of enhancing it
- Possible therapeutic benefit
- Recognises and reinforces good practice
- Gives participants / storytellers permission to talk about both positive and negative aspects of their experience in a safe non-judgemental environment. [Source: Dewar et al. 2010]

The process proved to be a powerful resource to use in busy in- patient settings with staff, patients, families and students. Staff commented that it was relatively quick to use when staff were pushed for time, although careful planning and preparation was required, for example considering who will give a story and gaining consent. Staff were surprised by the fact that each story uncovered a new piece of learning.

Using this process can however be potentially challenging for the listener / interviewer. Knowing how to react when people talk about aspects of their lives or indeed their care that they have found to be distressing can be difficult.

For example the quote below illustrates how a particular patient felt which could be hard to hear:

Sometimes if I think staff are being unkind, I have to think why are they being unkind and when I think it through I think they are trying to help me. I get a bit annoyed when they are unkind or make me do things for myself but I understand. I get so frustrated with myself. (Patient Story).

The work requires emotional investment and needs to be supported in the workplace. The process of ET provided a valuable framework to hear a story; however it also required good facilitation/interview skills with the ability to use exploratory questions. Skilled facilitation is also required in feeding back the story to staff, enabling them to see both positive and negative aspects and then discussing new learning and how to move to action, should this be appropriate. The use of the appreciative inquiry approach would be beneficial in these circumstances.

We know that 'real' dialogue that engages emotionally is a vital part of compassionate caring (Firth-Cozens & Cornwell, 2009). The method of emotional touchpoints used in this study made a very real contribution to our knowledge base about how to support such emotional engagement in practice.

It was evident that feedback that contained this emotional dialogue touched people's heart and minds and prompted them to take action. Increasingly this method is being used across the organisation as a way of tapping into the patient experience, and in addition it has been used to support staff in exploring their feelings and actions about complaints.

The significance of this method in the programme can be evidenced not only in specific outcomes for those involved in the programme, but in repeated requests locally and nationally from those out with the project, including policy developers, practitioners, researchers and educationalists who have invited the Leadership in Compassionate Care Team to share their learning and further development of this method so that it can be used more widely.

Key Learning Points: Emotional Touchpoints (ET)

Emotional touchpoints proved important for a number of reasons:

- Provided a focused framework to hear the participants' story;
- Selection of a touchpoint enabled participants to focus on the important parts of their experience;
- Choosing emotional words associated with the touchpoint helped participants to give a richer account that got to the heart of their experience;
- Providing a range of words gave participants permission to talk about both positive and negative aspects of their experience;
- The process of ET provided a valuable framework to hear a story; however it also required good facilitation/interview skills with the ability to use exploratory questions;
- In general, staff have required a level of on-going support to feel confident to use this process. It can be useful to start with taking student stories;
- Requires emotional energy on the part of the person eliciting the story and this needs to be recognised and supported;
- Requires a time to carry it out and careful planning is required. In feeding back the story to staff this requires skilled facilitation to enable people to hear both positive and negative points of the story;

- Skilled facilitation is required in order to support discussions that help staff to prioritise and take action based on key themes from the story;
- Stories proved to be one of the most powerful triggers for development of compassionate caring practice.

2.7 Observation

Observation, both informal and formal has contributed to revealing the essential components of compassionate care and the process of practice development within the Beacon and Development sites. Observation has been used historically in many ethnographic and cultural studies to describe, understand and theorise about the observed cultures, without necessarily seeking to bring about any changes in them (O'Reilly 2009).

In the Leadership in Compassionate Care Programme the use of observation has been as part of the action research to highlight taken for granted practice and bring it to staff's attention, discussing it with them, with a view to understanding, sharing it and subsequently agreeing what actions (if any) to change practice would be taken forward. The observers asked curious non- judgemental questions in order to fully understand what was observed and the perspectives of staff and patients involved. Observation was conducted both informally by the Senior Nurse feeding back 'in the moment' observations made whilst in the clinical area, or more formally using an observational tool. The number of observations conducted and the activities observed as part of the LCCP is detailed in Appendix 24.

Two formal observation tools have been used at different times, initially the Workplace Culture Critical Analysis Tool (WCCAT) developed by McCormack et al. (2009) and in the development sites an adaptation of this and the Quality Interaction Schedule (QUIS; Dean et al. 1993)(See Appendix 4).

The WCCAT tool was chosen because the values and ways of working it incorporates fit with those of the Leadership in Compassionate Care Programme, that of working with people towards a shared understanding and taking action which promotes person centered care. It also has the value of including observation of the environment in which care is happening as well as the interpersonal interactions between individuals.

It was however quite complex and can be quite challenging to use for example the process of involving staff in observation and facilitating discussions afterwards could be demanding for the facilitator and some staff found it difficult to be observed. Initially staff usually responded by picking up on any negative parts of the observation rather than being proud of good care achieved.

Moving the discussions from observations to action was also challenging if all staff were to be involved in changing practice. Recording the process of the observation and discussions, then making them available for staff to read and further discuss was one solution to this. Using an Appreciative Inquiry approach was essential within the process of observation so that staff understood that the intention was to focus on the positive.

In the development units the modified QUIS tool was used; this tool explicitly observes interactions in the ward environment. Interactions are recorded over a 20 minute period and an assessment made as to whether it constituted a positive, neutral or negative interaction. This information is fed back to staff who can help to group the interactions under the appropriate heading.

This has potential for use by staff as a measure of change and can be reported. For example in regular ward meetings Dean et al. (1993) who developed QUiS reported that when used in a care setting at 3 monthly time intervals the percentage of positive interactions increased over time.

This was a powerful tool to pick up on specific interactions that staff were generally unaware of. For example,staff in one area referred to a patient as a feeder; in another area a handshake was used to greet a new relative to the ward; staff asked patients in a bay if they were feeling okay and said this when they were walking around looking at charts; staff asked a patient if he had any questions following the Doctors round.

Staff also welcomed getting a score for the overall rating. In one area they had received a score of 76% in positive interactions, 14% neutral and 10 negative. They were keen to redo this a month later and were pleased to be able to report 96% positive interaction score and no negative score.

Key Learning Points: Observation

The important elements related to observation are presented below:

- It has been crucial for the effectiveness of the observation to check out each individual's understanding with participants as near to real time as possible;
- Provided valuable learning opportunities for both the participants and those undertaking the observation;
- It could feel uncomfortable for those doing the observation as well as those being observed. For example the person being observed concerned about not doing things correctly;
- Some observers found it challenging to consider and ask curious questions about practice that they had observed and were unsure of in a way that fitted with appreciative inquiry approach and the principles underpinning the WCATT tool;
- Informal observations (working alongside staff) over time and in different contexts gave insight into ways of working, culture and values. It provided the opportunity to gain a rounded understanding, a backdrop, to how the area worked. This enabled Senior Nurses to develop and share an enhanced contextual understanding of other data collection activities such as stories;
- Enabled Senior Nurses to ask real questions about any dissonance between espoused values and practice;
- Informed the development of positive care practices – as did all of the methods – especially stories of key reflections at the end;
- Some researchers have found this have found this a challenging process for multiple reasons. This requires further exploration.
- The use of the QUis enabled the observation of interaction, a key component of compassionate care. This tool was reasonably quick to use – 20 minutes.
- There was value in specifically providing feedback on interaction using the QUis tool since ways of interaction can remain at the subconscious level.

2.8 Action Learning

Charge nurses and/or the key staff member responsible for leading the programme in the beacon ward or development site were supported in their development through action learning sets. These sets took place every 6 weeks and became an integrated aspect of the Leadership Programme (See Chapter 3 for more detail).

Action learning (AL) is a process of learning and reflection that happens with the support of a group or set of colleagues working with real problems with the intention of getting things done (McGill & Brockbank 2004). To date it has been used as a process to foster professional development and leadership (Rayner, Chisholm & Appleby 2002; Hardacre & Keep 2003; Marlow et al. 2008; Chambers et al. 2011; Currie et al. 2011).

This process is increasingly being used in action research or practice development initiatives to support practitioners throughout the change process (McCormack et al. 2002; Meyer et al. 2003; Ashburner et al. 2004; Hockley, Dewar and Watson 2005; Smith & Shaw 2007; McCormack et al. 2009; Bamford-Wade and Moss 2010).

Participants in an action learning set (usually made up of between 6-8 participants) come together to support each other to explore particular experiences they have found challenging in the workplace. It is a structured process whereby participants work within a discipline which includes an agreement to work within certain principles, such as a commitment to support individuals to develop their own understanding of a situation through careful questioning and an expectation of being challenged. This allows the development of new understandings about the situation, which in turn allows participants to take new actions. There is

also a commitment to take responsibility in this process and to work with the personal values, feelings and attitudes that arise in any situation (Dewar & Sharp 2006; McCormack et al. 2009). The process is cyclical and involves reflection and action. The learning sets were supported in this programme by experienced facilitators.

Evidence of the effectiveness of this approach refer to outcomes such as enhancing critical thinking, finding creative solutions to problems in the workplace as well as increasing self-confidence and developing communication skills (Johnson, 1998; Booth et al. 2003; Dewar & Sharp, 2006; Douglas 2010; Suffolk Nurse Leaders Group 2011). These outcomes were supported in this study as evidenced by reflections in the exit interviews (See Section 3.13.1).

The inclusion of the process of action learning in this study helped participants to explore challenges to developing compassionate caring practice in their areas. Common themes to emerge from presentations by participants during the action learning sets included:

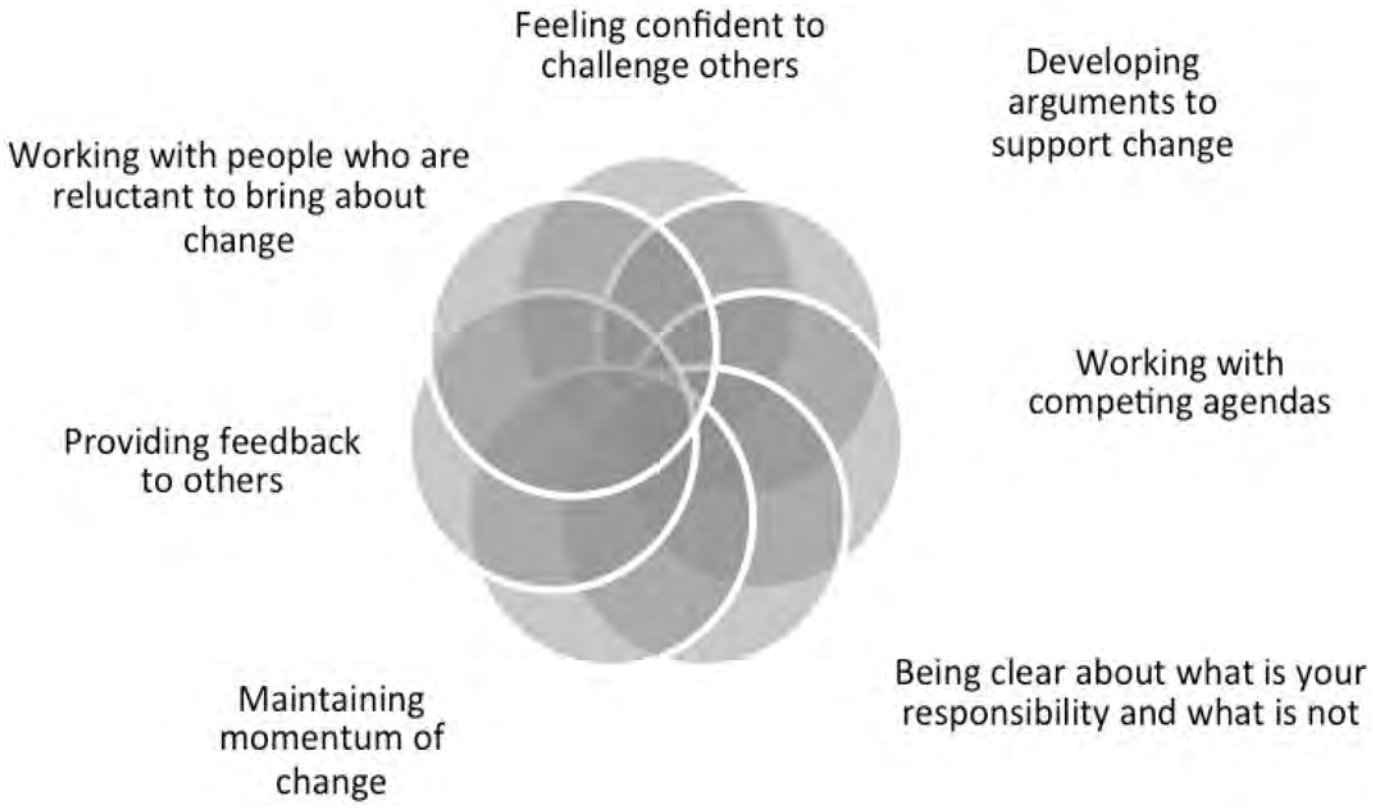
Illustration 3: Emergent Themes from Action Learning Sets

Key actions were developed by participants to help them respond to such challenges in the workplace. The skills and confidence of participants as facilitators were also enhanced, with potential benefits for all aspects of their practice, including more effective communication strategies and the skills to continue to be researchers of their own practice.

One staff participant stated:

'The action learning has been the biggest thing for me in the project. I have changed the way I speak to staff now. I try to ask them questions more rather than just coming up with the answers for them. It has made them take a bit more responsibility'

Participants were invited to continue action learning beyond the time that their unit was the focus of intense development. Few participants felt able to continue with this, due to difficulties of being released from the wards. Charge nurses were among the few who were able to continue with action learning, possibly reflecting more autonomy they had over their time at work. This raises important considerations for the organisation about how all grades of practitioners are supported to continue to develop reflective practice and development in their roles.



Key Learning Points: Action Learning

There were a number of vital elements identified as crucial to successful action learning:

- Facilitation skills are crucial to ensure that the group have a robust structure where they can feel safe to engage with the action learning process;
- There were organisational challenges in supporting senior nurses to develop these skills quickly;
- An integral process in terms of professional development and leadership;
- To work well, action learning requires mutual commitment to participate;
- Skills that are learnt by participants in action learning are readily transferable to their professional practice e.g. suspending judgement (see Appendix 5 and 6).
- Participants found it easier to attend action learning sets when they were embedded within the workshops (Leadership programme);
- Participants found it problematic when they attempted to organise and attend action learning sets as part of their clinical working day e.g. due to service pressures;

2.9 Focus Groups

The RCN Dignity DVD was developed as part of the RCN Dignity Campaign in 2008. The purpose of the DVD was to "...help nurses to further develop dignified care by exploring the meaning of dignity, how loss of dignity occurs and how dignity can be promoted in the reality of day to day care" (RCN 2008).

Dr. Stephen Smith, Lead Nurse Compassionate Care Team and Richard Mackay, Charge Nurse of a Beacon Ward were interviewed and contributed to the DVD.

Senior Nurses used the RCN dignity DVD while working in development sites. Staff were invited to take part in focus groups where scenarios from the DVD where shown. A set of questions were developed to guide facilitation in the focus groups:

- Which statement struck a chord with you most?
- What issues or feelings have these clips brought up for you?
- What impact did they have?
- What was most striking for you?
- How do these issues look here?
- How could they be different?
- What have you learned?

Participants considered, reflected and shared their views about the reality of dignified care in their area.

Staff said:

"Although the clips are funny and out of place, they are things that you do at work. Thinking about them now, they are also things I would not want to happen to me"

"Watching the scenario makes me feel bad because I do some of these things here"

Some responses focused on the negative aspects of the scenarios. Using Appreciative Inquiry methodology Senior Nurses helped participants to think about the scenarios in a different light. They asked participants to identify what, if anything, they did that made care dignified in each of the situations.

The follow up questions used by the facilitator helped the group to collectively name and share the positive things they were doing to maintain dignity in their area. One of the scenarios related to the lack of privacy when using a toilet in hospital. An example of the discussion was:

"Are there things you do just now to stop the person getting a shock when they are using the toilet and someone comes to the cubicle door?" (Facilitator)

"Yes, I say to them I'll pop back to make sure they are ok or I just knock on the door and wait for an answer." (Staff)

Participants came up with specific things they did day to day to prevent the undignified care suggested in the scenarios. They then moved to

working out how they could make these practices more explicit to their colleagues and how they could make them happen more often. This discussion created a momentum to take things forward at a local level.

The RCN DVD provided a stimulating resource that engaged staff in thinking and sharing how they give care. It was used by Senior Nurses in different clinical areas where staff were able to apply the scenarios to their context.

Focus groups RCN Dignity DVD scenarios:

- These were engaging because they do not portray a clinical setting;
- Paradoxically, there was a possibility that participants could distance themselves with what was happening in the scenes as this was seen not to happen in their area;
- Were generic enough to be relevant to different clinical areas;
- Provided a quirky and creative resource that facilitated sharing and discussion of practice, including what currently worked well. This led to the consideration of positive developments in practice.
- Potentially could be patronising therefore clear and skilled facilitation was required.

2.10 Real time Feedback to Staff

Providing feedback is a skill which is a vital ingredient in the learning process and is important for motivation. Either too little or too much feedback will inhibit learning. People need to know how well they are doing at each stage of learning. The purpose of giving feedback is to facilitate an individual's personal and professional growth (RCN 2005).

Staff received many thank you cards/chocolates from patients and relatives. Staff often said thank you to each other at the end of a shift. However it seemed that only negative feedback was really analysed and acted upon. Therefore feedback for many practitioners can take on negative connotations. Giving feedback in real time required bravery, commitment and energy on the part of the senior nurses as facilitators. It was challenging to do as it is dependent on active noticing skills using 'fresh eyes' and being able to analyse and feedback in the moment using a curious approach. Senior nurses met staff who did not want feedback, some were scared of feedback, and for others getting no feedback meant that things must be OK.

In the Beacon wards Senior Nurses tried to find out what staff did that made care compassionate. Staff did not find it easy to recognise what was special about their day to day practice. For example one nurse described compassionate care as 'being able to take a patient out to a shopping centre to buy new shoes.' Although this was a very compassionate act that had been weeks in the making, the contextual background and nuances are difficult to translate to other settings.

Senior Nurses worked alongside staff and gave real time feedback so that staff could unpick and uncover what was at the heart of what they did that made care compassionate. This discussion in the moment was crucial as it enabled analysis, which was meaningful and relevant to context. Talking increased reflection for staff and led to recognition and understanding of positive care practices. When practitioners knew the practices that worked well, they were able to make them happen more often. Senior Nurses found it challenging as it was dependent on active noticing skills using fresh eyes and being able to analyse and feedback in the moment using a curious approach.

Sometimes staff focused on the less positive aspects of feedback and responding was an increased challenge for Senior Nurses. An example was when the response from staff was defensive when feedback from a relative said they felt bewildered talking with staff. The Senior Nurse needed all their skills to quickly think how to help staff to see beyond the words and respond to the feeling. Gradually, staff were able to put forward suggestions by looking for good practice in what they do. Table 1 overleaf summarises the challenges and benefits of giving feedback in real time.

Table 1: Challenges and benefits of providing feedback in 'real time'

Key Learning Points: Real Time Feedback

Feeding back to staff, in the moment, is crucial to develop an accurate understanding of care;

This required bravery, commitment and energy on the part of the senior nurses as facilitators. As feedback can be perceived by staff as negative and it was not usual to hear feedback in the moment;

Challenging to do as it is dependent on active noticing skills using 'fresh eyes' and being able to analyse and feedback in the moment using a curious approach;

Meaningful and relevant to context;

Participation in real time feedback enables a sense of local ownership to develop practice;

Having feedback in real time created a momentum to take things forward;

There were challenges to finding opportunities to give real time feedback within busy clinical settings. We needed a range i.e. opportunistic moments, formal meetings, handovers and displaying information in various ways;

When feedback appeared less positive, it was challenging to think and respond whilst in the moment;

Attention needs to be given to how to support people to develop this skill of noticing, analysis in the moment and feedback using curious questioning.

2.11 Positive Practice Statements

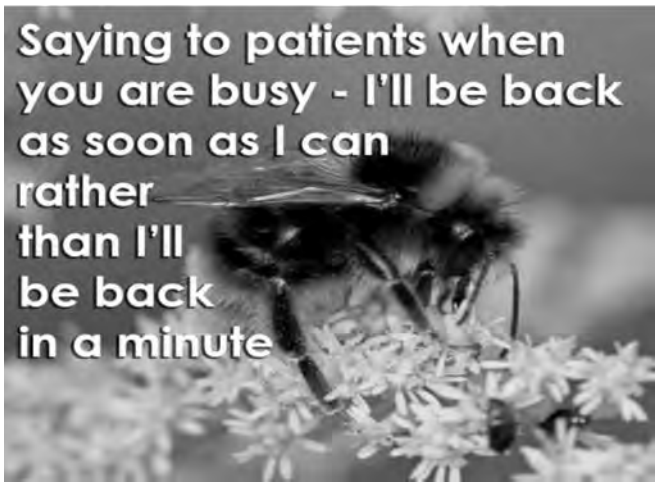
Positive care practices were identified through methods already mentioned above such as observation, and stories. A positive care practice in the LCCP is an act that happens in practice or is developed as an outcome from feedback and is considered by those in the setting to be an important practice that supports people to deliver compassionate care (Dewar, Pullin & Tocher 2011).

These care practices were then developed into statements that summarised and captured the essence of the positive practice so that they were meaningful to others. So, for example, in relation to the positive care practice observed that was about shaking a new relatives hand when you first meet them a statement was developed that stated:

"We believe a deliberate welcome is important when we meet new patients and families, it costs nothing. We go out of our way to welcome them, for example by shaking their hand when we first meet them and introducing ourselves by our first name. When we do this it helps us to make a connection with them and develop relationships more quickly."

Staff helped us to reshape the language on these statements. Using words such as 'continue to' implied the practice was already happening, and using words like 'remembering to' implied that the practice was happening but sometimes it may be overlooked. Both these words helped to reinforce the busy context in which staff worked and in some way made the statements feel real and possible to staff.

We were acutely aware of the complexity of sharing ideas and actions in the contemporary world of practice where communication is becoming an increasing challenge. Therefore, in communicating positive care practices to all staff, the statements were mapped against images that reflected the essence of the statement. This was done as we believed that people might make a connection with the image and the statements and that this would help in recall. So, for example, one member of staff talked about how she kept the image of the bumble bee (see below) in her head when she was busy, and that this helped her to be more aware what she said and did when she was speaking to patients and feeling rushed.



[1]Image based on original image called Bumble bee by Ahisgett distributed under control of creative commons attribution license http://www.flickr.com/photos/hisgett/4849358448/

In many of the areas, these images with statements were displayed using a digital photo-frame whereby each image would be shown in turn. In some areas up to 50 images and statements were displayed in this way.

To encourage meaningful discussion of these statements that helped practitioners to reflect on practice and consider action, a set of questions was developed to support the discussions. These were:

- How does the statement make you feel?
- Does it happen most of the time?
- What helps it to happen?
- How can it happen more of the time?
- What action do we need to take?
- How will we know if we are doing this more of the time?

An example of a discussion around the positive care practice is shown in Appendix 7. Statements were adapted in the light of these discussions and actions were agreed if appropriate. Thus, what developed was a collective vision for the ward that was live and dynamic and included contributions from all staff.

It is important to note however that staff generally found it hard to identify the positive aspects of their practice. Indeed when the senior nurses fed back positive aspects of practice, although staff were pleased to hear this feedback, staff tended to be embarrassed because what we had identified seemed like normal practice, nothing special.

What the initiative of developing positive care practices did was encourage people to notice what worked well, affirm it as part of their vision and develop actions to enable these things happen more of the time.

Skilled facilitation was crucial to the success of this initiative to support staff to consider and implement actions in a way that felt possible and was shared by the team.

Key Learning Points: Positive Care Practices

The importance of identifying and sharing positive care practices was crucial to the programme:

- The researchers had to engage in focused and determined activity to identify positive care practices, and then lead the process of really working with staff so that these became part of day-to-day compassionate practice;
- Seeking out positive aspects of compassionate caring practice, naming them and continuously feeding these back to staff became a core part of the facilitating practice development;
- Wording of the positive care practices was particularly important to ensure that they reflected reality and that staff were able to connect with them;
- Working together with staff to agree the wording of the statement was important as was recognition that it might not be perfect and go with the best that could be agreed. Achieving this was challenging because of the need to get the heart of the message across in a succinct and clear way which was relevant to the multi-disciplinary team;
- Identifying and celebrating specific positive practices in this way is not necessarily embedded within the culture of this organisation. Introducing and sustaining this on-going development was therefore challenging;
- Sustaining activity at ward level to stimulate debate and discussions on an on-going basis required identification of opportunities; for example used at staff induction to help new staff to learn about "the way things are done around here";
- It was helpful to integrate these discussions into existing meetings;
- Despite the challenges, once established this method provided a way in which quick, clear messages about compassionate caring practice could be shared with significant numbers of staff across the area involved.

2.12 Facilitating Action Projects

Facilitation has been a key element within the LCCP. It was found that time spent in developing relationships between the senior nurses and staff supported aspects of facilitation. In describing the role and function of facilitation, Harvey et al. (2002: 581) describe that when "*facilitation is focussed more broadly on developing and empowering individuals and teams there is as least an equal emphasis on the development of a helping (enabling) process or relationship.*"

Allowing staff to discuss the experiences that have been heard and enabling them to challenge and celebrate practice was crucial. Facilitation enables staff to feel a part of developing and having some control over the service they provided. Using an appreciative inquiry approach to this was powerful in helping staff to look at issues around care objectively. Finding time and opportunities within clinical staff's busy working lives has been a challenge in some areas. This can be in the sense the workload of staff on a day to day basis but also on the numbers of staff to feedback to. Feedback not only incorporates the reading out of data but the facilitation of discussion and people's views on that information. It is important for the facilitator to make notes of the discussion and any key points or actions that arose from it so that they can be shared with the wider team. This was often a challenge and senior nurses found a range of different ways to communicate actions e.g. ward communication book, visual displays.

In a busy combined assessment area handovers were used to feedback either part or whole stories to staff. The charge nurse in that area made a conscious effort to make sessions in exploring these experiences as a priority and actively encouraged staff to attend these discussion. Open questions are essential to explore a person's experiences and the feelings of staff around those experiences. Knowing what stood out for them and how it made them feel before understanding the different viewpoints of the experience. It is only then staff can consider as to how that experience could look differently or how it could be made to happen more.

Due to the range and depth of the data gathered there was the possibility for multiple actions to emerge and to potentially be over-whelming for practitioners and facilitators. Careful discussions and prioritisation were essential and it was not always possible to gain a consensus for action.

Another key role in facilitating action projects was the ability to prioritise and spot opportunities to embed actions in existing developments. For example in one area there was a need to develop more information for patients to learn about details of different care homes. This was also a priority for the social worker on the ward and therefore one member of staff worked together with them to take this forward. For those areas where there was more success in moving to action this was attributed to the commitment of more senior members of staff who demonstrated skills of influencing authority and maturity e.g. the charge nurse

Some staff were more ready to engage in this than others and these key people were integral and provided consistency in the development of actions that were taken forward.

One member of staff stated that the value of the Senior Nurse was that it enabled them to keep their developments on the agenda. Knowing they would have regular meetings and plans to move forward. If that had not been in place then even though they valued what was developing it may have fallen off the agenda with other competing demands.

It was not always possible to include patients and families in decisions about actions. Senior nurses did try to ask patients and families during data generation e.g stories if there were other ways the service could be improved.

Key Learning Points: Facilitating Action Projects

The following are the key learning points gained from facilitating action projects:

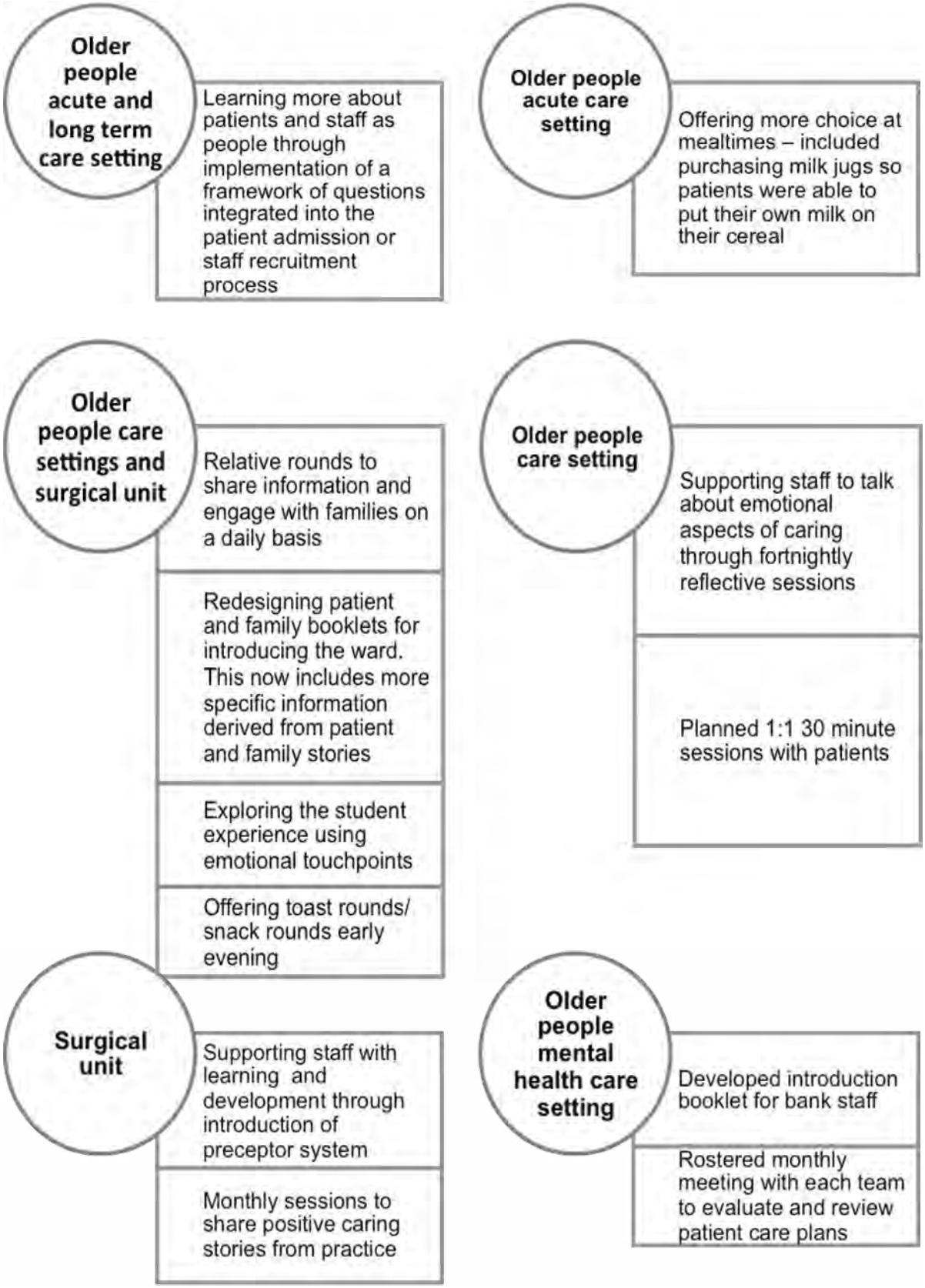
- In general, the more senior the member of staff actively involved in the action project the more likely it will progress (Influencing skills, maturity, practical know-how, being brave);
- In general, more junior members of staff require support at a number of levels to enable them to feel confident to take forward action (for example, at a team meeting a clinical support worker was supported to raise as idea to improve practice);
- Due to the range and depth of the data gathered there was the possibility for multiple actions to emerge and to potentially be over-whelming for practitioners and facilitators. Careful discussions and prioritisation were essential and it was not always possible to gain a consensus for action;
- Spotting opportunities to discuss action projects requires creativity and persistence, particularly when staff perceived themselves to have no available time e.g. integrating short discussions into existing meetings;
- Facilitation also required that the senior nurses adopted a whole range of communication strategies to help all staff to engage with the actions e.g. Decisions made about actions being documented in the ward communication book and visual displays that identified actions and the person with lead responsibility;
- The senior nurses had to provide focused discussions that enabled an individual's idea about an action to be considered and taken on board collectively by the team. This was not always possible and some potential actions were not followed through at that time;
- The senior nurses had to spot opportunities to streamline actions into existing practices and ways of working;
- The senior nurses asked key questions during data generation activities with patients and families and staff to elicit possible actions to develop the service.
- Action projects that are aligned to the values of ward staff and that prove to be locally effective are more likely to be successful and become normal ways of working

2.13 Evaluating Action Projects

The Leadership in Compassionate Care Programme Evaluation Board was created, chaired by Professor Morag Gray, and oversaw the entire evaluation process. A range of action projects were taken forward in each care setting.

These were developed in response to data that had emerged from each site and were thus context dependent. Examples of action projects are detailed in the Table below:

Table 2 Examples of action projects undertaken in LCCP



In relation to the evaluation of these projects a flexible and eclectic approach was taken. Senior nurses worked hard at involving staff in the on-going evaluation of initiatives and encouraging them to develop ways of evaluating initiatives that fitted into their day to day work and was within their 'comfort' zone in relation to knowledge and skills of evaluation techniques.

Types of evaluation included:

- Specific evaluation of an action project e.g. evaluation of the impact of using a set of key questions to learn more about the patient as a person by interviewing patients and staff about the process and carrying out a documentation audit;
- Continued use of data generation activities which were in themselves evaluation methods for care on the ward e.g. emotional touchpoints, observation and feedback sheets;
- Informal checking out by staff of continued development e.g. in one area, staff had committed to making sure that they introduce themselves to patients and explain their role at the start of their shift. The Deputy Charge Nurse made a point of asking patients in bays periodically if they knew this information and results were fed back to the team;
- Continual review of positive care practices enabled staff to question themselves and each other on a routine basis whether the care practices that they aspired to were being achieved most of the time;
- Wider organisational audits and evaluations. Where possible action projects were embedded into the existing structures of the ward so that existing evaluation methods could assess effectiveness. For example in one area they were integrating compassionate care elements derived from the project into a Dementia training course for Care Assistants. The impact of this would be evaluated as part of the overall training course;
- Critical commentary from external audiences was achieved through presenting the action projects at ward open days and external presentations. Valuable feedback was sought about ways in which these projects could be developed further.

Staff were encouraged to complete a short summary report for each initiative. These summary reports were called 'Improving Experience Briefings' and a selection of these are shown in Appendix 8.

This enabled information about initiatives to be shared more widely across the organisation.

Challenges of evaluating projects included:

- The fact that many of the patients and families would not have been aware of how things were previously making a before and after design based on the impact for them difficult;
- The desire to integrate evaluation into the day to day work of the staff rather than being seen as another thing to do;
- Adding to an already overloaded audit culture;
- Enhancing staff awareness of the importance of on-going evaluation;
- Developing evaluation skills of the Senior Nurses who were to take a lead with this aspect of the programme;
- Evaluating a number of projects at the same time

Evaluation continued beyond the intensive period of working with the Senior Nurses and many of the Charge Nurses continued to feedback data to the team about the impact of changes.

Key Learning Points: Evaluating Action Projects

- Senior nurses needed to be creative in spotting opportunities to embed evaluation into existing organisational processes so that it did not seem like an extra e.g. Using existing weekly Releasing Time to Care meetings to follow-up staff action from patient feedback;
- Further consideration is required as to planning and implementing evaluation, in a deliberate and systematic way, at the start of an action project with all participating staff;
- Baseline data regarding metrics such as sickness, recruitment and retention, incidence of falls etc. were not collected. These are often

used as global measures of a change in quality of care and culture (although collected by the organisation they have not been used by LCCP) Concerns regarding this focussed on the specific links between this form of data and LCCP interventions and the generality of conclusions that may arise.

- Critical to achieving on-going evaluation is that staff, with the support of the senior nurse, take responsibility and ownership for making it happen, and acting on it;

2.13.1 Exit interviews with Staff

Exit interviews were carried out in each area with staff participants at the end of their intensive period of involvement with the senior nurses. The purpose of the exit interviews was to establish:

- Evaluation of the story so far looking at the experience of working on the project, the learning and any outcomes;
- The nature of continued involvement and support both for the staff on the ward and for the senior nurses;
- Our purpose for evaluation was not necessarily to measure change over time but to take another look to see what was happening. A key outcome of this programme was the extent to which the project encouraged people to reflect on practice and turn that into initiatives for development. The exit interviews thus did not mark an end point to the programme of work but rather served as a useful reflection point to help staff to consider development and further actions.

Having adopted an action research approach to the study it was important that any evaluation fitted with participatory research principles. It was important to find out the extent to which the study met its aims and enabled all stakeholders to access knowledge, as well as playing a legitimate role in its production, use, evaluation and dissemination.

The authenticity criteria refined by Nolan et al. (2003) specifically addresses these aspects.

The criteria are:

- Equal access – are views of all stakeholders solicited and represented in a balanced way?
- Enhanced awareness – do individuals better understand their own situation and that of others?
- Encourage action – is action stimulated and facilitated?
- Enable action – to what extent have people been given the tools to change things?

These criteria were used to construct the evaluation questions for use in the one to one interviews. Modifications were made to these questions throughout the programme in response to feedback from staff. The focus of the questions related to: staff experience of being involved in the programme; the practitioners learning about themselves and others; the impact on their own practice; the impact on the team's practice; and what had changed if anything and perceptions of sustainability. Questions also focused on understandings of compassionate care.

All staff on the ward were invited to participate in an exit interview either on a one to one basis, as part of a group or alternatively asked if they would like to complete the written set of questions and send this back anonymously to the senior nurse. Most of the staff opted for a one to one interview. The interviews were conducted in a private room and lasted from 20 minutes to 1 hour. They were audio-recorded and notes from the interview were typed up and given back to the participants to check for accuracy, ask for additions or deletions and to check if they were happy that quotes were included in a short report that would be disseminated to all staff, the consultants on the ward and the ward manager.

The information from these interviews gave important information about what worked well and what we could do differently in future sites.

Examples of aspects that staff felt could be developed included:

Clearer information at the outset of the project about what was involved and expectations. (the written information was redeveloped to include

examples of action projects and a representative from the beacon ward was invited to visit new areas embarking on the project)

More involvement from managers (a specific contract was introduced which was a tripartite agreement with senior nurse, manager and lead from the ward for compassionate care)

Overall staff were extremely positive about the experiences of being involved in the programme and reported significant differences in the way they now gave care. A summary of the key differences that happened as a result of taking part in the project as perceived by staff is detailed in Appendices 9a, b, and c.

There were a few negative comments made about how people felt. These included:

'I have found the whole thing difficult to do. I know what the project is about and what you want but it is hard. Like talking to patients and then there are 2 buzzers going you are being pulled in many directions. It does not mean that I don't think about these things and I do have consideration but it is hard to keep your cool when there are so many other pressures. '

I have felt listened to by you. I think at first people said yes that sounds good but then nobody has followed things through. Things have dwindled and it has been hard to do it on my own. I think there is something about my leadership – it needs to be stronger.

It's been strange. It's felt a bit insecure. I think it's made staff ask more questions and it's brought up some stuff that is hard to think about. I think being observed was a bit difficult. Staff are more defensive now. I tried to give a positive take on the project but I have just given up. I never felt I had time to spend on it. I had other things I wanted to achieve.

Although these quotes reflect some negative feelings about involvement in the programme in some instances they prompted further self awareness of challenges and personal leadership.

A summary of the key differences that happened as a result of taking part in the project as perceived by staff is detailed in Appendices 9a, b, and c.

Key Learning Points: Exit Interviews with Staff

- Over time it became useful to adopt a variety of approaches to exit interviews, such as completion of questionnaires and focus groups as well as interviews. Available time and how comfortable people felt about interviews influenced how they participated in this process;
- The number of people who participated was variable across the areas for a variety of reasons e.g. level of active engagement with the programme by staff and the ward leader, confidence of facilitators and competing service demands;
- There was an apprehension by some of the Senior Nurses that the interviews they conducted may elicit brief, superficial responses. Would staff feel able to be open and honest when responding directly to the senior nurse who had facilitated the programme in their ward?
- Potential factors that influenced staff's ability to contribute to exit interviews in an open and honest manner included: their working relationship with the senior nurse; their familiarity with the feedback processes used during the programme; and responding to the role modelling provided by the senior nurse (giving feedback in real time);
- Some Senior Nurses experienced apprehension when conducting exit interviews as feedback about the programme would reflect their performance as facilitators;
- Data from the exit interviews identified in-depth feedback including both positive and negative comments. These data and the provision of an evaluation report gave an opportunity to identify areas for further development, take another look at practice, generated new ways of working/thinking and reinforced staff's' awareness of their ability to bring about change. Overall, staff were able to consider progress rather than seeing this as an end point.

2.14 Analysis process and development of a compassionate care framework

An inductive and collaborative approach to analysis was undertaken. Early on in the LCCP, 5 broad themes were developed and were derived from:

- early work in the field;
- team members in depth knowledge of both practice development;
- compassionate caring; and
- literature.

Key themes emerged as a result of the research team undertaking an iterative process of analysis and reflection. Following this each piece of data from one site was read several times and assigned one or more subthemes. As much as possible the words and phrases in the quotes were used as a heading for the sub-theme The themes related to processes that appeared necessary for compassionate care to take place. These sub-themes were then presented to the rest of the team who then grouped their data under these headings. Any data that did not seem to fit was reviewed by the team and further sub-themes developed. The subthemes were then examined to categorise them under one of the main 5 key themes.

An iterative process took place where there was movement backward and forward between data, initial analyses and further data. Analysis was therefore a continuous and inductive joint activity between participants (primarily NHS staff) and researchers (Senior Nurses and Lead Nurse).

Once all the data were assigned to sub-themes and situated under different key themes this was reread to check that each data entry continued to reflect the overall sub-theme and theme. An initial framework for compassionate relationship centred care was developed. This initial framework was shared with some participants on the wards to ascertain their interpretations.

In the Development sites data were analysed as it emerged and sub-themes developed and refined as appropriate. An additional sixth theme of 'the environment' was added at this point in response to evidence from patients, relatives and staff that highlighted the need to consider and adapt the caring environment in order to provide compassionate care. Following this the Senior Nurses and Lead Nurse undertook a process of secondary analysis to refine sub-themes, to make the framework more manageable in size and re-examine data in relation to any duplication.

Underpinned by positive caring, the following 6 broad themes formed the initial framework from which data were further analysed and categorised.

Caring conversations	Flexible person centred risk taking	Feedback	Knowing me, knowing you	Involving, valuing and transparency	Creating spaces that work; The environment
Discussing, sharing, debating and learning how care is provided, amongst staff, patients and relatives and the way in which we talk about caring practice.	Making and justifying decisions about care in respect of context and working creatively with patient choice, staff experience and best practice	Staff, patients and families giving and receiving specific feedback about their experience of care	Developing mutual relationships and knowing the persons priorities, to enable negotiation in the way things are done around here	Creating an environment throughout the organisation where staff, patients and families actively influence and participate in the way things are done around here	Need to consider the wider environment and where necessary be flexible and adapt the environment to provide compassionate care

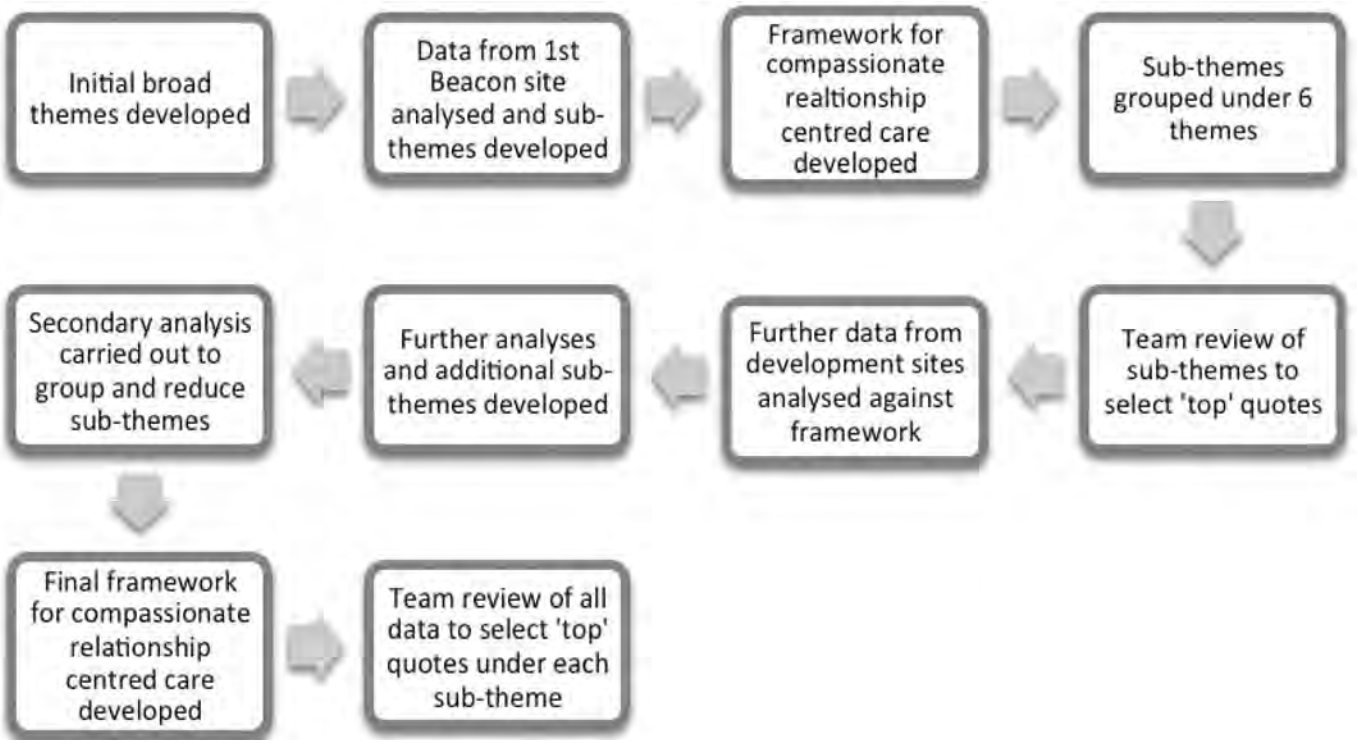


Table 3: Broad themes making up the initial framework

The final analytic framework for compassionate care, with examples of quotes that reflect each sub- theme is presented in Appendix 10. This process of analysis is illustrated in the diagram above.

Diagram 2 Process of analysis and development of compassionate care framework

2.15 Development of Measurement Process from Compassionate Care Framework

As the compassionate care framework developed it was evident that a measurement process was required to determine evidence of baseline practice, and then capture developments related to the key themes of the framework. Measures were required that could provide comparisons within a ward and across wards and hospitals. A measurement process would also enable the evaluation of the interventions detailed above identifying enhancements in compassionate caring.

It is well recognised that measurement or assessment of caring behaviours is difficult. Maben et al. (2009) identified that, *'in the audit culture second-order activities that is, measurable activities are privileged over first-order activities, the intimate professional–patient interactions, which are important but hard to measure.' Maben (2008) concluded that due to the ch*allenges of measuring caring related behaviours, the art of caring is subordinated but moreover can appear hidden. Goodrich and Cornwell (2008) highlight the need to hear the stories and complaints of patients in order to see the person in the patient and to develop practice informed by patient experience. The activities of this research has focused on this approach, hearing stories from patients, relatives and staff has been a crucial approach in both understanding and actively developing compassionate care practice. However assessing the impact of local developments in compassionate care within ward settings [although important and necessary], does not provide a way of understanding and comparing compassionate care across settings and within organisations. The aim being not to dwell on results or outcomes per sae, but use these to target resource and support continuous cycles of improvement and development, indeed highlighting and sharing excellent practice as a core approach to development.

The Lead Nurse and Senior Nurses (Research Team) began to develop questions based on the compassionate care framework. The questions were formed considering the following principles:

- Questions would adopt a relationship centred theory approach this would involve developing questions for patients, relatives and staff;
- Results of questionnaires would be used as part of a quality improvement cycle and development process;
- In regard to the development of compassionate care practice, questionnaire results would be used alongside other evidence (observation, stories etc.) to focus on areas for practice development. In themselves they are also a rich tool to develop practice.

Initially the research team developed questions based on the key themes and sub themes.

The team briefly tested out the questions with NHS staff but they appeared overly generalised and relied upon broad opinion and generalised views of practice. Reviewing this process the research team then developed questions using specific data. The example below is taken from the key theme Caring Conversations and the questions are designed for a member staff.

During bed making the staff nurse was telling the charge nurse and the patient about planning to travel through Thailand. The patient mentioned that she had lived in Thailand for 4 and half years. Although the staff nurse and charge nurse were having this conversation, they included the patient.

To what extent do you feel you include patients in social conversations?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely

Appendix 10a provides examples of draft questions for the theme Caring Conversations. To date the team have tested out the Caring Conversations questionnaires with participants on the Leadership Strand and in a development unit. Evaluation of the experience of using the questions in a variety of settings has been sought from participants. Feedback to date includes the following; the examples in the questions needed to be changed to include the local context, the questionnaire involves considerable reading and concentration, the questions raised useful discussion.

The development of the measurement process is at an early stage and rigorous testing and robust research is required to ensure a valid and reliable tool is developed.

2.16 Mapping of LCCP Framework to NHS Quality Strategy, Leading Better Care and Releasing Time to Care

A mapping exercise was undertaken to demonstrate the alignment of the Leadership in Compassionate Care Programme activities to the following key policy and development programmes:

- NHS Quality Strategy;
- Scottish Patient Safety Programme
- Leading Better Care (LBC)
- Releasing Time for Care (RTC)
- Better Together

The result of this mapping can be seen in Table 4 overleaf:

NHS Quality Strategy	Scottish Patient Safety Programme	Leading Better Care	Releasing Time to Care (RTC)	Better Together	Leadership in Compassionate Care Programme
Caring and compassionate staff and services	Cooperative multi-disciplinary team (MDT) approach involving all	Charge Nurse role to enhance patient experience	More time for direct care following RTC input	Gather patient stories to enhance staff understanding of their experience	Gather stories and feedback to understand the experiences of patients, families, students and staff. Discuss and use to enhance care.
Clear communication	Open and clear communication vital for safety	Open and clear communication vital for safety	Open and clear communication vital for engaging staff in change	National Patient Experience Surveys	Open and clear communication to discuss caring, what is done well and how to make it even better
Effective collaboration between clinicians, patients and others	Changing cultures to promote safety, use of audit cycles to demonstrate improvements	Manage and develop performance of the team	Systematically examine ways of working to increase efficiency	National Patient Experience Surveys	Share results of feedback, observations with MDT, ask patients what changes would make their experience better. Take forward positive care practices
A clean and safe environment		Ensure safe and effective practice	Well organised environment safer and more efficient	National Patient Experience Surveys	Supports staff to enact their values and act to promote the best in all aspects of providing care
Continuity of care	Ensure all staff groups follow agreed practice	Manage and develop performance of the team		National Patient Experience Surveys	Supports staff to share good practices and ensure continuity of approach to patients, families and staff
Clinical excellence	Evidence based practice	Ensure safe and effective practice	Practices observed and reviewed to improve patient experience	National Patient Experience Surveys	Support staff to consider care practices and stand up for those that support individual needs within the context of the care environment

Table 4: Mapping of LCCP activities and framework to NHS Quality Strategy, Scottish Patient Safety Programme, Leading Better Care, Releasing Time to Care and Better Together

2.17 Feeding back and influencing NHS Lothian

The researchers undertook a range of feedback and influencing strategies. The aim was to ensure a flow of information, active awareness and engagement with staff about the programme and contact with a range of staff across the organisation. The following diagram illustrates the means and methods by which activities were undertaken.

Diagram 3: Means and Methods of Feedback and Influencing Activities

The list below identifies these activities in brief:

- Project Executive Board: the board consisted of senior staff from NHS Lothian and Edinburgh Napier University and directed the activities of the programme. This forum offered many opportunities to influence and engage the organisation;
- Newsletters: Four newsletters were distributed during each year of the programme. Three and a half thousand copies were distributed widely across the organisation, for example to all wards;
- Experience briefings: these identified the processes used as part of the LCCP and are available to all staff on the NHS Lothian Intranet. For example a guide about how to use emotional touchpoints to hear experience;
- Compassionate Care half day workshops to Chief Nurses and Clinical Nurse Managers: a taster session was provided where participants had the opportunity to see and take part in the practice development processes used in the LCCP;
- Articles in NHS Lothian's Connections magazine: a number of articles during the lifetime of the programme were published in this magazine;
- Presentations to all Senior Charge Nurses and staff on the Leading Better Care Charge Nurse Development Programme (3monthly presentations);
- Presentations to NHS Lothian Board members and the Nurse Director's meeting updating them on the work of the LCCP and future plans;
- LCCP Lead Nurse became a member of strategic NHS Lothian steering groups for example Delivering Better Care steering group, Releasing Time to Care steering group and Improving the Patient Experience steering group;
- The celebration event, the culmination of the Leadership strand was opened up to line managers and chief nurses to ensure dissemination of good practice and awareness of compassionate care;
- A wide number of examples where communities of practice have been established. Where staff come together locally to share their developments and encourage one another. These have worked particularly well when nurse managers and chief nurses have provided support;
- International conference in Compassionate Care: two conferences were held in 2010 and 2011. NHS Lothian staff participated in giving presentations and attending this event. The presence of the Scottish Government's Cabinet Secretary for Health and Wellbeing and Chief Nursing Officer at these conferences was an important factor in emphasising the importance of this work.

Determining the success of influencing activities on an organisation such as NHS Lothian is complex. Factors that could be identified as success are that the organisation has the development of compassionate care identified as an organisational objective. Participating clinical

areas have won awards as part of NHS Lothian's celebrating achievement process. The research team have been invited to give presentations about compassionate care throughout the life of the programme to a wide range of staff in NHS Lothian.

2.18 Recommendations and way forward

A world cafe event for staff was held in June 2011 to make time to stop, reflect and learn from the programme.

Aims of the day

The purpose of this world cafe event was to bring NHS Lothian stakeholders together to reflect on their involvement and the impact of the Leadership in Compassionate Care Programme. The half day also focussed on seeking the views of participants in regard to mainstreaming and further developing this initiative across NHS Lothian.

The aim of the world cafe event was to ensure participants had the opportunity to reflect, share and debate their experiences with one another, thereby identifying a collective experience and views for future development of this work. NHS Lothian will use the key messages from this event to plan the future development and embedding of compassionate care across the organisation.

Participants

Thirty three NHS Lothian staff participated in the event. Participants had experience of involvement with the programme, some from its conception through to those who had participated in recent activities as part of development units and the staff leadership programme (now known as Delivering Better Care Leadership Programme). Staff represented a wide range of nursing positions within the organisation, working in both acute and community in-patient settings; the list below identifies the range of post holders represented.

- Staff Nurse
- Senior Staff Nurse
- Senior Charge Nurse
- Nurse Manager
- Chief Nurse
- Lead Practitioners for Clinical Leadership, Research, Releasing Time to Care
- Practice Education Facilitators

Processes used as part of the World Cafe Event

Image work

Participants were asked to select from a wide range of images those that meant something to them in terms of summing up the impact of being involved with the LCCP. Once the image was selected, participants wrote down their thoughts about the image and how it related to impact; they then discussed this with fellow participants.

World Cafe Process

'The cafe is built on the assumption that people already have within them the wisdom and creativity to confront even the most difficult challenges. The opportunity to move between tables, meet new people and actively contribute your thinking, and link the essence of your discoveries to ever widening circles of thought is a distinguishing feature of a world cafe. As participants carry key ideas and themes to new tables they exchange perspectives greatly enriching the possibility for surprising new insights' (The World Cafe Community, 2002). During this event participants took part in a series of discussions around a table. The discussions addressed key questions and participants moved from table to table to discuss each question in turn.

Table discussions were organised in such a way that participants had as much opportunity as possible to meet different participants for each question.

During the World Cafe event scribes were present at each of the four tables and recorded the discussions. The scribes did not participate in the discussion but recorded the key points raised by participants. They did not attempt to record in detail the discussions rather provided bullet points of the key issues identified. Participants were encouraged to write on tablecloths during the discussion as another means of recording ideas generated.

The discussions revolved around three key questions:

1 What factors contributed to the success and sustainability of your developments in Compassionate Care?

2 How can we continue to support Compassionate Care from the following perspectives: Individual; Teams; and Organisation?

3 What needs to be put in place to support the integration of quality initiatives at an organisational level?

The data collected during the day were subjected to thematic analysis by each facilitator, collectively discussed and key messages identified. These are now presented below.

What factors contributed to the success and sustainability of your developments in Compassionate Care?

- Local steering groups chaired by chief nurse and nurse manager
- Good leadership skills (at all levels) and enthusiasm and commitment of staff are critical for the compassionate care program to succeed.
- The leadership programme helped to 'tie everything together'
- Getting the 'right person' to be the lead
- Senior management buy in essential
- Organisational structure that works well and integrates compassionate care.
- Getting the whole team on board, generating ideas and all engaging with what needs done.
- Appreciating the contribution of each person and the team
- Focusing on the positives and not the negatives *e.g.* complaints.
- Initially change is difficult, realising this, focusing on small changes
- Meeting, updating and goal setting are required to achieve a positive impact.
- Involving patients and learning from experience and feedback had a positive effect.

What needs to be put in place to support the integration of quality initiatives at an organisational level?

- Long term commitment to development of compassionate care and cultural change
- Proper systematic data / evidence to demonstrate improvement in quality care across NHSL linked to existing targets and finance monitoring.
- Organisation wide communication and embedding of compassionate care culture and good practice, e.g. induction, mandatory training, PDP, policy development
- Co-ordinate and influence quality initiatives, e.g. link Releasing Time to Care and Compassionate Care activities and outcomes
- Make explicit that compassionate care has equal priority to other issues such as infection control, hand washing
- To support the development of compassionate care, it is necessary to acknowledge that teams have differing levels of experience and cultures of learning.
- Strategic planning and direction ensures staff are involved at all levels of the organisation
- Establish patterns of compassionate care activity and recording e.g. taking two patient stories a month, identifying good practice, developments and recording outcomes.

How can we continue to support Compassionate Care from the following perspectives: Individual; Teams; and Organisation?

- **Individuals**
  - Prevention! Give patients/families the opportunity to speak about experiences
  - Model behaviour
  - Tackle the attitude- 'this doesn't relate to us'
  - Bring forward ideas and be heard
  - Give and receive positive feedback
  - Share learning and experience with one another
  - Being positive can challenge the negativity of others
  - Positive feedback is a strong motivator for practice
- **Teams**
  - Hold surgeries for patients and relatives to hear about experience
  - Hearing and utilising feedback following complaints
  - Modelling compassion at team meetings
  - Understanding the teams beliefs and values, developing a vision
  - Recognition of the programme
  - Ability to share learning, opportunities for regular forums
  - Whole team need to be involved
  - Celebrate successes and change
  - Link compassionate care work with processes such as PDP
- **Organisation**
  - Providing feedback following complaints
  - All levels of management involved and across disciplines
  - Recognition of the programme and link initiatives across the organisation
  - Think of Compassionate Care as managing MRSA, ramp up the profile and action
  - Identify and utilise experts in compassionate care
  - Celebrate successes and change
  - Use outcomes and measurement in compassionate care for learning and development
  - Continue to develop links with Edinburgh Napier University and drive this agenda for future nurses.

A large amount of data was collected from the 'Wall of Intent' as well as the Images and Statement activities. These data were also subjected to thematic analysis and together with the findings presented above were reduced into an overall summary of important points to consider, develop and implement as the way forward.

The way-forward: Overall summary from the World Cafe event

- Integration of Compassionate Care with other quality initiatives
- Integration of Compassionate Care with other organisational processes
- Sharing excellence in compassionate care across the organisation
- Engaging wider teams and management structures
- Develop leadership capacity in Compassionate Care
- Developing as an appreciative organisation
- Establish compassionate care activities organisationally e.g. hearing and responding to feedback from patients, share learning and development
- Creation and utilising of a compassionate care evidence base / measures linked to organisational objectives
- Consider meaningful strategies to make core principles of compassionate care mandatory learning
- Consider further the role patients and families can play in the development of compassionate care
- Raise the profile of Compassionate Care alongside other important organisational priorities e.g. infection control.

Conclusions about the way forward

It is clear from the evidence above that stakeholders identified the need for a range of activities to integrate and influence practice in regard to compassionate care; integration of the learning from the LCCP with quality initiatives whilst impacting organisational processes such as training and audit; sharing learning and engaging with wider teams; developing and utilising an evidence base and increasing the activity and impact of measurement were identified. Strengthening and building upon leadership was also highlighted.

Chapter 3: Programme Strand 2

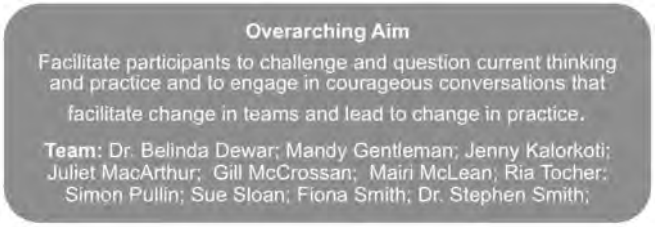
Facilitating the development of leadership skills in Compassionate Care in NHS Lothian

3 Introduction

To facilitate and support key individuals, this programme strand was designed to provide leadership development opportunities.

3.1 Aim

The overarching aim of the leadership development element was to:



3.2 Executive Summary

This strand was also underpinned by a focus on Relationship Centred Care with an explicit focus on Appreciative Inquiry and the Senses Framework (Nolan et al. 2006). It aimed to ensure that:

- Participants had an equal opportunity to participate in the programme and to have their voice heard;
- Participants' understanding of their own situation was enhanced;
- Participants' understanding of the situation of others in their work environment, especially their work colleagues, patients and family carers was enhanced;
- Participants were encouraged to take action and develop aspects of their practice/work situation in response to local evidence gathered during the programme.

The Leadership programme involved participants attending workshops (n=10), receiving individual coaching and participating in action learning sets over a period of 11 months. In total 106 participants have participated in the leadership programme, the programme has run annually over three years. Participants have included nurses, allied health professionals and one doctor. Content of the study days included information related to Relationship Centred Care; The Senses Framework, Appreciative Inquiry, Transactional Analysis, Emotional Intelligence and the FISH philosophy. Learning was shared from the LCCP activity within clinical practice. During the programme participants were required to identify and develop an action project within their clinical area focussed on an aspect of compassionate care. Processes such as emotional touch point interviews, observation of care, feedback were presented at study days and participants were encouraged to utilise these processes within their clinical setting. Gathering evidence of experience in this way would provide the basis for their local action project. At the end of the programme participants gave a short presentation to peers and managers about their experience of undertaking the leadership programme and their action project. Study days and action learning were evaluated; participants took part in focus groups where they reviewed their experience of the programme.

Whilst the programme itself would not provide participants with greater resources, the intention was that it would enable them to deal with competing demands more effectively and equip them with the skills to motivate their teams so that they were more supportive of change.

For most participants, the programme as a whole, and the 'Senses Framework' in particular, resulted in some quite profound changes, not only to their views on compassionate caring but also to their understanding of themselves. Several participants described improved confidence, assertiveness and the ability to delegate – all key leadership attributes. Moreover, participants' senses of purpose and achievement seemed to have been improved significantly and, for some, this had an almost 'existential' effect leading them to reflect on who they were, both professionally and personally.

The Leadership programme has empowered participants to initiate change, and in turn stimulate and lead others to think anew about 'the way things are done'. But having encouraged and enabled these practitioners to engage in *'courageous conversations'* it is essential that they continue to enjoy the support they need to maintain, and indeed to extend, their dialogue, such as the opportunity to participate in reflection. In order to support this it is planned for the Leadership Programme to continue but also to strengthen links with past participants of the programme, for example utilise their experience by budding up with participants on new programmes.

Key Learning Points:

- Enhancing personal skills within the Leadership in Compassionate Care Programme demonstrates that health professionals each possess the capability to deliver relationship-centred compassionate care more effectively when they recognise and utilise their leadership and influencing capacity.
- It is clear that focusing on the 'being' dimension of care produced positive effects for patients, their relatives and the multi-professional team.
- From active participation and leading projects which were centred on Compassionate Care, raised participants' confidence and self-belief. We believe that participants have been empowered to optimize their leadership capability using autonomous motivation as a personal resource.
- Our findings support existing leadership research and extend our understanding of how personal leadership can be taught and nurtured through engagement, motivation, participation and support.

3.3 Literature Review

In a health care system that is increasingly dominated by a 'target' driven culture (NMC 2009) the risk is that we will lose sight of the 'person behind the patient' (Firth-Cozens and Cornwell 2009). The leadership programme evolved following year one of the programme. It was built around the principles of relationship-centred care and underpinned by a framework for practice, the 'Senses Framework' (Nolan et al. 2006) that was developed by researchers at the University of Sheffield working with practitioners, older people and their family carers. This framework proposes that an enriched environment of care is created when all parties experience six Senses: Security; Belonging; Continuity; Purpose; Achievement; Significance.

The inclusion of the Senses Framework has been a major factor, and the programme has reaffirmed the conclusions of prior studies that the Senses seem to capture the complex and often intangible elements of high quality care in a way that explicitly recognises the contribution of staff (Davies et al. 1999; Nolan et al. 2002; 2004; 2006; Brown 2006; Brown et al. 2008a, Brown et al. 2008b). The programme aimed to build upon the knowledge, skills and values of relationship-centred care as identified by the task force that originally proposed such a model (Tresolini and Pew-Fetzer Task Force 1994).

These were to:

- Focus on improving self-awareness
- Enhance the patient experience of health and illness
- Develop and maintain caring relationships
- Improve effective communication.

The effectiveness of education in leadership development as a means of promoting change, whether in health care environments or elsewhere, has been the subject of debate for many years. Some 25 years ago Cerveo (1985) identified four factors that are seen to exert considerable influence. These are:

- The quality of the educational input;
- The motivation of the individual;
- The nature, complexity and acceptability of the change initiative;
- The receptivity of the care environment and its organisational context.

These factors are as relevant today as when they were first published and have influenced the design and planning of the leadership workshops throughout the programme.

The 'Self as Leader' workshops for the final programme were designed to respond to previous participant's feedback and were informed by three main theoretical approaches: emotional intelligence, transactional analysis and resilience, with a practical skills session on managing challenging conversations. The content reflected the NHS Scotland Leadership Development (2009), specifically examples from Personal Qualities such as self-awareness, self-management and resilience, developing teams, asking difficult questions and listening empathetically.

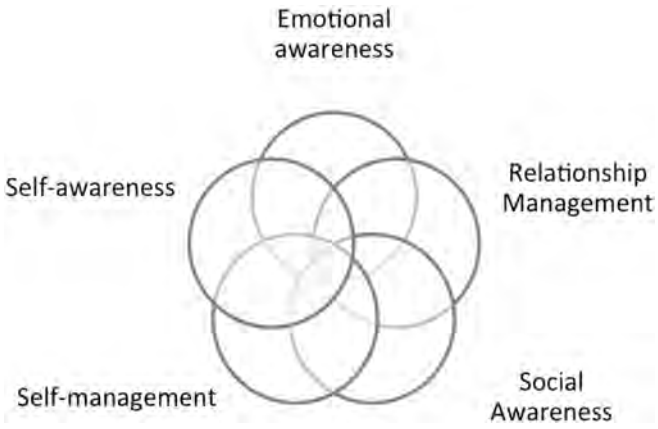
Goleman, Boyatzis and Mckee (2002), suggested that good leaders have to develop other abilities apart from technical management skills. These abilities are summarised by the term Emotional Intelligence and are self-awareness, self-management, social awareness and relationship management. At the heart of this model is self- awareness; that is the ability to recognise our emotions and how we respond in certain situations and with whom. However leaders need to be able to self-manage, to regulate responses and be adaptable, positive and goal focused. Social awareness captures the notion of empathy and awareness of the business, the customers or in this case patients and carers. Finally relationship management is then our ability to, with emotional awareness, work effectively with others through activities such as inspiring; coaching, influencing, teamwork and managing conflict (See Diagram 4). A good leader, they argue, may not need to be fully competent in each area; however they do need to be aware of the competencies they need to develop their leadership performance.

More recently, Goleman and Boyatzis (2008) outlined how as leaders, if we work relationally with staff, with empathy and awareness of our impact on others, the team performs more effectively and are less stressed.

Diagram 4 Abilities of a Good Leader (after Goleman et al. 2002)

Transactional Analysis (TA) is a theory of personality, communication and change. It was developed by Eric Berne in the 1960's and he integrated psychoanalytic, behavioural and humanistic psychologies. TA has applications in counselling and psychotherapy, education and organisations. It analyses behaviours from four perspectives: structural, transactional, games and script (Lapworth, Sills and Fish, 2003; Lee and Poole 2005; Martin 2011).

For the purposes of the programme the main focus of the workshops was on structural analysis: that is looking at the parent, adult child ego state model and the transactional component or the part that examines how we communicate. Ego states are described as 'coherent systems of thought and feeling manifested by corresponding patterns of behaviour' (Berne, 1972). A transaction is a unit of communication and the theory takes



its name from this. TA assists our understanding of interpersonal communication and how we relate. The theory enabled participants to explore relationships at work and reflect on what was happening when there were communication breakdowns. It also gave them an idea of what do to repair relationships and suggested some alternative strategies.

The concept of resilience was introduced towards the end of the programme when participants had started their programme work.

Resilience can be described as the ability to bounce back from difficult situations, to be able to get through challenging times and the abilit to seek out new experiences. Resilience may be a main factor in coping with change.

Reivich and Shatté (2002) described seven learnable skills of resilience: emotional awareness and regulation, impulse control, causal analysis, self-efficacy, realistic optimism, empathy and reaching out. Learning these skills can help individuals, teams or organisations be more effective and keep healthy during times of pressure.

3.4 Description of Leadership Programme Scope

In total a 106 participants have participated in the leadership programme. The programme has run annually over three years.

Leadership Programme	Participants
Cohort 1 – 2008	19
Cohort 2 – 2009	32
Cohort 3 – 2010	55

Following separate successful pilots in 2008, the Compassionate Care Leadership Programme (LCCP) and Leading into the Future (LIF led by Sue Sloan, Lead Practitioner Clinical Leadership, Continuing Professional and Practice Development (CPPD) Department came together to run as one programme in 2009 and 2010.

Participants	Compassionate Care Leadership Programme	Leading into the Future
Cohort 2 – 2009	15	17
Cohort 3 – 2010	38	17

Participants were made up from the staff as detailed below, with the majority being nurses who were Bands 5, 6, and 7. (N=106)

	2008	2009	2010	Total
Charge Nurse/Midwife	3	16	23	42
Staff Nurse/Midwife	16	15	25	56
Allied Health Professional	0	1	3	4
Education	0	0	3	3
Consultant Psychiatrist	0	0	1	1

Below are details of participants attending from each division within NHS Lothian. There were 7 participants grouped as others that included participants from private sector and NHS Borders. (N=106).

Lothian University Hospital Division	52
Edinburgh Community Healthcare Partnership	21
Royal Edinburgh & Associated hospitals	12
West Lothian Community Healthcare Partnership	8
East Lothian and Midlothian Community Healthcare Partnership	6
Others	7

Participants were drawn from a wide range of specialities as detailed below (N=106) as can be seen in the figure below.

Figure 2: Participants from a wide range of specialities

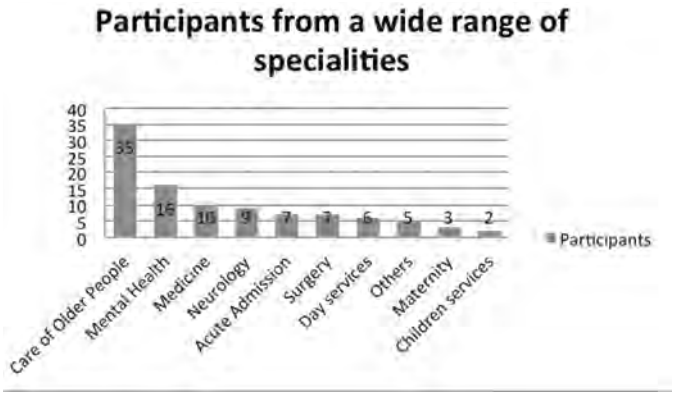
3.5 Leadership programme: Taught Content and Learning Activities

The aim of this strand was to facilitate participants to challenge and question current thinking and practice and to engage in courageous conversations that facilitate chang in teams and lead to change in practice.

The programme aimed to ensure that:

- Participants had an equal opportunity to participate in the programme and to have their voice heard;
- Participants' understanding of their own situation was enhanced;
- Participants' understanding of the situation of others in their work environment, especially their work colleagues, patients and family carers was enhanced;
- Participants were encouraged to take action and develop aspects of their practice/work situation in response to local evidence gathered during the programme.

During the first year (2008) participants attended 2 workshops, which focused on exploring creative ways to lead and develop projects. Participants were asked to lead a practice development activity, the nature of which was dependent on the needs of their clinical area. Their projects focussed on compassion and Relationship Centred Care and had to be manageable pieces of work, taking into consideration ward activity, staffing and time. The LCCP team actively worked with participants and their teams to support their individual learning and leadership development, whilst agreeing outcomes for their individual projects. The LCCP team visited participants at their clinical area and facilitated monthly action learning sets. In the second year invitations were sent to the original Beacon Wards and new Development Sites to participate.



An opportunity to deliver the leadership programme in conjunction with another NHS Lothian programme, *Leading into the Future* for Older People's* Services arose. This enabled optimum use of resources in terms of facilitators and also provided the participants with a network across a much wider diverse group, and a richer learning experience.

The programme was delivered during March- Dec 2009 and responded to feedback to increase the taught content and include action learning within this "protected time" of a workshop. The 13 workshops included two days away from the work environment in a residential setting. The purpose of the residential workshops was to enable participants to connect with and get to know each other. In terms of participants, the majority were nurses; other staff groups such as Allied Health Professionals were invited and one Speech and Language Therapist engaged with the programme.-The extension to a greater number of "taught" days enabled participants to remain connected to other participants and the LCCP team. This also provided greater opportunities for networking and sharing best practice and issues they faced. Participants were also able to co design the taught content of the programme based on their needs. E.g. a workshop focussing on Equality and Diversity. The third year of the programme commenced in March 2010 with 55 participants, including an Occupational Therapist, Dietician, Consultant Psychiatrist, Nurses and Midwives.

The programme again involved a combination of facilitated workshops and action learning. One-to-one coaching was offered in the workplace to support participants to engage with their teams, apply their learning to practice and take forward their projects. The overarching concepts to the programme are centred on compassion, appreciation and relationship centred care. An opportunity for participants to talk with staff from Edinburgh Napier University with a view of achieving academic accreditation of their work through the programme was also available, few participants took this opportunity. Participants were encouraged in conjunction with their coaches to agree a project plan and learning outcomes with their line managers.

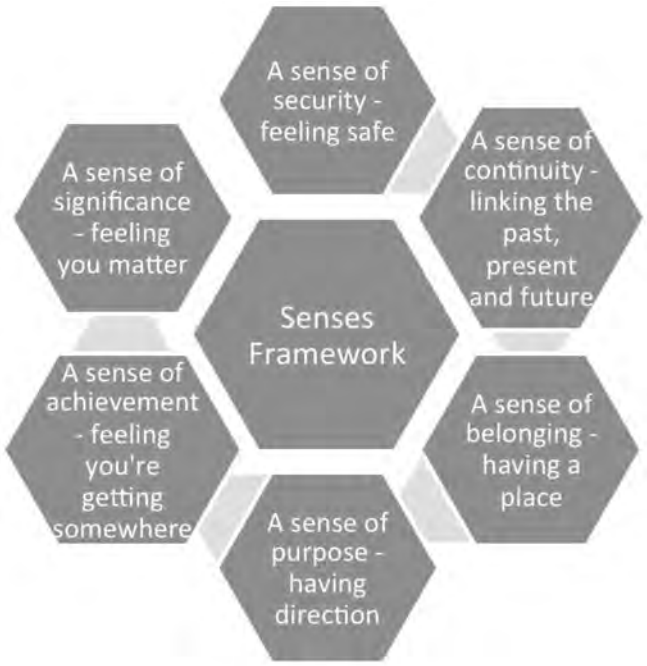
Workshops were provided as a collection of taught sessions, group discussion and creative/ practical facilitation using, for example, imagery and collage. A variety of methods and concepts provided content to the programme and below the core elements are detailed. The intention was that participants could learn and apply the approaches within their own clinical settings:

Elements included in the Leadership Programme

The Senses Framework

At its core is the concept of relationship-centred care based on the Senses Framework (Nolan et al 2006), where there is an emphasis on fostering relationships to meet the needs of all parties including patients, families, staff and students.

The senses include:



The Fish Philosophy

This derived from a way of working developed by staff at the Pike fish market in Seattle (Christensen 2009). Its key message is: To change your perspective about life at work for the better as even the most mundane jobs can be transformed if people choose to put energy and passion into them

There are 4 key elements to the Fish Philosophy:

- Make their Day: Customers (Clients/patients) respond when people smile and "do the little things that make a big difference"
- Be There: Get involved in the job, take an interest, open up opportunities and enjoy what's being done. Be there for colleagues and customers
- Choose your attitude: The bedrock of this philosophy – the attitude you have right now is the one you're choosing – is it the one you want?
- Play: Have fun – what's more important for innovation than being spontaneous and creative – having fun at work is a great motivator and work made fun gets done!

Emotional Touchpoints

This technique of gathering stories uses positive and negative words to associate with the way the individual feels about a particular aspect (touchpoint) of their experience. Participants had the opportunity to practice the technique within the programme and this gave them the confidence to use it in practice. (Please see section

Focus on appreciation and feedback

Appreciative Inquiry (Cooperrider et al. 2003; 2008) was a consistent theme throughout the programme in which we look for what works well. It is an approach that is positive and appreciative, a way of inquiry that is curious about how things are done. (Please see section

Beliefs and Values clarification

This technique of engagement with the staff team involves exploring individual's underpinning values and beliefs and examining how these can influence the ways of working in a ward/ department. (Please see section

Imagery

Creative ways in enabling participants to explore, debate and reflect on issues were encouraged in the programme content. For example, the use of photo elicitation to enable participants to describe, their understanding of compassion and leadership. Collage was also used for this purpose and to evaluate the programmes. (Please see section

Self as Leader

The workshops focused on enabling participants to enhance their self-awareness, reflect on their personal impact and manage relationships at work. Themes included emotional intelligence,

resilience and managing difficult conversations and an underlying theoretical approach was Transactional Analysis.

3.6 Leadership Programme: Workbook and Resources

A resource guide was developed to support the leadership programme. The purpose of this resource was to provide illustrative material and tools that practitioners could use as part of their leadership development. In addition the resource provided further reference material.

The resource guide was modelled on an existing resource pack that had been developed by Dewar and Walker (2004), as part of a study about leadership in partnership working funded by the Burdett Trust for Nursing.

The resource was originally developed to be used by a range of staff and relatives and therefore the language used within this was accessible and user friendly. The resource guide was further developed for this programme and contained an introduction to the concepts of leadership, relationship centred care, appreciative inquiry and compassion.

Further detail was given about methods for practice development and cultural change. This included a range of methods such as beliefs and values exploration, emotional touchpoints, observation in the workplace and creative expression work such as creating collage to clarify visions for the future. Real life examples drawn from the compassionate care data were integrated into the resource guide to provide clarity of context and meaning. Efforts were made in the writing of this resource to use a positive tone and active voice.

Participants used the resource alongside the leadership workshops. In addition they were encouraged to draw on elements within this resource during coaching sessions. Participants valued the resource guide as a useful source that supported their learning.

Many of the participants found value in the inclusion of specific practice development tools, such as reflective prompts, feedback sheets and emotional words, as they were able to use these as part of their day to day practice. For future sessions there would be value in providing participants with this resource in an electronic format so that they could adapt resources to meet individual unit requirements.

3.7 Action Learning

Action Learning was initially timed separately to the workshops, this proved difficult for some staff to negotiate attendance. Changing the timing of sets to meet in the afternoons following the workshops improved attendance.

Staff were able to bring any issues that concerned them to Action Learning not necessarily those relating directly to the project. Concerns often related to relationships with others in the workplace and how to change these to achieve more positive working relationships. Staff reflected that many of them had not previously had any opportunity to be supported in this way; that it helped them think differently about issues and gain confidence both in presenting them to the group and then subsequently working through them in their workplace. They valued having a safe but challenging environment to explore new ways of approaching concerns. Please see Strand 1 Section 2.8 for information about action learning. (Please see section)

3.8 Coaching

Participants on The Compassionate Care Leadership Programme (CCLP)/Leading into the Future (LiF) were provided with regular coaching sessions by the programme facilitators in conjunction with other approaches to promote the development of individuals' leadership knowledge and skills. It was important to recognise individual learning styles and provide a range of approaches to enhance and support the diversity of learning. Coaching sessions, along with a series of workshops and Action Learning Sets were made available to each participant on the Leadership Programme. The provision of coaching also aligned with NHS Lothian's Human Resources and Organisational Development Strategy (November 2008 – October 2011) which states that a 'Coaching Development Plan' will be developed to enhance staff development and performance as engaging leaders within the organisation.

NHS Scotland Delivering Quality through Leadership Framework

Definition of Leadership

Leadership is a performing art – a collection of practices and behaviours rather than a position (Kouzes and Posner 2005)

Definition of Coaching

The International Coach Federation (no date) defines coaching as *"partnering with clients in a thought-provoking and creative process that inspires them to maximize their personal and professional potential"*. Coaching is seen as a goal-directed and result-orientated process delivered through a professional and collaborative partnership between the coach and the coachee (in this instance, the facilitator and the participant respectively).

Process

The aim of the coaching relationship in the context of LCCP/LiF was to provide some additional, individual support for the participants in their place of work to enable them to move towards achieving their goal(s) in relation to delivering their Compassionate Care Programme. Facilitators worked with the participants for a specific period of time, generally a 4-weekly one hour session over a six month period and an appreciative inquiry approach (affirming and supportive) was adopted to enhance the collaborative working relationship.

There was an expectation that participants would demonstrate commitment and be active in their own leadership development. Facilitators were obliged to ensure that coaching sessions were future focused and goal orientated. Facilitators used open questions and provided the participants with feedback to allow them to formulate their goals and review progress of their achievement at each coaching session.

Outcomes

Participants have an opportunity to present their projects and share their learning at the end of the Leadership Programme at the 'Celebration Event'. Below are a few examples:

''I have gained a lot more confidence and my approach has changed quite a lot. I am more forth coming now and in putting my point across whereas before I used to be quite quiet'

'Now there is more of an appreciative approach of what you have done well and more a celebration of what you have done well and suppose trying to share, share all of these good stories and good practice... it's about seeing opportunities.... like trying to tap into what was good'

'Instead of trying to fix it I pass it back to them, I ask what should we do? What do you think? And get them to come up with the solution which then makes it easier to move forward ... so if it doesn't work it's a team thing that hasn't worked and we need to look at it again and so I think that it works better this way'

3.9 Participant Project Activities

The participants on the Leadership Programme each undertook a work-based project linked to one of the themes of the Senses Framework. The projects focused on issues relating to communication, improving the patient experience, developing relationships with relatives, understanding the person, enhancing patient safety, creating a positive ward culture and supporting staff. Table 5 below illustrates some examples of the work taken forward.

Sense / Achievement	Theme	Examples
Belonging	Positive Ward Culture	• Agreement of a 'Happy Philosophy' to help 'get through difficult days in a positive way': • **Hear** how people are feeling • **Attitude** – up beat, head down and get on • **Plan** who is working where and who needs help • **Prioritise** what needs done and what can wait • **Yes, yes, yes** – try hard to celebrate the things that have gone well.
Continuity	Understanding the Person	• Introduction of 'All About Me' sheets • Specific work for people with dementia focusing on 'the person they were'.
Purpose	Enhancing the Patient Experience	• Introduction of protected mealtimes • Mealtime environments being altered to promote dignity and comfort
Security	Patient Safety Staff Support	• Minimising interruptions during drug rounds. • Delegation of answering telephone calls during key periods to minimise interruptions to nurse in charge. • Creation of Staff Charter 'Safe in each other's hands'
Significance	Relationships with Relatives	• Proactive contact during visiting times. • Care planning for weekly communication with relatives in rehabilitation setting • 'Report card' for daily update for relatives in older person mental health day unit.

Table 5 Examples of work taken forward

3.10 Celebration Day

Each Leadership Programme culminated in a 'Celebration Day', where participants had the opportunity to present their experiences and projects to their peers, managers and key stakeholders, including the Nurse Director. For some participants this was the first time they had undertaken either a project or a formal presentation. However, their enthusiasm for what they had learned along with the sense of security they had clearly developed by being part of the group led to very confident and inspiring performances.

Each day included participants undertaking collage work in groups to articulate their experience, which were then presented to the invited audience with opportunity for questions.

The creativity and imagination sparked by this approach to evaluation led to very insightful descriptions of the journey that most participants felt they had undertaken. The main messages related to confidence-building and re-energising enthusiasm for their work. The presentations of the project work illustrated three main themes: impact on individuals, changes in ways of working and impact on the wider team.

Theme 1: Impact on individuals

Whilst some examples described were individual, it was clear that many were universal and included:

- Increased confidence and assertiveness.
- Increased sense of purpose about their role as Charge Nurse/Staff Nurse, including championing nursing care in the wider sense.
- Improved ability to manage staff conflict and deal with difficult situations.
- Increased understanding of the need for evidence on the quality of care and patient experience.
- A change in attitude towards work, which was not only recognised by themselves but also their peers, staff and managers.

Changes in ways of working

There had been important changes in the way individuals approached their work, particularly their relationships with colleagues. Examples include:

- Much more interaction with staff teams including setting up meetings, asking 'what are we doing right?'; what could we do better?'; seeking ideas and listening to different perspectives;
- Increased inclusion of clinical support workers in a range of care and organisational activities;
- Increased tendency to let staff sort out issues themselves rather than feeling the need to take the lead;
- Increased focus on the needs of relatives

Impact on teams

The nurses described the wider impact on their teams:

- Increased morale and motivation;
- Staff regularly coming up with ideas for change;
- Much more discussion, which had led to greater appreciation of each other's roles;
- Increased self-belief as a result of evidence gathered from seeking feedback from students and relatives;
- Increased sense of a team approach; a 'we did it' attitude.
- Much better team relationships with a sense of both caring for, valuing and being able to rely on each other.

The sense of achievement and change was palpable, with an overriding impression of renewed drive to implement new ideas and to take their teams *with* them. The concept of relationship-centred care appeared to be embedded in participant's thinking and the projects demonstrated a commitment to improving staff relationships, which in turn was impacting on care delivery to patients and their families.

3.11 Evaluation and Findings

The Leadership in Compassionate Care Programme (LCCP) is focused on the development of personal leadership qualities and skills with specific emphasis on relationship and person centred practice in the delivery of care. The Programme uses innovative techniques to empower each participant to devise, develop and implement an action project designed to improve compassionate care within their clinical area.

The aim of this evaluation was to assess the effectiveness of a programme, focused on compassionate care leadership as reported by participants. It was important to understand the impact of the LCCP on practice within various clinical settings and in context of the wider organisation, however more specifically we wished to evaluate the experiences of the participants, focusing on what has been learned and what had

changed. As an evaluation team we wanted to capture descriptive data and shifts in practic as a key output of their involvement in the programme. We also wanted to identify results associated with the programme that could be categorised as transformative.

Background

The evaluation centred upon the project outcomes and personal journey of the participants during the LCCP. Each project was driven by needs of the clinical area as discovered by the participant using various methods which included appreciative enquiry and action learning. The LCCP required each participant to foster the interest, engagement, participation and motivation of their clinical colleagues allowing key leadership skills to be appraised through this evaluation.

Three cohorts have participated in the Leadership Programme, the first cohort in 2008, the second in 2009 and the final cohort in 2010. The 2009 cohort was followed during the year long programme by the research team.

The participants (n=30) included a range of clinical staff including band 5, 6 and 7 Registered Nurses and an Allied Health Professional. The areas of practice were diverse and included acute (e.g. Combined Assessment Area), mental health, long term care, out patients, and palliative care.

Methods

Evaluation studies are important for patient-centred care as they assure that current practice is appropriate for the organisation and the delivery and quality of service (Gerrish and Lacey 2010; Parahoo 2006). Therefore a qualitative, longitudinal approach was used for this evaluation study to trace progress and development over time as perceived by the participants (Holloway and Wheeler, 2010).

Ethical approval was sought and granted from Edinburgh Napier's School of Nursing, Midwifery and Social Care Research Ethics Committee within the Higher Education Institution (HEI), which meets the standards of the Research Governance Framework (Scottish Executive, 2006). All participants gave informed consent to participate in the research.

Data were collected by a variety of methods, including a pre course questionnaire, evaluation of each study day and small group interviews at the end of the LCCP. The data were collected throughout the Programme, as demonstrated in the examples provided in Appendices 12a; 12b; 12c; and 12d. These data enabled observation of the evolution, or not, of personal leadership qualities and the impact this had on the participants and their clinical setting.

The approaches to data collection and analysis were concurrent, reflexive and flexible as this approach opened up opportunities for further data collection after the initial analysis, with the aim of eliciting deeper, more insightful descriptions of the informant's experience (Polit and Beck, 2010).

Transcripts and field notes were anonymised and analysed using the constant comparative method (Glaser and Strauss 1967) allowing the researchers to give the emerging concepts depth and specificity (Parahoo, 2006).

Results

Prior to the programme questionnaires revealed a wide range of perspectives on current practice and leadership. Although 9 participants reflected on theoretical frameworks for professional development e.g. Knowledge and Skills Framework or Senior Charge Nurse Review, the remaining 17 participants cited either no formal model or framework guiding practice (n=10) or cited patient management tools (n=7) guiding their current practice. When asked their views on current leadership roles a range of concepts were identified including delegating and implementing clinical changes/protocols.

Few of the participants identified the characteristics of an effective leader emerging from a concurrent review of leadership literature.

Data gathered during non-participant observation of the Programme's first workshop, revealed that the participants, when asked to identify aspects they considered important in creating a positive culture within their work environment clearly identified aspects of effective/active leadership.

Despite the lack of leadership styles or roles identified by the participants in documenting their own leadership role it was apparent that they did have a vision of what constitutes 'good' or effective/active leadership.

Data were gathered from the monthly action learning sets that the participants took part in. The evaluations of these days and the action learning recording sheets (which asked questions such as 'what have you learned from today' and 'what will you do differently') resulted in data illuminating that it was clear that over the 7 months significant change was occurring within the participants. Leadership attributes that were aspirational for the participants at the start of the Programme were emerging:

'I shall listen more to other people's problems and ask questions without giving advice' 'I have the strength to change things and keep motivation going' and 'I will give more real time feedback'.

Data gathered from the small group interviews, held after the participants had completed the Leadership Programme, revealed that some significant changes to the participant's personal qualities and leadership skills had taken place. The evaluation team sought to map these self-perceived changes to current leadership theory and leadership models.

From pertinent literature the model that resonates with the Leadership in Compassionate Care evaluation is Bass and Avolio's (1994) Full Range of Leadership Model (see Appendix 18 for model and explanation). Using this theoretical framework it is evident that the participants have reported a change in their leadership behaviour and have moved from the passive/ineffective domain, as demonstrated in their pre-programme questionnaire to the active/effective domain from comments elicited during the small group interviews.

Through learning new skills and techniques such as transactional analysis and 'emotional touch points', the programme participants were supported in developing a programme pertinent to their area. The participants therefore had to ascertain and agree upon what was required in their clinical area by questioning staff, patients and relatives.

The perceived reward for the participants were firmly centred upon improving the patient experience, one participant stated

'I suppose it inspired me to believe that it is still possible to make a difference as a ground floor person to what happens to our patients'.

When asked what key changes the participants had seen in themselves and their team as a result of their experience of the LCCP, the elicited responses reflected a move from transactional (and non-transactional for some) to a transformational leadership style where leaders and followers are inextricably bound to precipitate change (Northouse, 2001; Salanova et al. 2011). Recognition for dissemination of new techniques and practices to work colleagues, patients and within the organisation was also evident which further demonstrates active/effective leadership and transformative outcomes resulting from participation in the programme.

Even those in less senior roles reported that they were *'in a position where I don't have any direct power to influence therefore it has all got to be indirect and me modelling things and me talking about things'.*

The data from the focus groups is rich with evidence to support the change from transactional leadership to transformational with many examples mapping to the 4 'I's' of the Bass and Avolio (1994) model (see Appendix 14). It is hoped that these changes will be sustained as the change has happened within the individual and therefore may be able to provide some long term motivation to sustain high levels of performance (Walumbwa et al. 2008).

3.12 Conclusion

Compassionate care is considered a common skill required by all nurses and allied health professionals to promote person-centred care (Scottish Government, 2010). With the guidance and support of the Compassionate Care programme team, participant's developed greater recognition of the needs of patients and their colleagues and discovered ways to embed compassionate care as an integral part of their

practice by utilising their personal leadership capacity. From the evidence gathered, enhancing existing personal leadership skills has produced positive effects and observable change in the participants, enabling a new sense of purpose in their practice.

3.13 Dissemination

The research team have been asked to submit an article to 'Nursing Management' and plan to prepare articles for publication in peer-review journals such as the 'Journal of Advanced Nursing' and 'Journal of Clinical Nursing' to disseminate our findings.

Our initial findings have been presented at the Royal College of Nursing International Research conference in May 2010 in Newcastle and at the inaugural International Compassionate Care conference in June 2010 in Edinburgh.

The research team are interested in analysing the impact the innovative techniques used within the educational programme on the participants development of personal attributes and leadership skills. The team are currently seeking funding to map these findings to graduate attributes (QAA 2010) and are keen to present these findings to education focused audiences.

3.14 Reflection – Key Learning Points

Through the programme we have observed that enhancing personal skills within the Leadership in Compassionate Care Programme demonstrates that health professionals each possess the capability to deliver relationship-centred compassionate care more effectively when they recognise and utilise their leadership and influencing capacity. It is clear that focusing on the 'being' dimension of care produced positive effects for patients, their relatives and the multi-professional team.

From active participation and leading projects which were centred on Compassionate Care raised participants' confidence and self-belief. We believe that participants have been empowered to optimize their leadership capability using autonomous motivation as a personal resource.

Our findings support existing leadership research and extend our understanding of how personal leadership can be taught and nurtured through engagement, motivation, participation and support. It is important however that we seek further insights on leadership in compassionate care as we continue to analyse data from our research. However in the true spirit of relationship-centred practice it is important to offer final thoughts from one of the participants, as (Kelly) perfectly illustrates the positive effects the LCCP has produced '*...try little things to see if they work... as small changes can* (and do) *have a big impact'*.

3.15 Recommendations and Way Forward

The factors that create an "enriched" caring and learning environment are the quality of interpersonal relationships, mediated by the existing skills and attributes of the participants and facilitators. Added to these is the enhanced knowledge and skills that will be gained from attending leadership programmes such as this. Conversely, influences that serve to 'impoverish' the environment include limited resources (staff, time and money), competing demands on participant's time, and a lack of support from colleagues and/or managers. Therefore continued investment in skilled facilitation and support to maintain and sustain leadership development is crucial. On-going delivery of leadership programmes and workshops which embed compassionate care, relationship- centred, safe and effective practice, will ensure that capacity and capability continues to grow and flourish throughout the Organisation for the benefit of our patients, carers and workforce.

There is extensive literature that attests to the difficulties of initiating and sustaining changes to practice (Powell et al. 2009). It is too early to say whether the changes brought about as a result of the programme will be enduring but the early evidence is very encouraging. The programme has empowered participants to initiate change and lead others to think anew about *'the way we do things around here'*. It is essential to emphasise the importance of individual/ participant "readiness" to fully engage with the programme as well as full and on-going manager's support.

The development and investment in the programme is indicative of an organisational culture that recognises the need for, and values staff development.

As recent systematic reviews of the success of quality improvement and change initiatives in health care settings have demonstrated (Bate et al. 2008; Powell et al. 2009), support for change at the very top of an organisation is essential to its success. Such support has clearly been evident in NHS Lothian and therefore it is vital that this is consistently sustained and developed.

Chapter 4:

Programme Strand 3

Embedding the principles of compassionate care within the undergraduate curriculum

4 Introduction

This programme strand provided an important approach to the education and support of nursing and midwifery students in learning how to practise and deliver compassionate care.

4.1 Aim

The aim of this strand was to embed the principles of compassionate care within the learning, teaching and assessment of the undergraduate nursing and midwifery curriculum at Edinburgh Napier University.

4.2 Executive Summary

This programme strand, focused on the undergraduate curriculum, and had two phases. The first phase involved conducting focus groups to explore lecturers' and students' views, values, attitudes and engagement in the principles of compassionate care within education and practice. The second phase used these findings to enhance the learning, teaching and assessment of compassionate care within the undergraduate programme through the development and delivery of a range of action projects.

Phase one

Ethical Approval was obtained from Edinburgh Napier University's Ethics Committee. Eight focus group discussions were held with Lecturers and students. Twenty eight lecturers (all 5 branch programmes were represented) and fifteen students participated.

The questions discussed at the groups focussed on:

- What does compassionate care looks like;
- Values about providing compassionate care;
- Experiences of teaching and learning about compassion in both the university context and clinical practice.

With permission, the focus groups were audio taped then transcribed. Data from transcriptions and notes (from an observer) were analysed using constant comparative analysis. All researchers were collectively involved in the analysis process. Each analysed their own group then a comparative analysis between focus groups was conducted.

Findings

Following the analysis of all the focus groups three key themes emerged.

1. Understanding and demonstrating compassion
2. Is there a cost to being compassionate?
3. Can compassionate care be learned?

Understanding and demonstrating compassion

Providing compassionate care involved demonstrating behaviours that were described as ordinary and subtle, however despite their subtlety, they were identified as having a significantly positive impact on care. Developing an understanding of compassion requires careful observation, reflection and development of insights that impact on the practitioner's ways of working.

The importance of positive role modelling of compassion from clinical staff to patients, and academic staff to students was highlighted as an important feature of experiential learning and instilling a culture of compassionate care.

Is there a cost to being compassionate?

The costs of providing compassionate care were identified as financial, emotional and related to time. These three factors were identified as interrelated. Financial pressures within the NHS result in an increasing focus upon efficiency and fast throughput of patients through our healthcare systems. Healthcare is an important but limited resource that requires robust management. Focus group discussions highlighted a tension between this situation and the time it takes to provide compassionate care, but also the emotional frustration of wanting to provide a level of compassionate person centred care within the parameters of this current system. Polarised views were expressed in discussions about the time required to give compassionate care: compassionate care takes a long time, to views that it does not take any additional time.

Can compassionate care be learned?

There was a consensus that an objective of the undergraduate curriculum is to nurture compassionate caring attributes amongst student nurses and midwives. The term nurture was positively acknowledged in preference to the terms, teach and learn. This is related to building upon and developing existing caring attributes. Participants highlighted the recruitment process for student nurses and midwives and the importance of identifying compassionate caring attributes in the selection process.

4.3 Phase 2 Action projects:

In the second phase six action projects were undertaken to use the findings from phase 1 to enhance the learning, teaching and assessment of compassionate care within the undergraduate programme. The action projects were:

1. Use of Patient Stories derived from clinical practice integrated across the undergraduate curriculum to enable an understanding of compassionate care;
2. Feedback to Placement Areas involved consideration of how students alongside their Mentors and Practice Education Facilitators could provide feedback about their experiences of compassion and caring;
3. Developing relationships in busy environments and assessing compassion skills;
4. Supporting Lecturers involved the consideration of developing proactive ways of dealing with the emotional costs associated with the provision of compassionate care to students and practice staff;
5. Enabling candidates to demonstrate their compassionate and caring attributes during recruitment and selection.
6. Including compassionate care as a component of a student's personal development planning process.

Key Learning Points and future development:

- **Project 1 Using stories within the curriculum:** The stories derived from clinical practice as part of the LCCP provided valuable insight into the patient, relative, staff and student experience. Stories have been made available as podcasts. A range of activities, such as story week were undertaken to highlight this resource to academic staff, further work is required to raise awareness and use of these stories within the school. Stories are being used in a number of forms in teaching, learning and assessment activities and evaluation is ongoing.
- **Project 2 Feedback to placement areas:** Lead mentorship forums will provide the appropriate focus for the dissemination of good practice in compassionate care. It has been agreed that an Appreciative Inquiry approach will be used to provide feedback to placement areas. The successful Edinburgh Napier University WebCT based 'mentor-centre' provides the focus for highlighting and exploring student and mentor stories. The Mentorship training programme is the vehicle to target learning related to compassionate care: what it is, how it is experienced and how this is demonstrated and valued in busy working environments.
- P**roject 3 Developing relationships and assessing compassion**: An existing Year 3 module 'Recognising Acute Illness and Deterioration' was used as a vehicle to explore

- the teaching, learning and assessment of compassionate care. The process of change used to make compassionate care more explicit within this module has been shared with colleagues as one example of how stories can be used successfully to influence teaching learning and assessment within the nursing and midwifery programmes.
- **Project 4 Supporting lecturers:** The supporting lecturers' action project provided a restorative space through a series of four facilitated three-hour workshops over a period of nine months. Through the development of a collaborative supportive network within the group and utilising creative approaches such as collage, participants were able to provide support to each other and to identify and participate in actions which could lead to positive change within the School.
- **Project 5 Identifying compassion at recruitment:** From the data a list of values-based personal attributes was derived which will be used to create a person-specification for prospective nursing and midwifery students. It is aimed that this will focus future candidates' awareness of the importance of compassionate care in preparation for their interview whilst providing those involved in recruitment a benchmark for selection.
- **Project 6 Incorporating compassionate care within Personal development planning process:** Interviews with students identified value in the role of the Personal Development Tutor (PDT) in regard to provision of academic support, the personal qualities of the tutor and the demonstration of compassion towards students. Lecturers identified the PDT role as providing academic support for example guidance with assessment, providing a professional relationship, namely a constant point for contact and a sense of belonging. Positive and challenging elements of the PDT role were identified such as finding a balance between academic and pastoral support. Lecturers also identified support needs for this role, e.g. a form of supervision. The next stage of this action project will be to explore the potential for an adapted version of the Senses Framework to further analyse data and consider this to be utilised within the actual PDT processes. On the basis of this recommendations will be made in terms of enhancing compassionate care within the PDT role.

4.4 Literature Review

Recent Scottish policy documents emphasise a need for models of practice that are focused on enhancing person centred, compassionate caring skills and values. Such documents include: Better Health Better Care (SGHD 2007); Delivering Care, Enabling Health (SEHD 2006a); Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland (SEHD 2006b); and most recently the NHS Scotland Quality Strategy (SGHD 2010).

In addition, and from a United Kingdom (UK) perspective, dignity in Healthcare, has received wide attention following a National Dignity Challenge Campaign, launched by Ivan Lewis the Care Services Minister in November 2006. The Royal College of Nursing launched their Dignity at the heart of Nursing Campaign in 2008. This campaign was launched following a nationwide survey of 2000 nurses which identified that they were very conscious of providing dignified care and identified three factors which either promoted or impacted upon the delivery of dignified care. These were the place of care; the processes involved in caring; and people, namely their attitudes and behaviours (Royal College of Nursing, 2008). It can be argued that issues related to the provision of dignity are similarly aligned to the provision of compassion. The NHS Confederation in May 2008 held a conference and produced a paper that raised the question: Compassion in healthcare: The missing dimension of healthcare reform? The paper argues that putting compassion and care back into healthcare requires action at system level; by organisational leaders; and by individuals (The NHS Confederation, 2008).

Amidst the challenge of seeking to enhance compassion and caring, it is important to recognise the complexity of contemporary healthcare.

'Providing care in hospitals today is more complex than ever before. Healthcare has changed, with more technology involved, more specialist care offered and more complex patient needs being supported. But the most fundamental aspects of care remain the same as they ever were: patients and users expect to be safe and to be treated with courtesy, respect and kindness. Those basic principles are vital to ensuring that patients have confidence in the care they receive' (Department of Health 2008: 3).

The quote above was taken from the document Confidence in Caring, an initiative that provided best practice guidance for those responsible for providing hospital care. A further activity aimed at tackling these fundamental issues.

Within a mental health context, The NHS Confederation and the Mental Health Network produced a report in 2007 entitled; Time and Trouble: towards proper and compassionate mental healthcare.

'Mental healthcare must be compassionate and understanding, and spare people battles with services that do not help them fast enough, well enough or indeed at all. And a big part of getting it right is finding ways to dovetail the formal evidence-base of which treatments work for whom, with what service users want' (The NHS Confederation and Mental Health Network 2007: 5). The Kings Fund programme document entitled The Point of Care, also addresses similar key issues. *'There is unease about the most important characteristic of any health system – how patients are treated, not in the sense of which medical intervention is offered, but how they are cared for, how they are looked after'* (Goodrich and Cornwell 2008: pvii).

This programme of work focuses on the terms kindness, compassion and person centred care in relation to experiences of hospital care.

A factor that contributes to the challenge of caring for people compassionately is the understanding of the term caring and recognition of what this activity involves. Finfgeld-Connett (2008) conducted a meta-analysis of qualitative research about caring and identified that

'...caring is a context-specific interpersonal process that is characterized by expert nursing practice, interpersonal sensitivity and intimate relationships. It is preceded by a recipient's need for and openness to caring, and the nurse's professional maturity and moral foundations. In addition, a working environment that is conducive to caring is necessary', (Finfgelt – Connett 2008: 196).

It is evident that there are complex factors involved in the notion of caring, when the term compassionate is then introduced, it is reasonable to assume further complexity.

The drive for a refocus on the caring dimension of health care can be seen to run alongside the importance that is placed upon the perceptions of the service user. There is strong evidence to suggest that patients and their families value 'the human touch' in caregiving and often cite this as more important than technical care (Kerrison and Pollock 2001). Service user involvement has become a critical factor in the modern NHS.

Within a Scottish context, the Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon, refers to the Scottish Government's focus on user involvement.

'That is why our action plan, Better Health, Better Care (2007), commits the NHS to working in partnership with you, the people it serves. A truly "mutual" NHS will be one where we all take more control of our health and become more active in deciding how NHS is run' (NHS Scotland, 2009).

Within the Scottish context of this research, a policy document from the Scottish Government Health Department entitled, Better Together (2008) outlines how to produce achievable and measurable changes which will ensure quality improvement and enhance patient and carer experience of healthcare in Scotland. This policy is grounded in collaborative working between health professionals and practitioners, patients and the public.

To summarise, from the literature identified in this part of the report, it is evident that clear concerns exist about the experience of care within

hospital settings, particularly involving aspects of caring and compassion. The number of key programmes of work that focus on this subject give weight to the severity and complexity of the challenge. Simultaneously there is an expressed need to involve service users in all aspects of their healthcare and to actively seek their opinions and experiences in order to develop services based on user experience.

In respect of student nurses and their learning and experience about care and compassion, it is concerning that a focus on the challenges of providing dignified, compassionate care exists within practice. Where will students consistently witness positive care and role models within their practice placements? How will learning and experience be achieved related to this subject?

In terms of providing a direction and focus for pre-registration undergraduate nursing curricula, The UK Nursing and Midwifery Council in 2006 highlighted the importance of care and compassion as part of student nurses essential skills clusters (NMC, 2006). NMC Guidance on Professional Conduct for Nursing and Midwifery students (NMC, 2009) identifies the following as a core principle: Make the care of people your first concern, treating them as individuals and respecting their dignity. Specifically the guidance specifies that students should**:**

Treat people as individuals and respect their dignity

Be polite, kind, caring and compassionate

Not discriminate in any way against those for whom you provide care

Recognise diversity and respect the cultural differences, values and beliefs of others, including the people you care for and other members of staff.

At first glance this guidance looks solid, and identifies an appropriate standard of care. When we consider the student learner and the statements made we would agree that it sets a level to work towards. Unpicking the learning involved in this is complex. Caring for people, who are aggressive, behave in strange ways or who overtly treat others badly can be an extremely difficult learning experience for the student. This involves for example witnessing such experiences, having the opportunity to reflect, receive feedback, share emotions and challenges and witness good role modelling of professionalism from mentors. The learning is complex and research identifies multiple factors that influence this. Research by Murphy et al. (2008) identified that student nurses in third year demonstrated less caring behaviours than their counterparts in first year. They concluded that rather than enhancing their caring behaviours over the course of their studies their educational experience appeared to diminish such caring attributes. This is supported by Watson et al.'s (1999) research whereby they identified that nursing students, experienced a loss of idealism at 12 months into their course. The reasons for these findings are likely to be multifactorial, students focusing on gaining technical ability, socialisation processes, a grounded reality in the challenges of nursing work and a focus on managing their workload.

It is evident from this brief literature review that government policy is consistently pushing towards healthcare practice that is person centred and compassionate. Recent initiatives focused on enhancing these aspects of the care experience, identify that standards of care are not being consistently achieved and efforts are required to support healthcare staff to deliver these. Student learning and development in this area requires further investigation and focused activity.

4.5 Description of Scope

The School of Nursing, Midwifery and Social Care at Edinburgh Napier University is based at the new state of the art campus at Sighthill, Edinburgh. The school offers an extensive range of programmes including a Diploma and Degree in Adult, Child Health, Learning Disability and Mental Health Nursing and Midwifery, at both full and part time BSc. and MSc. Programmes in Nursing Practice. The School also offers a BSc. Veterinary Nursing programme in collaboration with the College of Animal Welfare, the first such programme in Scotland. The School is one of the largest providers in Scotland of pre-registration Nursing programmes in the specialisms of Child Health, Mental Health

and Learning Disabilities, offering awards at Diploma, Degree and Honours level.

In addition to the focus groups and action projects undertaken as part of the undergraduate strand of the LCCP, the LCCP team have undertaken a number of teaching commitments working directly with nursing students during their programmes. Direct teaching opportunities have emerged through a serendipitous process, the LCCP team taking opportunities to teach following invitations from module leaders. A challenge within this context is to strike a balance of working alongside academic staff to develop specific practices such as using patient stories in the curriculum, whilst providing direct teaching that does not necessarily foster joint working but provides an opportunity to directly raise the issues of compassionate care with students. It is fair to state that a number of lecturers already include many aspects associated with compassion and caring and this is included in many module descriptors within the curriculum. The following list identifies the regular teaching sessions where compassionate care was presented by the LCCP team directly.

- Theory module for nursing students (Year 1, all 5 branch programmes) 1 hour, titled Compassionate Care – practice and theory;
- Reflection session for Nursing students (Year 1 Adult programme) 3 hours titled Leadership in Compassionate Care;
- Theory module (Year 2, Adult programme) 1 hour, Titled Caring in nursing;
- Consolidation (Year 3, Adult programme) 1✣ hours, Opportunities for newly qualified nurses – compassionate care.

With regard to the action projects undertaken as part of this strand of the LCCP, action research principles of collaboration and participation were employed. This involved working with academics, students and practitioners pertinent to each project. In this way an increasing number of academic staff became involved in LCCP activities. In total twelve staff from the School of Nursing Midwifery and Social Care are actively involved in these projects, and this does not include LCCP team of Senior Nurses and Lead Nurse.

4.6 Focus Groups with students and academic staff: process and key findings

Process

The aim of this research was to explore lecturers' and students' views, values, attitudes and their engagement with the principles of compassionate care. Ethical aspects of this research were considered as evidenced in Appendices 14 – 16. Data were collected using focus groups (n=8) involving lecturers (n=28) and students (n=15).

Separate focus groups were conducted for students and lecturers to allow for freedom of discussion about these issues, and to allow participants to feel comfortable and develop a sense of trust between them and the researchers within the focus group interviews (Clarke 2006).

Participants were allocated a pseudonym to protect their identity. Focus group interviews were situated within University and NHS Lothian premises depending on the work-base of the lecturers and students. These sites were selected for convenience, but were private and quiet areas for interviews which lasted between 60 to 90 minutes (McCann and Clark 2005).

Questions within the focus groups were open in nature and we engaged participants in discussion using verbatim quotes from other parts of the LCCP and from nursing literature. Questions were arranged in order to provide a general interview guide following a semi-structured approach (McCann and Clark 2005) (Appendix 16 and 17). This allowed for supplementary questions to be used as appropriate. Each interview was tape-recorded and transcribed verbatim.

Two researchers and an observer were present at each of the Lecturers' focus groups: One researcher set the scene and ground rules and led the questioning. The second researcher asked additional questions which aimed to clarify specific points and further focus on key issues being discussed. The observer took observation notes throughout, noting group dynamics, non-verbal communication, contradictions or agreement.

During the student focus groups (n=3) two researchers facilitated two groups and one researcher facilitated a third group. The variation in facilitation between lecturer and student focus groups was due to a need to respond to the students learning situation and be ready to conduct a focus group if this was feasible. It was not feasible to have three researchers available on a standby basis. The Lead researcher and observer were consistent in two of the focus groups, the third focus group which was facilitated by the lead researcher.

Data from transcriptions and observer notes were analysed using constant comparative analysis which involves developing codes, categories and themes. All researchers were collectively involved in the analysis process. Each analysed their own group then a comparative analysis between focus groups was conducted. This involved meetings of researchers to discuss and compare data.

Key findings

Understanding and demonstrating compassion

Providing compassionate care involved demonstrating behaviours that were described as ordinary and subtle, however despite their subtlety, they were identified as having a significantly positive impact on care. Developing an understanding of compassion requires careful observation, reflection and development of insights that impact on the practitioner's ways of working.

The importance of positive role modelling of compassion from clinical staff to patients, and academic staff to students was highlighted as an important feature of experiential learning and instilling a culture of compassionate care.

Is there a cost to being compassionate?

The costs of providing compassionate care were identified as financial, emotional and related to time. These three factors were identified as interrelated. Financial pressures within the NHS result in an increasing focus upon efficiency and fast throughput of patients through our healthcare systems. Healthcare is an important but limited resource that requires robust management. Focus group discussions highlighted a tension between this situation and the time it takes to provide compassionate care, but also the emotional frustration of wanting to provide a level of compassionate person centred care within the parameters of this current system. Polarised views were expressed in discussions about the time required to give compassionate care: compassionate care takes a long time, to views that it does not take any additional time.

Can compassionate care be learned?

There was a consensus that an objective of the undergraduate curriculum is to nurture compassionate caring attributes amongst student nurses and midwives. The term nurture was positively acknowledged in preference to the terms, teach and learn. This is related to building upon and developing existing caring attributes. Participants highlighted the recruitment process for student nurses and midwives and the importance of identifying compassionate caring attributes in the selection process.

4.7 Presentation of Action Projects

4.7.1 Patient Stories

Presenting patient stories throughout the curriculum to enable a developing understanding of compassionate care. Team: Liz Adamson, Dr. Belinda Dewar, Anne Waugh

The stories derived from clinical practice as part of the LCCP have provided valuable insight into the patient, relative, staff and student experience. Research has shown that patient stories have the power to engage and move the listener and shed light on the hospital experience.

They can also reveal how the process of caring in the acute setting relates to the patient's unique and personal world (Dewar et al. 2009). It is encouraging to know that learning from these

stories had influenced and informed clinical practice but to take this further it was important to find ways of using the stories to influence pre-registration programmes within the University.

A number of different strategies were introduced including releasing example stories on a regular basis by e-mail in order to introduce the lecturers to them. The stories were recorded and made available as audio files to be used in lectures, within online teaching materials or released as podcasts.

Stories week was used to launch the Podcast site where the audio files were hosted and to encourage staff to use the stories in their teaching. Subsequently, an action day held within the School of Nursing Midwifery and Social Care provided an opportunity for staff already using the stories, to share their experiences and ideas. The work was disseminated/shared at the **Edinburgh Napier University Inaugural International Conference on Compassionate Care** (June 2010); Second **International Conference on Compassionate Care (June 2011);** and the RCN's Enhancing Practice Conference in Belfast (September 2010).

In addition to the LCCP stories, others were also highlighted during the Story Week sessions. These included several DVDs focussing on experiences of Compassionate Care made by the programme team and thought provoking scenarios on the RCN Dignity Project DVD.

Students were invited to submit their own story/ experience of compassionate care to earn a place at the International Compassionate Care Conference. One of these was read to the delegates during a keynote session and so well received that extra sessions were provided where each of the student's stories were made available.

The students were also given the opportunity to develop them into digital stories. The process for development of the audio files will now be discussed in more detail.

Podcasts/audio files

Two Teaching Fellowship grants were obtained through the University which facilitated an expert in media to be employed to record and edit the stories. A presenter from Radio Clyde provided an 'ident' in order to provide a project image for the stories and music was chosen to accompany the introduction to each story. The relatives and staff who had shared their stories were all invited to read and record them and a number agreed to do this. The others were read by volunteer lecturers, senior nurses from the LCCP and nursing students. Around 60 stories were recorded.

One of the challenges that emerged during discussion was how to share the stories so that they could be used for education, while preventing them being made readily available to the public on the World Wide Web. Although the participants had given consent to their stories being used, when the team began to recognise the possibilities for stories to be downloaded and copied, they questioned whether the participants had fully understood the potential implications. Therefore in order to restrict access, software that offered the opportunity to select privacy settings was selected (podbean.com).

A podbean site was set up and customised and used to host the audio files and a number of restrictions put in place to prevent the stories being used out with the University. The stories were themed and key words identified prior to uploading the stories onto the site.

Evaluation of the site, the stories and their use within teaching is on-going. It is evident that activities are required to remind and prompt staff about the stories as a teaching, learning and assessment resource within the School. The following evaluation strategies are being used:

1. Email staff to ask for feedback

- Used the stories?
- Which one/ones?
- How did you use them?
- Which module?
- Your views?
- Feedback from students?

1. Staff are encouraged to leave a comment on the online podbean site
2. A section within the student evaluation has been developed to explore student views on the stories and us of podcasts
3. Staff and students will be invited to participate on focus groups and share their views of using narratives for LTA

4.7.2 Feedback to Placement Areas

The team responsible for driving this strand forward are representative of both practice and higher education and are working together in partnership. However, it is likely that the team membership of this project will continue to evolve and grow as the work progresses.

Rationale for Action Project

Research has highlighted that caring for healthcare staff is strongly linked to enhanced patient care and better outcomes (Cornwell 2010). Carter et al. (2008) identified that caring teams and a supportive peer culture are pivotal to creating and sustaining a caring and healing environment.

Nurses in Carter's study maintained that they were more likely to be inspired to care for others by being cared for themselves (Carter et al. 2008). Based on this, the aims of the project focused on enhancing the mentor and student relationship. Thus by focusing on the benefits of supportive mentorship and the significance of caring role-modelling it is envisaged that this approach will reinforce the value of caring relationships amongst co-workers.

System in place pre commencement of Action Project

Within the current system there is limited opportunity for feedback to practice placements in relation to student and mentor experiences of compassion and caring within practice settings. The existing practice placement audit form completed by students and mentors consists of only one broad statement that focuses on compassionate care, which is:

Standard 2.2 – 'the core values of care and compassion are integrated and evident within the placement'.

Therefore in order to further develop the compassionate care theme and to make it much more explicit in the audit feedback documentation it was decided to review these and to add statements specifically relating to compassion and the practice placement experience.

Aims

Following a review of the existing audit feedback mechanism, the aims of this action project were:

- To improve the student and mentor experience of caring and compassion in clinical practice;
- To develop 'new ways of working and learning' that will support mentors to develop a compassionate and caring approach to mentoring students;
- To make compassionate care more explicit in the practice placement audit form that will enable more meaningful and tangible feedback;
- To explore how we can share and develop good practice in caring for both students and mentors.

Activity Plan

Activities to progress this strand have focused on the following key areas.

Student and Mentor Stories

As a starting point, student and mentor stories were collated for a presentation at the International Compassionate Care Conference, in June 2010. To elicit student and mentor experiences data were collated using emotional touchpoints (Dewar et al. 2010). The stories were themed and analysed using the Senses Framework

(Nolan et al. 2006). The Senses Framework was chosen as it has the potential to promote understanding of the experiences of others, thus enhancing communication and the ability to work in partnership. This framework is relationship-centred and provided us with a clear structure to enable us to obtain feedback from both students and mentors regarding what is important to them in relation to compassionate care in practice.

Placement audit review

A review of the existing student and mentor feedback mechanisms was undertaken by key stakeholders from practice, higher education and a representative from Nursing Education Scotland. A series of regular meetings were held and chaired by the lead practitioner for the Practice Education Facilitators (PEFs). Currently the Lead PEF and the PEF team meet 6 weekly and it is proposed that the audit review working group will work together to develop and share good practice.

New nursing curriculum – changes to placement audit forms

Working alongside the School of Nursing, Midwifery and Social Care's Director for the undergraduate pre-registration programme, changes will be proposed to ensure that compassionate care is made more explicit in the student and mentor audit forms. Statements will be identified and included so as to tease out experiences specific to compassion and caring. The national nursing and midwifery standards will be used to guide and underpin this work (NMC 2011).

Feedback to placements

Following the collation and analysis of future audit documentation, it is envisaged that this feedback will be disseminated to each placements will be disseminated by the link lecturer / PEF/ CHEF (Care Home Education Facilitator). Presently the role of the Link Lecturer is under review, and this is likely to present us with an opportune time in which to propose new ways of working in relation to providing feedback to placements. There is however likely to be a number of related training issues for both practice and academic staff and these will need to be addressed.

New lead mentorship forums have already been set up by the PEF group in many of the placement areas. It is expected these mentors are well placed to share and disseminate any good practice in relation to student and mentor placement feedback. In addition discussions are also taking place as to how such audit feedback can be best presented to share with our colleagues in practice and education and with hopefully health service users.

It is proposed that an appreciative inquiry approach (Reed, 2007) will be utilised to provide feedback to placements. The use of appreciative inquiry promotes practitioner involvement and allows them to recognise and celebrate what works well and motivates (Dewar and MacKay 2010).

This will go some way towards enhancing the caring cultures within our practice placements and support the Compassionate Care Programme values.

Mentorship development and support

It is envisaged that the already successful Edinburgh Napier University WebCT based 'mentor-centre' is a resource that can be used to highlight and explore student and mentor stories. There are two mentorship programmes that have been identified to support this development: the mentorship preparation programme for new mentors and the more recently developed 'up-skilling' sessions for existing mentors. The programme content will focus more on issues related to compassionate care: what it is, how it is experienced and how this is demonstrated and valued in busy clinical environments.

4.7.3 Developing Relationships in Busy Environments and Assessing Compassion Skills

Assessing compassion skills
Team: Liz Adamson; Dr. Belinda Dewar; Ria Tocher

Compassionate nursing practice within areas of high patient turnover has been considered to be a particular challenge (Kings Fund Point of Care 2011) and yet stories gathered within one such area as part of the programme contradicted this.

One of the priorities of the programme was to use the findings from the observations and story gathering within practice to influence and inform the nursing and midwifery curriculum in order to ensure that compassionate care is embedded within the programmes. After much discussion two action projects were taken forward as part of this. These were to ensure that compassionate care was not only taught but assessed and the second was to explore ways to teach students how to consistently provide compassionate nursing care in areas where this may be most challenging, for example in the acute emergency environment.

A module offered to third year nursing students was selected as a good place to start as the module focuses on the recognition of acute illness and deterioration within acute areas of practice. The aim was to make teaching compassionate care more explicit and ensure that it was also assessed. One important aspect emphasised was that the process provided a unique opportunity for practice and education to work closely together thereby informing this development which is known to provide unique learning opportunities for both organisations (Rattray, Paul and Tully 2006).

The module was developed in response to a growing awareness that nurses often fail to recognise the signs that patients' conditions are deteriorating. The module focused on teaching and facilitating learning so that student nurses know how to do this. The theory component is delivered online through WebCT in a series of units and students also participate in simulated practice where they managed scenarios such as a patient who was brought by ambulance to Accident and Emergency after being found collapsed in a wine bar or a patient knocked down by a car in the street. The teaching team participate in the scenarios as members of the multi-disciplinary team. This approach enables students to contextualise the theory within a 'near life' simulation using actor patients and manikins.

Students are asked to demonstrate within the practical simulation examination that they have the ability to recognise acute illness and deterioration, and take appropriate action to manage patient care. In a reflective session (debrief) following the practical assessment students are asked to give a rationale for their decision making and encouraged to reflect on their actions and learning.

Within a written examination, students are asked to demonstrate their evidence base used to guide actions and decision making. However from past experience of teaching these sessions, students were sometimes so focused on technical aspects of care that they forgot to speak to the patient and demonstrate interpersonal skills integral to compassionate caring. Although aspects of compassionate care were included within the scenarios the teaching team became aware that this was not explicit and was not assessed, making this appear more optional than necessary. This realisation led to a significant change.

What we did to change this:

We invited a range of participants, including lecturers, senior nurses in compassionate care, students and charge nurses to participate in an action meeting to explore key compassionate elements that needed to be integrated into the module. The participants reflected upon what matters to patients and families in the acute admission phase to hospital; key elements that nurses need to consider; and how care provision during this acute period can be not only safe and effective but also compassionate. We examined the findings in the context of the teaching and assessment materials including patient scenarios used within the module. The key elements discussed were found to be consistent with key themes drawn from data generated in the Beacon wards as part of the wider Leadership in Compassionate Care Programme. These are as follows:

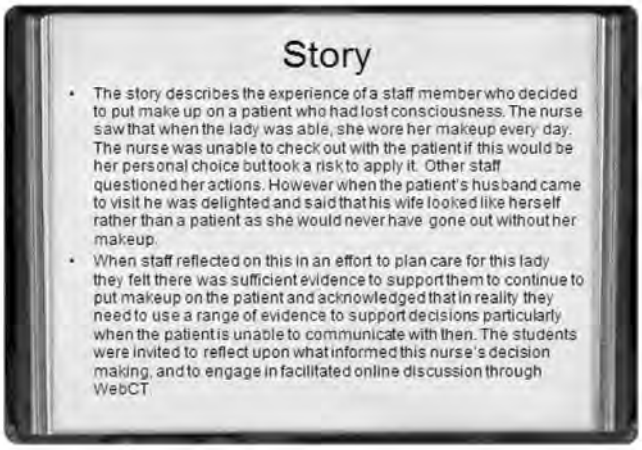
- a deliberate welcome and a smile costs nothing;
- making a connection and 'clicking' or helping others to connect;
- knowing how people are feeling, acting and responding;
- knowing the little things that matter;
- being kept in the loop;

- considering the dilemmas of giving compassionate relationship centred care;
- being open and real about expectations.

These themes were then further developed, described and incorporated into the module teaching and assessment materials; in the online theory; the practical simulation and written assessments. We will now look at these aspects in a little more depth.

Online theory delivered through WebCT

Through previous research and the recent findings arising from the LCCP, aspects of compassionate care were identified including the key themes that emerged and these were introduced to students. Quotations taken from the stories derived from the research in the Beacon Wards were presented to the students to encourage reflection around aspects of compassionate care. The students were then encouraged to consider the meaning of compassionate care, what matters to patients and relatives and how they can use this knowledge to influence their caring practice. The stories have been recorded and those aligning to the topics being taught were made available to students as podcasts throughout the module.



Research suggests that listening to the stories of patients enables a deeper and richer understanding resulting in more effective care interventions (Haddon 2009). Stories were chosen if they related to the topic material dealt with in each unit of online study. For example, the first unit of study deals with decision making and the following story will be used to discuss decision making in relation to compassionate caring.

The assessments

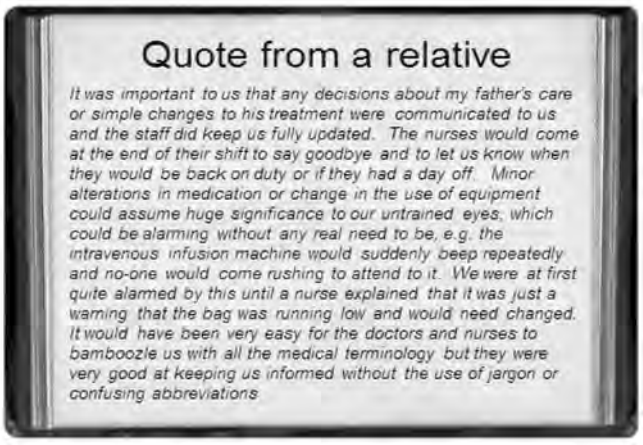
The assessment marking criteria was updated to include aspects of compassionate care. The students were awarded marks not only for taking appropriate action in relation to care management but for aspects of compassionate nursing practice.

Practical teaching sessions

A number of strategies were used to ensure that compassionate care was made more explicit within the practical teaching sessions. The ways in which two of these themes were made explicit within the simulated patient scenarios are now shared.

Theme 1: Being kept in the loop

Knowing what is happening and why things are happening is important to staff, patients and families. Being kept in the loop, particularly in the initial admission to hospital, is crucial since it is at this point that the patient and family may be particularly anxious and waiting to find out what is wrong.

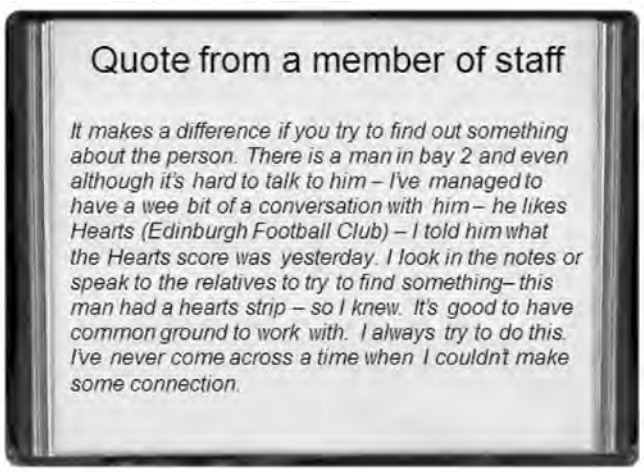


In order to ensure that keeping patients and their families "in the loop" was made explicit for students during the practical teaching sessions, information and instructions for actor patients' were reviewed. When the students failed to provide regular and appropriate information the actors prompted the students by using cues such as "What are you doing?" Will that hurt?" "When can I have a drink?" "How long before I get the results?"

The actors were encouraged to question the students when they use medical jargon such as "I'll just do your obs now" or "What are the sats?" During the facilitated reflective session (the debrief) that follows the practical patient scenario, students had the opportunity to reflect on what they did well and what they could have done differently and receive feedback from the lecturers which included aspects of compassionate care.

Theme 2: Making a connection and clicking or helping others to connect

The following quote demonstrates that making a connection is important:



The actor patients were asked to wear a tie or a scarf or some other item that could provide insight about the patient as an individual and that would open up conversation enabling a connection to be made. Importantly during the reflective session that follows the actor patient(s) are invited to provide feedback to the students on how they felt during the simulation and in particular in relation to aspects of compassionate care. Ramsey et al. (2008) found that most students rated feedback from actor patients as useful to their learning.

Results

The assessment results demonstrated that students were aware of the importance of compassionate nursing practice within areas of high patient turnover. The module evaluations showed that the students who listened to the podcasts (this was optional rather than compulsory) found the stories very moving and informative, and said that they had caused them to reflect on the experience of the patient, relative or staff member. The quotations from stories presented to the students within the module teaching materials resulted in some very sensitive intuitive responses in the online discussions.

Lecturers felt that there was definitely more discussion around aspects of compassionate care during the debrief (reflective session that followed teaching) and skills workshops.

Feedback from the actor patients included

"The students are now more personal. Two of three years ago they just did it and that was it, but now they try to connect with us since you have emphasised compassionate care"

What now?

The process of change used to make compassionate care more explicit within this module has been shared with colleagues as one example of how the stories can be used successfully to influence teaching learning and assessment within the nursing and midwifery programmes.

4.7.4 Supporting Lecturers

Consider proactive ways of supporting lecturers with emotional costs associated with the provision of compassionate care to students and practice staff

Team: Daphne Loads; Mandy Gentleman; Simon Pullin; Dr. Stephen Smith

This action project originally arose from focus groups that were conducted with nurse educators (lecturers and other staff from the School of Nursing, Midwifery and Social Care, Edinburgh Napier University) to explore their beliefs and values about Compassionate Care. There was agreement that compassionate care was a complex notion which could be influenced by both the context of care, and the individual(s) involved. Concurrently, there was also the emergence of other themes which included the importance of supportive student relationships, especially in relation to the role of the Personal Development Tutor (PDT), the role of the Mentor, and the

impact of these roles on student nurses when teaching the importance of respectful and caring interactions with patients. There was a sense that it was expected that nurse educators would be able to provide and nurture compassionate care in student nurses and practice staff but in reality there was little space, and busy timetables resulted in, limited opportunities where nurse educators could take the time to gather themselves, reflect and sustain themselves for this challenging work.

The project was based on the principles of Action Research, and the aim was to provide a restorative space through a series of four facilitated three-hour workshops over a period of nine months.

Nurse educators were invited to explore and reflect individually and together on their practice as compassionate educators using creative means. This project was facilitated by three of the staff members from the Compassionate Care Programme and one of the Academic Support Lecturers, who had expertise in using creative means as a method of working. The expectation was that the facilitators would also participate in the process and therefore formed part of the group.

Process

Attendees at an Open Day held by The School of Nursing and Midwifery were invited along to a 'Restorative Space Taster Session' and through the use of images participants were invited to explore their role within their School. Following this session an invitation was sent to all nurse educators within the School asking them if they would like to continue this work through the series of facilitated workshops. Six people responded and expressed an interest, giving a total of 10 (including the facilitators) participants.

Verbal informed consent from participants was obtained and it was confirmed that participation was voluntary and participants could withdraw from the project at any time.

Participants had the opportunity to:

- To identify their experiences of teaching and learning meant to them as nurse educators working in the University and in practice areas.
- Explore and reflect on individual and others' practice.
- Meet with colleagues from the School with whom they did not normally have significant contact with and/ also met with colleagues with whom they were familiar with and worked together in a novel and meaningful way using creative means to explore their practice
- Collage was chosen as a creative, non-threatening activity that provided an alternative and enjoyable way of representing individual experience(s). The revisiting of the artwork over a period of time supported and recorded the process of the development of key themes.
- Evaluation of the sessions allowed the identification of individual and group actions which could result in positive change.

Key themes emerged from this piece of work and both individual and collective actions were identified which may result in positive changes within individuals' practice but also that participants were able to reach a consensus as to what actions that they wanted to take forward collectively. There would be an opportunity for the research findings of this project to be conveyed to the Senior Management Team (SMT) within The School of Nursing, Midwifery and Social Care (SNMSC) and possible actions identified which may result in positive change on a strategic level.

Over the course of the four workshops participants were asked to explore and reflect on:

- How I am at work?
- How I want to be at work?
- How I can be part of, and influence the way that thing are done?
- How do I feel safe and supported to try new ways of working?
- What are we going to do next?

A short piece of music, 'Trauma, Trivia and Joy' was introduced at the start of each of the workshops as warm-up exercises (ice-breakers) to allow participants to convey how they were feeling

in an informal manner. Participants were also reminded of the staff counselling service which could offer additional support if required.

The creation of individual collage work was used as the means for participants to express their experiences, which was revisited throughout the four workshops. In the final workshop, a group collage was created which reflected the collective views of participants and identified the key themes that they wished to be taken forward and fed back to the SMT.

Through the development of a collaborative supportive network within the group, participants were able to provide support to each other and to identify and participate in actions which could possibly lead to positive change within the School (Loads, 2009).

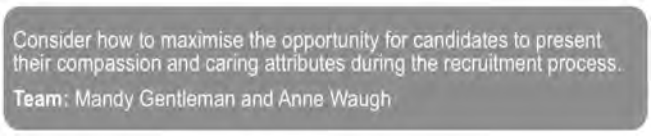
Outcomes

At the start of the process, agreed ways of working were discussed and a consensus reached as to what they should be and these were highlighted at the start of each session (Appendix 19). The use of collage provided an alternative way of exploring and sharing the participants' values and anecdotally participants have commented how using this creative means has helped them to articulate their thoughts and feelings (Williams, 2002; Barron et al. 2008). There have also been comments that it has been useful to look at the artwork again at each session as it has helped people to focus and remember what was discussed at the previous workshop. Key themes emerged from the workshops (Appendix 20) which enabled participants to discuss and reflect upon, and to consider how these impacted on their experiences of teaching and learning. Participants reported that as a result of having participated in these workshops, they feel they have developed an increase in their own self-belief as compassionate nurse educators as well as a greater appreciation of their own and their colleagues work. This requires further exploration.

Challenges

It has not been possible for all of the group participants to attend a workshop at any one time. This has been due to a variety of reasons including sickness and annual leave, however, the main reason for people not being able to attend the workshops has been due to their teaching commitments and being unable to make alternative arrangements. In some instances, people have been unable to prioritise the workshops due to their workload and an expectation that they will make the deadline set. On occasions, people have been called to unscheduled and 'urgent' meetings and there has been an expectation that they will attend regardless of what they has scheduled in their diary. There was a sense that the current ways of working can be fairly inflexible, expectations are placed upon people that are not always viewed as realistic and that the workload is not always as organised as it could possibly be. These factors could result in people feeling that they have little control over planning their diary. This requires further exploration.

4.7.5 Enabling candidates to demonstrate their compassionate and caring attributes during recruitment and selection



This project emerged from the first cycle of action research around the undergraduate curriculum which revealed this as an area where existing practice could be explored. Recruitment and selection processes would be reviewed using an appreciative inquiry approach.

A literature review was carried out with the aim of identifying current practice in respect of recruitment and selection of nursing and midwifery students and also those characteristics or attributes that enable students to complete their programmes and register with the NMC. In addition, retention was explored however the literature revealed many reasons for attrition rather than completion. In summary, the literature was inconclusive suggesting that this area required further exploration

An Appreciative Inquiry approach (Cooperrider et al. 2003; 2008) was used to underpin the project:

- *Discover* what is working well in your area;
- *Dream* of things we would like to see happening;
- *Design* how to achieve these things;
- *Destiny* how developments can be sustained.
- The first step, discovery, involved reviewing the established recruitment and selection processes used within the School and to benchmark these externally with the intention of retaining the positive aspects of current practice.

Three outcomes that emerged from the dream stage became the project aims:

- Candidates can apply for Nursing and Midwifery programmes using an Edinburgh Napier University person specification as a benchmark to allow for a degree of self-evaluation when considering an application to the programmes;
- Edinburgh Napier University staff are able to select candidates with appropriate personal attributes;
- Candidates will have an opportunity to demonstrate their caring and compassionate attributes during the selection process.

The UCAS website was searched to benchmark the Edinburgh Napier University entry. All Scottish nursing and midwifery programmes were reviewed as well as a selection of English programmes. A Google search for 'person specifications' and 'entry profiles' for student nurses and midwives was carried out but revealed only one exemplar. Two careers websites that included personal attributes were identified. This meant development of an Edinburgh Napier University person specification / entry profile for candidates would be required. Several HEI entries included links to the HEA UK-wide nursing and midwifery employability profiles and it was agreed to add these to the University entry. Navigation to the Edinburgh Napier programmes was improved so that people making a UCAS course search inquiry would see the University listed on the page of programme providers.

During the design stage a series of steps were involved. The first was to identify attributes for the Edinburgh Napier nursing and midwifery person specification. A list was created from the examples found to which ideas from the team were added (Table 6). It was decided to consult on personal attributes through a survey, which would inform development of the person specifications which could then be piloted. Finally the existing selection process would be reviewed.

Table 6
Values-based personal attributes included in the survey

- Responsible, good listener, reflective, patience, tact, sensitivity, good communication skills, compassionate , cheerful, numerate, literate, insightful, motivated, observant, good team player, honesty, trustworthiness

Ethical approval was granted by the Faculty Research and Ethics Governance Committee and review of the intended project was then sought from NHS Lothian Research Ethics Service. The project was classified as service evaluation which, following registration with NHS Lothian Quality Improvement Programme did not require further approval and the survey could proceed. A small pilot study was conducted to test the reliability and validity of the questionnaire. The full survey is included as Appendix 21.

The online Ultimate Survey™ included all academic staff and students in the School of Nursing, Midwifery and Social Care and all NHS Lothian Registered Nurses and Midwives. It was undertaken during four weeks in summer 2010. Identical paper questionnaires were made available to delegates at the Inaugural International Leadership in Compassionate Care conference hosted by the University in June.

The link to the online questionnaire was e-mailed to all staff and students in the School and posted on the Student Portal and MentorCentre[1]. The NHS Lothian Director of Nursing cascaded it to all registered nurses and midwives via the Chief Nurses and the NHS Lothian Lead for Practice Education also forwarded the link. A reminder was sent through all these mechanisms one week before the survey closed. The data from the

survey (n=520) are being analysed at the time of writing and will be disseminated in due course.

Destiny, the final stage is as yet to be realised but will result in development of a person specification for prospective nursing and midwifery students and also ensure a fair and transparent University recruitment process that enables all candidates to have the opportunity to demonstrate their compassionate and caring attributes. A recent Scottish Government (2010) report indicated that there is no person specification available for prospective nursing and midwifery students and the final stage of this project will provide a useful resource for HEIs nationally.

4.7.6 Compassion within students' Personal Development Planning Process: An evaluation

Consider how to include compassionate care as a component of a student's personal development planning process

Team: Linda King; Janis Ross and Mandy Gentleman

Background

This evaluation study formed part of the Leadership in Compassionate Care Programme (LCCP) and relates to Programme Strand 3 which broadly involves consideration of embedding the principles of person-centred compassionate care within the undergraduate curriculum.

The aim of this study was to evaluate the current Personal Development Tutor role in terms of the support provided in the context of this role and to consider how to include or further enhance compassionate care as a component of a student's personal development planning process.

The Personal Development Tutor (PDT) has been in operation at Edinburgh Napier University since 2006/07 and involves students and academic staff and has the overall aim of enhancing the student experience throughout their programme. The system is designed to offer support and help to students throughout their programme and involves on-going reviews of academic progress and performance. The form of communication between students and PDTs includes one-to-one meetings, group tutorials, email and telephone communication and can vary depending on Faculty and Subject area (Edinburgh Napier University, 2009). The role of the PDT is broadly defined as advising on academic matters; sign-posting relevant sources of support; active engagement in supporting students in the personal development planning process and in working with students to write mutually agreed references (Lambert & Johnston, 2010).

Methodology

The Leadership in Compassionate Care Programme (LCCP) used an action research approach to embed compassionate care in healthcare practice and education. The aim of this study was to ascertain what students and staff who were acting as Personal Development Teachers (PDT) deemed to be important in terms of the support provided within the context of the Personal Development Teacher role.

Data were generated using the emotional touchpoint method with 6 students and 5 lecturers. This involved using prompt cards to facilitate and promote discussion surrounding the PDT experience.

The benefits of this approach are that it allows participants to see in a more balanced way the positive and negative aspects of an experience and to help them take part in a meaningful way in developing provision of the service.

Students (n=6) were asked to think about the key times in their experience of personal development support and guidance. This could have occurred during the trimester professional development discussion or other student-personal development teacher interaction. We asked students how they felt about their experience within the context of the PDT relationship.

Staff (n=5) were asked to think about key times in their experience of the personal development teacher role and the kind of support and guidance they provided. We wanted to know

how they felt about their experience as a PDT and they were asked about what aspects of the experience they valued and what aspects of the experience they felt could be improved upon. This might be during the trimester professional development discussion or other student-personal development teacher interaction.

Emotional Touchpoint process

A comparison was then made between what students' value in terms of the PDT role and what staff' value and on the basis of this it can be established to what extent compassionate care is already a part of the PDT and student relationship and to make recommendations to enhance this element of the PDT role.

Results

Interviews using the Emotional Touchpoint method were carried out and audio recordings and interview notes were taken from staff (n=5) and students (n=6). On the basis of information obtained from these interviews, themes were derived for both staff and student interviews and these are outlined below:

Student Interviews – Themes

Three themes emerged from the data analysis and these can be seen in Table 7 overleaf:

Table 7: Themes emerging from Student Interviews

Students also expressed their views regarding the outcomes related to their personal development planning process and highlighted areas that they believed were challenging.

Academic	Personal Qualities	Compassionate towards students
• Challenging–in a good way/appropriate balance between supporting and challenging • Knowledgeable/competent • Resourceful/pointing me in the right direction as to other sources of support • Sign posting–guiding/ moving me forward • Positive experience related to working together on academic assignments/ this builds a positive relationship and continuity • Providing Reference • Face to face communication at essential points • PDT is important academically, personally and professionally– understands nursing and professional issues • Mentor	• Going the extra mile/ exceeding expectations • Inspiring • Non-judgemental • Giving and enabling/2 way respect • Time/making and giving time–often going beyond may be considered reasonable • Enthusiastic and encouraging • Interested in student	• Feeling safe–knowing someone is there for me and interested • Building a relationship and working together/positive mutual regard/trust building/not necessarily hierarchical despite differences in power • Counsellor–caring role/ demonstrated compassion and insight • Taking the time to care/ taking a personal interest • Personal and professional support • Making time for me and my personal issues/face-to-face important • Feeling respected and respecting-mutually

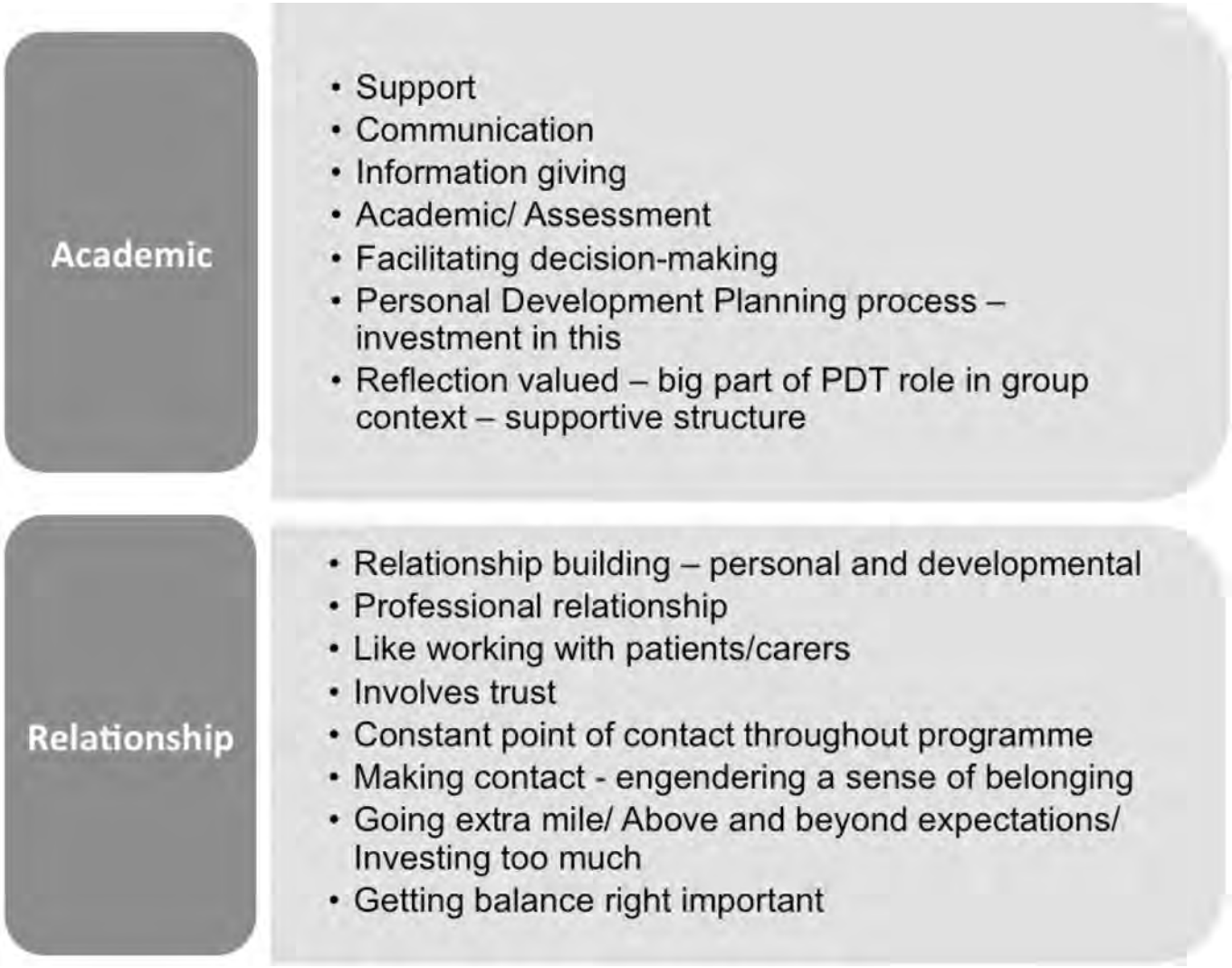
Students also expressed their views regarding the outcomes related to their personal development planning process and highlighted areas that they believed were challenging.

Outcomes

- A developmental relationship that builds over the 3 years / one 'constant' relationship in the University/ most important relationship to you
- Influences attrition rates
- 1:1 meetings were important/ worthwhile
- E-mail responses/communication were useful and supportive
- Enabled me to succeed
- Confidence building
- A point of contact – especially in such a big organisation/ not feeling alone/key person
- They got to know me/know what help I needed and how best to provide help – person centred
- Experienced positive role modelling – learning about communication / listening/use of silence – enhancing your own skills that are then used in practice.
- Developing you to become more of an adult learner/ challenged in a good way
- Some confusion about what the role is and how we the students should best use it. Defining difficult though as there needs to be flexibility as it is about the relationship (individual and unique)
- Student expressed preference for Edinburgh Napier University approach compared with other university experience of PDT. Not just there for problems – a relationship and contributor to personal development.
- Student felt valued and motivated
- Student appreciated support and has remained on the programme (leaving had been a real possibility)
- Student would know how to deal with difficult situations in the future
- Promoted personal development and confidence

Challenges

- Time – student time to see PDT (on placement)/PDT to see students (number of students)
- Communication – OK once method agreed.
- Improved use of whiteboard communication.



Lecturer/PDT Interviews – Themes

Two themes emerged from the data analysis:

Lecturers reflecting on their personal development tutor role identified three areas of importance to them:

Positive aspects of PDT role

- Increased involvement with students – interested
- Compassion towards students
- Making a difference
- Enthusiasm for role
- Rewarding – sense of satisfaction
- Academic achievement – PDT contribution – satisfying when students do well
- Feeling appreciated and valued
- Mutual support

Challenges of the PDT role

- Expectations variable (role/contact)
- First opportunity to introduce ourselves/
- meet in a group important but not able to do this last trimester
- Powerlessness – university policy/systems
- Conflicts in role – between personal and professional aspects
- PDT role changed – more expected
- Balance between academic and pastoral support
- Pressured role/time
- Frustrating
- Challenging

Support requirements in the PDT role

- Colleagues support
- Need some form of clinical supervision
- New lecturers – need support – Noddy`s Guide to being a PDT

4.8 Next steps

The next stage of the evaluation process is to use an adapted version of the Senses Framework (Andrew et al. 2011) as a tool for analysing the student and lecturer data. This will focus on the student and lecturer experience of the PDT role and explore the potential for the Senses Framework to underpin a learning community. On the basis of this recommendations will be made in terms of enhancing compassionate care within the PDT role.

4.9 Conclusions from Strand 3 Embedding the principles of compassionate care within the undergraduate curriculum

Activities with this strand were varied and deliberately attempted to address issues of compassionate care in different contexts within the School of Nursing Midwifery and Social Care. The direction of travel was indicated following focus groups with students and academic staff. Focusing on activities such as recruitment / selection, and the personal development planning of students, enabled compassion to be highlighted within these important processes, particularly in regard to support and ongoing development of students. Introducing stories and focusing on the integration of evidence and the assessment of compassion directly targeted teaching learning and assessment activities. Providing feedback to placement areas aimed to ensure that this strand had an impact on the experience of student learning within clinical practice and working directly with academic staff within the context of a restorative space ensured a focus on compassion the providers of education.

It is evident that work and evaluation is ongoing in all of these projects and development requires to be consistent with processes and regulations in nursing and midwifery education practice such as validation of programmes and addressing Nursing and Midwifery Council standards for undergraduate education for student nurses and midwives. For example at a recent programme validation event, the activity of feedback to clinical areas was strengthened in light of the feedback received by reviewers.

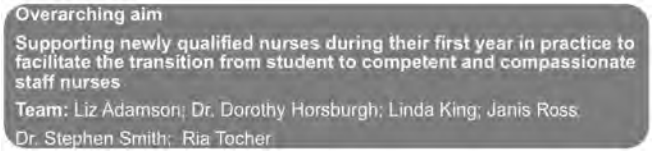
Integration and sharing learning between practice and education as part of the LCCP has been crucial for developments to take place. Future work involves completing the action projects described above and sharing the learning from this report with academic staff across the School of Nursing Midwifery and Social Care.

Chapter 5: Programme Strand 4

5 Introduction

This strand involved newly qualified nurses during their first year in practice, taking part in a number of specifically tailored study days. The theme used an action research approach with participants learning together as well as providing data through study-day evaluation questionnaires and interviews.

5.1 Executive Summary



This strand involved newly qualified nurses during their first year in practice, taking part in a number of specifically tailored study days. Within the study days a range of teaching and learning activities were undertaken. Five study days were held each year and newly qualified practitioners were invited to each. Study days included a motivational presentation from an experienced health care provider, interactive sessions focussed on compassionate care, small group activities that linked to the NES Flying Start™ programme for registered health care practitioners. Participants were able to complete an aspect of their portfolio as a result of this activity. Participants also took part in small reflective groups where they shared their experiences and supported one another, this was highly valued. Creative activities were incorporated into the study days, these were focused on key themes from the LCCP, for example the Clown Doctors ran sessions on communication and feedback. Evaluation of the study days involved participants completing study-day evaluation questionnaires, comments indicated that the relaxed atmosphere of the study days, in conjunction with their content, made these a positive and thought-provoking experience with the potential to enhance participants' practice.

Participants in the study day had the opportunity to take part in qualitative research, the research question was:

Research Question: To explore newly qualified staff nurses' perceptions of compassionate care and factors that facilitate and inhibit its delivery

A constructivist grounded theory approach was adopted and the study was was carried out with participants during their first year following registration. Data collection was by focus group interviews (n=7, total participants =42), small group interviews (n=1, participants = 2) and individual interviews (n=2), using a flexible agenda to guide discussion but which ensured that participants were able to address issues relevant to them within the remit of the research questions.

Findings of the study identified that support for newly qualified staff was eclectic rather than systematic with participants stating that they did not realise at the time how supported they had been during their undergraduate practice placements. Some participants considered that the undergraduate curriculum should focus in final theory and placements on the realities of practice rather than providing what they considered to be an idealised view. Participants felt that they were 'flung in at the deep end' and 'left to sink or swim'. Some staff were perceived as being 'in with the bricks' and resistant to change of even a minor nature, creating an environment described by one participant as 'institutionalised negativity'. Clinical supervision was perceived as a very positive support in areas where it was used and a 'buddy' system was suggested by one focus group.

Compassionate care was a tautology for most participants i.e. care would not be care in the absence of compassion. The concept was frequently described by examples of situations in which compassion was not present. Nursing was described as 'more than just a job' and an occupation in which 'emotional engagement' is not only desirable but is a prerequisite for provision of high quality care.

The findings indicated a tension between 'agency' i.e. the ability of individuals to act and 'structure' i.e. the physical, social, managerial and cultural environments within which care takes place. Supportive environments facilitate provision of compassionate care although individuals are accountable for their own practice regardless of the structures within which they operate.

Key Learning Points:

- There are implications for the undergraduate programme in preparing students for the reality of practice i.e. providing strategies to deal with the transition and advice about support mechanisms that will be available to them e.g. clinical supervision.
- There are implications for managers of care settings in ensuring that support systems are in place to reduce the feelings of initial inadequacy and eclectic support described by staff nurses in this study. Support systems need to be formalised rather than ad hoc.

5.2 Literature Review

A literature search was carried out at the start of the programme and re-run on two occasions during its course, the final search being undertaken in December 2010. The Elton B Stephens Company (EBSCOHOST) was used to access the Allied and Complementary Medicine Database (AMED), the British Nursing Index (BNI), Cumulative Index to Nursing and Allied Health Literature (CINAHL) and MEDLINE with searches commencing in 2000.

Initially a Boolean search for 'newly qualified' (without occupational specification to ascertain whether research about newly qualified practitioners in other professions might yield transferable material) AND 'compassion' OR 'compassionate' yielded 2 results, neither of which was relevant. The December 2010 search yielded one additional paper by Adamson et al. (2009) relating to development of a nurse education project as one component of the Leadership in Compassionate Care Programme.

A second search was carried out of the above databases using 'newly qualified', yielding 624 results. Titles were scrutinised and, when these appeared relevant, abstracts were read. Nineteen papers were reviewed, the following ten of which are the most relevant for the purpose of this short report.

Gerrish (2000) reported on her interview studies with newly qualified nurses in the UK thirteen years apart (1985 n=10 and 1998 n=35) exploring their transition period. One finding was that whilst the more recently qualified nurses demonstrated a more active learning style in conjunction with preceptor support compared with the earlier group who 'fumbled along' there remained a need to develop undergraduate curricula and supportive measures to ensure a smooth transition in role.

Whitehead (2001) undertook a small scale qualitative study (n=6) in the UK of newly-qualified staff but the details provided are very brief. Her findings indicated themes of uncertainty, responsibility and accountability, lack of support, insufficient preparation and training for the role and the need for management experience in advance of, and subsequent to, registration. Preceptorship following registration was suggested.

Ross and Clifford (2002) in the UK studied the experiences of a subset of one cohort of students (n=30) by questionnaire (completed by 19 students) three months prior to completion of their programme followed by semi-structured interviews with four volunteers from the group to confirm themes. Four months following registration the questionnaire was distributed again to explore the reality of practice (completed by 13 of the original 19 participants). Findings suggested that the transition period was stressful and the authors advocated undergraduate curriculum change and measures to address inconsistencies within preceptorship programmes for newly qualified staff.

Fox, Henderson and Malko-Nyhan's (2005) longitudinal study of new staff (not specified as newly qualified) in Australia stated that 'they

survive despite the organizational culture, not because of it'. Their findings were that between 2-3 months following appointment, participants highlighted negative interactions with other staff and inadequate assistance and support. Between 6-9 months participants reported being self-reliant and familiar with work systems.

Clark and Holmes (2007) conducted an exploratory study in the UK using 12 focus groups (n = 105) with newly qualified staff, experienced staff (preceptors) and practice development nurses. Individual interviews were carried out with ward managers (n=5).

Newly-qualified staff considered that they were expected to complete work for which they felt themselves unprepared and ward managers' expectations of newly qualified staff were not high. The authors emphasised the need for relevant support of newly qualified staff to ensure their competence and confidence.

O'Shea and Kelly (2007) interviewed ten newly qualified staff nurses in the Republic of Ireland who described stressful experiences related to the responsibility of their role and their perceived deficit in management and clinical skills.

The authors concluded that development of undergraduate curricula was required to ease the transition from student to staff nurse and also that systems were required to support newly qualified nurses in their new role.

Maben, Latter and Macleod Clark (2007) provided evidence from a longitudinal study of the sustainability of ideals and values in newly qualified nurses in the UK. A questionnaire was completed by final week student nurses (n=72), 26 of whom were interviewed in-depth at 4-6 months and again at 11-15 months post qualification. Findings indicated that the first two years post-registration resulted in 'sustained idealists', 'compromised idealists' and 'crushed idealists'.

Evans, Boxer and Sanber (2008) carried out individual qualitative interviews with newly qualified (n=9) and experienced (n=13) staff nurses in Australia, the purpose of which was to gather data about programmes in place to aid the transition period. The support provided by programmes was viewed as a strength but clinical environments were unsupportive and expectations of the competence of newly qualified staff were unrealistically high.

Data about psychological stress experienced by qualified nurses and nursing students, collected in a longitudinal study in the UK between 1994-1997 were subject to fresh analysis by multi-level modelling (Watson et al. 2009). Findings indicated that stress was higher in newly qualified nurses but that this returned to the same level as nursing students over a four year period. Aside from possible challenges to multi-level statistical modelling the authors acknowledged that participants' personality traits at baseline were not identified, making subsequent comparison impossible and that the transition from student to newly-qualified and experienced staff nurse was not followed through in individuals over the period of the study; the participants were cohorts of staff nurses in years one to four following registration. Additionally, the most recent data were collected 13 years ago, since which time care environments have undergone considerable change.

Duchscher (2009) used the term 'Transition Shock' to theorise how newly qualified nurses in Canada were confronted with many changes, physical, intellectual, emotional, developmental and sociocultural. She concluded that transition shock has implications for an undergraduate preparation that ensures successful integration of qualified nurses into the world of practice.

Pellico, Brewer and Kovner (2009) analysed 612 US newly licensed registered nurses' comments about work provided by mail survey and identified themes of 'Colliding Expectations', 'The Need For Speed', 'You Want Too Much' and 'How Dare You' (the latter referring to the nurses' feelings about the way in which they were treated).

Stacey and Hardy (2010) in the UK suggested that what they termed the 'reality shock' of becoming a staff nurse could be ameliorated by an approach using digital story-telling by newly qualified staff. Digital stories about challenging events provided a tool for students to reflect on the challenges associated with professional practice.

Higgins, Spencer and Kane (2010) conducted a systematic review of the experiences and perceptions of newly qualified nurses in the UK.

Their reference list was checked for sources not located by the EBSOHOST search and three additional papers of relevance were identified; conversely the EBSOHOST search had yielded papers that Higgins, Spencer and Kane did not review. They concluded that transition to newly qualified staff nurse was a stressful experience, one cause being lack of support once qualified. Recommendations were for further research in relation to transition, including undergraduate preparation for registration and the need for support in practice.

This brief literature review indicated that the transition period from student to newly qualified staff nurse was stressful, that preparation for practice in undergraduate programmes was insufficient and that there was inadequate support of newly qualified staff in practice. There was nothing in the literature that provided information about compassionate care and newly qualified staff, a gap which the LCCP study attempted to address.

5.3 Description of scope

Newly qualified nurses working within NHS Lothian were invited to study days. Past nursing students from Edinburgh Napier University received letters of invitation, and other universities in Edinburgh were provided with information about the study days. Flyers advertising the study days were also distributed across NHS Lothian. Newly Qualified Nurses were invited to attend during their first year of registration. The study days aimed to inspire and motivate newly qualified nurses and to help them engage with NHS Education Scotland's Flying Start™ Programme.

Learning outcomes for study day were:

1 In response to hearing the experiences of others, consider issues of personal motivation and achievement;

2 Develop an enhanced understanding of care and compassion;

3 Consider the opportunities and challenges (both personal and organisational) to providing care that is compassionate within your practice setting;

4 Identify methods and actions that enable progression through the Flying Start™ programme.

The study days included a talk from an inspirational speaker; group discussion; reflection sessions; presentation from the LCCP team; and an opportunity to complete an aspect of the Flying Start Programme. The study days were planned so that participants could attend one or five within their first year, as each day had new content. The study days included lunch and were held in pleasant surroundings usually in Edinburgh Napier University's Craighouse Campus. The team considered these aspects an important part of the participants' experience.

Evaluation forms were completed by participants at the end of each day and focus groups / interviews were held by the research team (Dr Dorothy Horsburgh and Janis Ross). An example of a completed evaluation form can be found in Appendix 12d. During 2009 and 2010, NHS Lothian developed a four day induction programme for all newly qualified practitioners, and the fourth day focussed on compassionate care and the LCCP study days were incorporated into this programme. This development broadened out the audience of the study days to include newly qualified allied health professionals and nurses. Participants attended from a wide range of healthcare settings and had varied roles e.g. community nursing; outpatient departments; and ward based roles. In 2008, there were four study days, in 2009, there were five study days and in 2010 there were five study days (total of 14 during the three year programme).

Monitoring numbers of participants that attended these study days was complicated due to the fact that different registers were held, one for those who came to the study days out-with the NHS Lothian induction programme and one for those staff participating in it. The numbers of participants per study day ranged from 25 up to 60. An estimate of the total number of attendees would be 420 assuming an average of 30 attendees per day allowing for some participants attending more than one study day.

5.4 Study Day Programme

Inspirational Speaker

Each study day commenced with a presentation from an inspirational speaker. The speakers were invited to the study days with the aim of inspiring and developing confident and compassionate nurses. All speakers were delighted to contribute to the project and valued the opportunity to meet with newly qualified staff and demonstrate their commitment to the compassionate care programme.

The speakers came from a wide range of professional roles within and out-with nursing all conveying a common goal: to inspire leadership and to explore the professional and personal qualities that help to overcome actual and perceived challenges. Speakers shared with the audience personal and professional challenges that they had encountered both in their life and career journey. Examples of this related to a story of tragedy and survival (mountaineer, Jamie Andrew), the highs and lows of a personal triumph (RCN Dignity in Care researcher, Charlotte Wilkinson) and the steps and decision making along a professional journey (Director of Nursing – Lothian, Melanie Hornett).

The overall structure of the study day enabled the group facilitators to make meaningful links with the speaker's presentation and as the day progressed group discussions and activities reinforced the inspirational speaker's key points.

The inspirational speakers' session was highly valued and positively evaluated. In particular positive comments related to the opportunity of having a real life meeting with the person behind the 'important' title and being able to engage face-to-face with the speaker in the question and answer session. Additionally, students commented that this session had made them feel valued and that the speaker's insight and experiences had helped them to release a mind-set that anything was possible.

Leadership in Compassionate Care Programme (LCCP) Inputs

Within each of the study days for Newly Qualified Practitioner programme the LCCP team shared experiences and examples from the LCCP programme. The premise of this was to encourage exploration, reflection and discussion of participants practice and learning from others.

Each of the study days were themed and focussed on a particular element of compassionate care. For example in the third year, the themes for each of the study days were:

The LCCP team used a variety of approaches to engage participants in these sessions that included:

- Providing an overview of the LCCP programme and examples from practice along with the opportunity for discussion;
- Workshops on the practical use of hearing peoples experiences of care using emotional touch points. This workshop included demonstrations of how this is done along with participants trying if out for themselves;
- Exploring real issues through acting out scenarios and asking participants in groups to consider how they felt, what they thought was going on. Then asking the characters questions to identify what was good and how could it be different;
- Using creative activities such as collage to explore participant's experiences of being newly qualified;
- Exploring the use of other methods used within the LCCP programme such as beliefs and values clarification and observation;
- Facilitated discussion groups on the challenges of being newly qualified and how to move to action in these challenges.
- Presentation with question and answer sessions from staff within the senior nurse's areas in their experiences of being newly qualified and how they have overcome this.

Creative Activity

Learning and Teaching Scotland (2010) define creativity as:

"A way of thinking in which we look at familiar things with a fresh eye, examine a problem with an open mind about how it might be solved, and use our imagination rather than our knowledge to explore new possibilities rather than established approaches."

This is why creativity was included into every Newly Qualified Study Day. We used methods such as collage work or making gifts, or invited Fischy Music or Hearts and Minds to deliver their unique approach to improving health and encouraging communication.

Collage work helped participants to explore and share their understanding of compassionate care. While making their collages they find a common language to discuss the complexity of delivering compassionate care in the real world of practice.

Making gifts is an exercise in giving and receiving feedback, which was the theme of the day. Participants were asked to choose a person and make a gift for them, using creative materials.

The giver of the gift then explains the significance to the receiver. Giving and receiving feedback is a challenge and a useful skill to develop as a newly qualified practitioner.

Fischy Music aims to promote emotional, social and spiritual health and wellbeing through songs. By joining in with Fischy Music, participants experienced how music affects individuals. The experience opened minds to the use of music in the workplace and life. Many participants had never considered using music in this way.

Hearts and Minds use clown-based techniques to encourage communication, interaction and laughter for people in hospital. They use techniques, which help participants to think about body language, expressions and to laugh with each other. This demonstrated the power of non-verbal communication. There was a lot of laughter and games, where making mistakes reminded us we are only human.

Flying Start™ Activity

Within the study day for newly qualified nurses we included a small group activity that was linked to the NES Flying Start programme for registered health care practitioners. Flying Start is an online programme of study designed to develop confident, capable health care practitioners and they are encouraged to complete this during their first year following registration.

Research has shown that due to a number of factors, many practitioners do not achieve this (Roxburgh et al. 2010; Banks et al. 2011). This study day was an ideal opportunity to link content to an appropriate Flying Start activity. The participants were able to achieve part of the flying start programme by the end of each study day.

The study day theme directed the choice of activity however we were also aware of topic areas flagged up by participants. For example giving and receiving feedback was highlighted as an area in which the newly qualified practitioners wanted to develop their skills and this is a topic covered in Flying Start.

We also incorporated quotations from stories derived from clinical practice to inform and encourage reflection, thus feeding back into the professional development of the very practitioners involved in the care delivery at the point of data collection. For example, on Staff Nurse shared:

"During my first shift I felt naked and exposed. I felt scared of what lay ahead of me. But by the end of the shift these feelings softened as I had developed a thin layer of familiarity and ease in my new working environment"

After reflecting on this quotation the practitioners were asked to explore their own views and feelings in relation to working within a team and share any positive experiences that helped them to be at ease in new environments.

The study evaluations demonstrated that the participants found the activities useful and it helped many of them progress through the flying start programme.

5.5 Evaluation methods

Evaluation of study days was conducted by questionnaire (please see Appendix 12d). Questions in the original version asked what participants had found most helpful and least helpful; there was minimal response to the latter question and the questionnaire subsequently asked whether anything that could be done differently. In addition participants were asked to state what they had learned from the day and if they would think differently about aspects of practice with a request to expand on this. The questionnaire concluded with space for free comment. Whilst it was not compulsory to complete the questionnaire most participants did so.

The research question was "How do newly qualified staff nurses perceive compassionate care and what facilitates and inhibits its delivery?"

Approval to undertake the study was provided by the Faculty of Health, Life and Social Sciences' Research Ethics and Governance Committee.

As there was no literature exploring experiences of newly qualified staff in relation to compassionate care a qualitative approach was appropriate. Data collection was from focus groups (n=7, total participants 42) a small group interview (n=1, with two participants) and individual interviews (n=2), facilitating exploration of the perceptions and perspectives of newly qualified staff.

Data from focus groups are forged in the interaction between participants which may enhance in-depth responses but they have the potential for some participants to dominate the discussion whilst others are inhibited. Facilitators ensured that all members of the group had the opportunity to participate actively in discussions.

A constructivist grounded theory approach (Charmaz 2006) informed the study, a development of Glaser and Strauss's (1967) and Glaser's (1978) grounded theory approach but which acknowledges the existence of many perspectives and views of reality. Symbolic interactionism, first described by Mead (1934, 1964) and expanded upon by Blumer (1969), is a theoretical underpinning compatible with grounded theory.

Symbolic interactionism is based on three premises; that people will act towards the things/people they encounter according to the meaning these things/people hold for them, that the meaning that things/people hold is learned and developed in social interaction and that such meanings are subject to review and possible modification by the person encountering them.

Sampling was purposive i.e. all staff nurses within one year of registration were well-placed to provide data relevant to the research questions. Participants were recruited at Study Days for Newly-Qualified staff nurses. At commencement of the day the researcher (Dr. Dorothy Horsburgh) outlined the study and distributed information sheets. She made herself available during the lunch period for questions and those who agreed to participate identified themselves following lunch. Focus groups and interviews were held in a separate room within the building lasting approximately 45 minutes.

Focus groups usually comprised participants from different areas; adult, child, mental health and learning disability. Participants were practising in a variety of locations; acute care, care of enduring conditions and community care. They were at different stages within their first year post registration.

As 'Flying Start™'[1] delegates attended a session specific to them that overlapped with focus groups/interviews they were seldom eligible to participate in the study. When able to do so, data indicated that their inclusion in all groups would have enhanced the study further.

The agenda for focus groups and interviews was flexible but covered the participants' perceptions of the following: discussion of expectations, support and undergraduate preparation for practice provided a useful route to discussion of compassionate care:

- expectations of their role
- whether expectations were met
- level of support in their new role
- preparation for practice in their undergraduate programme
- concept of compassionate care
- factors that facilitate/inhibit provision of the best possible care

Focus groups and interviews were audiotaped and transcribed verbatim. At focus groups a note-taker was present in addition to the interviewer, providing a useful guide as to which participant was speaking and non-verbal communication. Collection and analysis of data by coding and categorising were on-going throughout the study i.e. analysis of one focus group/ interview was compared to earlier data.

5.6 Findings

Study Day Evaluation Questionnaires

Questionnaires related to content of the study days. Participants reported enjoying both the atmosphere of the study days and the activities. Motivational speakers were described as inspirational and participants reported renewed enthusiasm for their job. The most significant thing they identified learning was that they were not alone in their feelings about the transition from student to staff nurse and the opportunity to discuss their experiences in a relaxed atmosphere increased their confidence.

In relation to thinking differently following the study day some participants identified emotional touchpoints or the use of humour where appropriate as being something they would consider implementing in future practice. One participant identified the need not to compromise practice in the light of some colleagues' reluctance to change and progress. Participants found that feeling rather 'out of their depth' was the norm rather than the exception, and identified the need to reflect on, and share, experiences.

One participant wrote that "Compassionate care is a misnomer. Care has to be compassionate or it isn't care", a sentiment reiterated by participants in focus groups and interviews.

Focus Groups / Small Group Interviewing / Individual Interviews

In relation to expectations versus reality participants stated that:

"It's a very big transition from student to staff... you think you're prepared and, you know, you're not". They found it "Scary...being out there on your own...people just think you'll know what you're doing" and "...the public sees you as a nurse; they don't see you as a newly qualified nurse...and you are expected to know about everything and you don't."

In relation to their preparation for practice during their undergraduate programme participants identified skills' sessions (psychomotor and affective) as useful although these were sometimes well in advance of their application to practice. Some theory sessions, for example "breaking bad news", provided concepts and strategies that could be implemented successfully in practice. Participants considered that greater focus should be placed on the reality of being a registered nurse rather than an idealised view.

The management/consolidation module that students undertook immediately prior to completion was of particular use, providing opportunities for 'practising' at being a staff nurse without ultimate accountability; "*I think the management placement is the best tool there is to prepare you." d*

One finding, repeated at most focus groups and interviews, was that newly qualified staff did not appreciate at the time how well-supported they were as students. (Students have formalised support networks comprising placement mentors, link lecturers, personal development teachers, module leaders, cohort leaders and programme leaders, all of whom may be approached with placement issues.)

The support participants received in their role differed widely and appeared to be 'the luck of the draw' rather than formalised and structured i.e. was down to individuals with whom the participants worked rather than co-ordinated by management.

They described having to *"sink or swim"* although for some, *"I think regardless of the amount of support you get you still feel like you've been thrown in at the deep end."*

The concept of 'the deep end' and 'being flung in' was reiterated by participants at all focus groups. A 'buddy system' was suggested by some participants as helpful during the transition. Clinical supervision was identified as very supportive in areas where it was used; in focus groups participants who had benefited from this provided information for the others about how to access it. Participants in two of the focus groups considered that the focus group discussion was in itself therapeutic.

'Flying Start' participants identified good support from the programme but insufficient time in which to make the best use of all it offered. At the end of a twelve hour shift staff felt the need to relax rather than study. Another finding was that undertaking 'Flying Start' in some cases made ward staff less supportive i.e. they assumed that 'Flying Start' was providing support thereby absolving them from any obligation to do so.

The phrase *"in with the bricks"* was used to describe the entrenched views and resistance to change of some staff. One participant said, *"...you've got loads of different fresh ideas that you want to implement,[but are] told that they're not going to work..."*. Another participant in a later focus group described *"institutionalised negativity"* in which staff were resistant to change of even a low key nature. One participant did however consider that staff shortages and the impact on those who had been in post for many years may have led to *'burnout'*.

Being a staff nurse in a Beacon Ward did not necessarily guarantee a 'smooth transition' as participants from one of these areas illustrated challenges within the care setting. For example 'feedback fortnight', for which staff compiled feedback for their colleagues and to which the participant contributed found that *"...the participation rate is not particularly high...extra work...we're busy enough without giving people other things to do, I guess."*

In relation to participants' perceptions of compassionate care the term was viewed by most as a tautology i.e. compassion was perceived as an integral feature of care; without it 'care' would not exist. Nursing was described by many as *"more than just a job"* e.g. *"We're not just here for the salary"* and as an occupation in which *"emotional engagement"* is unavoidable and is indeed a prerequisite for good care, involving *"Going that extra mile..." and "...working with the person rather than working for the person."* Compassionate care extended beyond a patient's death to the final act of care and to the patient's relatives.

Compassionate care was often identified when it was lacking, for example a situation in which a patient who was dying was transferred from the Acute Receiving Unit (ARU) to the ward to ensure that the four hour timeline for patients' stay in ARU was not breached. The patient died within 7 minutes of arrival in the ward, creating issues for the staff in providing optimum care for the patient and relatives.

It was suggested that some environments may be more conducive to provision of compassionate care than others; community settings were identified by participants as promoting therapeutic relationships between staff and patients. *"... [you] have time to actually spend with the patient...less stressed and less task-orientated."* Conversely, one participant who had commenced work in primary care felt pressurised due to lack of supervision and support, being left to make decisions with little knowledge and experience to support them.

Importantly, compassionate care was not perceived by participants as confined to staff/patient relationships but extended to patient/patient interactions and those between healthcare staff of the same and different grades and occupational groups.

Examples were provided of situations in which these relationships were the focus of compassionate, or unsupportive, interactions.

An underpinning theme in the data analysis was the tension between 'agency' i.e. the ability of individuals to act and 'structure' i.e. the physical, managerial and cultural environment within which staff had to operate. Structures that are supportive have greater potential to foster compassionate care by all-to-all but, equally, individuals play an active part in creating the cultural structures.

It is appreciated that the numbers in this study are relatively small scale. Attenders at study days were well-placed to provide relevant data by virtue of being newly qualified but they may, or may not, be a 'representative' population of newly qualified staff nurses as a whole e.g. they may be more highly motivated and/or more idealistic than others.

It is acknowledged also that the people who agreed to participate in the focus groups and interviews may, or may not, be 'representative' of study day attenders in general. Findings did however resonate with those from literature during the past decade about the experiences of newly qualified staff and shed light on the perceptions and perspectives of newly qualified staff in relation to provision of compassionate care. The Wordle™ below reflects the main points from the findings.

5.7 Reflection: Learning points from the team

There are implications in the findings for the undergraduate programme. It would have been useful if staff in 'Flying Start' could have been able to participate in more of the focus groups. Theoretical sampling could be used in further research, for example to explore the experiences and perceptions of newly qualified staff nurses who did not attend study days or participate in the 'Flying Start' programme.

Chapter 6: Conclusion to the Final Report

6 Conclusion to the Final Report

Over the three-year period of the programme considerable work and achievements have been made. These could have not been achieved without the collaborative and compassionate involvement of all members of the team and those they interacted with. This conclusion will finish with the presentation of the key learning points from the myriad yet cohesive projects undertaken during the three years.

During the LCCP the adoption of action research, relationship centred care and appreciative inquiry approaches were important in delivering a programme focussed on compassionate caring. These theoretical approaches required to be in tune with the focus of study, therefore collaboration, change and development undertaken with a focus on positive care practices and within the context of relationships was an important and relevant approach.

The collaboration between the university and practice throughout the LCCP was critical to learning and developments. It is worthy of note that the key recommendations identified in the following section are applicable and relevant within both settings, for example the need to examine the extent to which appreciative approaches may inform quality activity across the organisation and identifying how staff challenge evidence of conflicting values about compassionate care within both higher education and clinical practice.

Engaging in caring conversations providing the opportunity to stop and reflect about how care is provided and understand differing perspectives was critical to developments in practice and education. The framework for compassionate care developed from this research provides a basis for continuing development in practice and measurement of this important activity.

It is important to re-emphasise the sense of gratitude the LCCP team would like to express to all participants of this programme.

6.1 Key Learning Points from each Programme Strand

6.1.2

- Key Learning Points: Establishing the LCCP
- The relationship between practice and higher education was extremely valuable and also unique. The different challenges and constraints faced by the two organisations became apparent; nevertheless an ability to work together and to progress when both partners share a common goal was a good lesson to learn;
- Sharing the vision was an important and on-going part of the work;
- Seeing the examples of compassionate care demonstrated within the Beacon Ward portfolios was encouraging for those who were privileged to read them. However it was also very special to see the pride and enthusiasm and the common aim within clinical teams as they shared and celebrated their excellent work.

6.1.3

Key Learning Points Strand 1: Establish excellence in compassionate care practice within NHS Lothian wards (Beacon Wards, Development Sites and Development Units)

Factors that helped achieve success

Organisational

- Creation of dedicated 'spaces' to have caring conversations to share perspectives about care and discuss practice. This needs to happen at local and organisational levels.
- Linking, aligning and integrating compassionate care activities to other organisational processes, targets, and quality initiatives would be imperative.
- Senior management support – e.g. local action groups led by senior staff and supported by Nurse Managers and Chief Nurses, focused on quality improvement and taking forward compassionate action programmes. Management being proactive in doing daily/ weekly 'walk- abouts' in the ward area to ask the outcomes of initiatives such as relative rounds. Updates of progress via the School Senior Management Team meetings.
- Reflective forums such as action learning greatly enhanced staff's ability to learn from practice, take forward change and develop transformational leadership skills. (However due to time constraints and priority given to such activity organisation wide, very few staff were able to continue with action learning following completion of the programme. Few staff who we have worked with over the last 4 years had access clinical supervision).
- Committed senior staff in both organisations who are actively involved in supporting development of compassionate care and who have the authority to support changes to practice.
- Leadership programme – in particular the opportunity this brings to increase and maintain capacity for leadership in compassionate care across the organisation.
- Patients and families involved in shaping service development and inform pre-registration curriculum delivery.
- Treating staff with dignity and respect as well as patients and families.

Interpersonal Communication at all levels

- Emotional support for senior nurses and staff involved in taking forward compassionate care developments e.g. previous leadership programme participants.
- In using a relationship centred model this valued not just the perspectives and experiences of patients but of families and staff. Staff felt their voices were also heard.
- When there was recognition of the complexity of this work and the emotional investment required. One manager stated that this was the hardest initiative she had ever been involved in taking forward.
- Working alongside people in their practice (both clinical and educational) helped to role model, question practices, and feedback about the less obvious or easy to articulate dimensions of compassionate care.

Processes used in LCCP

- Methods used within the programme helped to get at the heart of what people felt and provided a powerful lever for development. Staff needed skilled facilitation in order to take this forward.
- Appreciative inquiry – supported people to examine what worked well rather than focusing on problems.
- Action research helped people to collaborate with the team, take forward changes that were relevant to local practice and context.
- When staff were able to devote time to learning lessons from the experience of others this worked well.

6.1.4

Key Learning Points Strand 2: Facilitating the Development of Leadership Skills in Compassionate Care in NHS Lothian

Enhancing personal skills within the Leadership in Compassionate Care Programme demonstrates that health professionals each possess the capability to deliver relationship-centred compassionate care more effectively when they recognise and utilise their leadership and influencing capacity.

It is clear that focusing on the 'being' dimension of care produced positive effects for patients, their relatives and the multi-professional team.

From active participation and leading projects which were centred on Compassionate Care raised participants' confidence and self-belief. We believe that participants have been empowered to optimize their leadership capability using autonomous motivation as a personal resource.

Our findings support existing leadership research and extend our understanding of how personal leadership can be taught and nurtured through engagement, motivation, participation and support.

6.1.5

Key Learning Points Strand 3: Embedding the Principles of Compassionate Care within the Undergraduate Curriculum

Project 1 Using stories within the curriculum: The stories derived from clinical practice as part of the LCCP provided valuable insight into the patient, relative, staff and student experience. Stories have been made available as podcasts. A range of activities, such as story week were undertaken to highlight this resource to academic staff, further work is required to raise awareness and use of these stories within the school. Stories are being used in a number of forms in teaching, learning and assessment activities and evaluation is ongoing.

Project 2 Feedback to placement areas: Lead mentorship forums will provide the appropriate focus for the dissemination of good practice in compassionate care. It has been agreed that an Appreciative Inquiry approach will be used to provide feedback to placement areas. The successful Edinburgh Napier University WebCT based 'mentor-centre' provides the focus for highlighting and exploring student and mentor stories. The Mentorship training programme is the vehicle to target learning related to compassionate care: what it is, how it is experienced and how this is demonstrated and valued in busy working environments.

P**roject 3 Developing relationships and assessing compassion**: An existing Year 3 module 'Recognising Acute Illness and Deterioration' was used as a vehicle to explore the teaching, learning and assessment of compassionate care. The process of change used to make compassionate care more explicit within this module has been shared with colleagues as one example of how stories can be used successfully to influence teaching learning and assessment within the nursing and midwifery programmes.

Project 4 Supporting lecturers: The supporting lecturers' action project provided a restorative space through a series of four facilitated three-

hour workshops over a period of nine months. Through the development of a collaborative supportive network within the group and utilising creative approaches such as collage, participants were able to provide support to each other and to identify and participate in actions which could lead to positive change within the School.

Project 5 Identifying compassion at recruitment: From the data a list of values-based personal attributes was derived which will be used to create a person-specification for prospective nursing and midwifery students. It is aimed that this will focus future candidates' awareness of the importance of compassionate care in preparation for their interview whilst providing those involved in recruitment a benchmarking process for selection.

- **Project 6 Incorporating compassionate care within Personal development planning process:** Interviews with students identified value in the role of the Personal Development Tutor (PDT) in regard to provision of academic support, the personal qualities of the tutor and the demonstration of compassion towards students. Lecturers identified the PDT role as providing academic support for example guidance with assessment, providing a professional relationship, namely a constant point for contact and a sense of belonging. Positive and challenging elements of the PDT role were identified such as finding a balance between academic and pastoral support. Lecturers also identified support needs for this role, e.g. a form of supervision. The next stage of this action project will be to explore the potential for an adapted version of the Senses Framework to further analyse data and consider this to be utilised within the actual PDT processes. On the basis of this recommendations will be made in terms of enhancing compassionate care within the PDT role.

6.1.6

Key Learning Points Strand 4: Supporting Newly Qualified Nurses during their First Year in Practice to Facilitate the Transition from Student to Competent and Compassionate Staff Nurses

- There are implications for the undergraduate programme in preparing students for the reality of practice i.e. providing strategies to deal with the transition and advice about support mechanisms that will be available to them e.g. clinical supervision.
- There are implications for managers of care settings in ensuring that support systems are in place to reduce the feelings of initial inadequacy and eclectic support described by staff nurses in this study. Support systems need to be formalised rather than ad hoc.

6.2

Future recommendations from the LCCP for NHS Lothian and Edinburgh Napier University

Organisational

Recognition that compassionate care requires high levels of skill and ongoing training and support. An example from practice where staff need ongoing support: altering patient documentation to ensure we ask people about what matters to them when they are in hospital. Working with patient responses to these questions can be hard and challenging for staff;

Staff and students should continue to be encouraged, supported and trained to understand from the patient and family perspective how care is experienced and how this can lead to developments in practice;

Recognition of the emotional intelligence required to do this type of work. Consideration given to how we value and support this more, for example staff participating in action learning, clinical supervision;

Consideration given to how to develop measures of people's experiences of giving and receiving compassionate care and embed this routinely into organisational learning, development and governance processes;

Consideration given to how to develop measures of compassionate care that matter to people;

Co-ordinate and integrate the work of the LCCP with other quality initiatives.

Pull together existing resources across NHS Lothian that seek feedback about experiences of care, make access to these easier, minimise duplication and maximise organisational learning and development;

Examine the extent to which appreciative approaches may inform quality activity across the organisation.

Identify how staff challenge evidence of conflicting values about compassionate care within the organisation;

The approach of relationship centred care, appreciation and principles of compassionate care could be made more explicit across a range of organisational processes and activity e.g. induction, mandatory online learning modules, complaints process;

Consider how can we identify and share positive care practices and the processes that enable these to happen in a more systematic way across both organisations;

More opportunities to include a wider group of leaders in compassionate care (to date have attracted nurses, AHP's, Medical staff, Educators and support staff – however recruitment of wide group could be developed further);

Share and embed compassionate care leadership skills across existing development and training programmes;

Continue to develop capacity of leaders in compassionate care – including senior management;

Consider greater scope for senior management to support, encourage, value and inquire about compassionate caring;

Debate how can we truly value and incentivise compassionate care;

Consider how to promote day-to-day activities that demonstrate organisation wide commitment to compassion, actions such as reading patient stories and resultant actions at board meetings; incorporating or highlighting aspects of compassion within existing audit activity; celebrating student learning and achievement in compassionate care.

Find ways in which compassionate care is identified as an organisational priority in line with other aspects of care e.g. infection control and prevention of falls.

Consider a range of ways in which to communicate and share compassionate caring evidence e.g. intranet, raising awareness sessions etc.;

Consider communication of more explicit messages to indicate organisations value and commitment and prioritisation of compassionate care.

7. References

Adamson, E., King, L., Ross, J., Waugh, A. (2009). Developing a nursing education project in partnership: leadership in compassionate care, *Nursing Times*. 105, 35.

Age Concern (2006). *Q is for Quality: The voices of older people on the need for better quality care and support*. Age Concern [Online] Available at: http://www.ageconcern.org.uk/AgeConcern/policy-QisforQualityreport.asp accessed 12/12/11.

Altun, I. (2003). The perceived problem solving ability and values of student nurses and midwives. *Nurse Education Today* 23(3) 575-584

Andrew, N., Robb, Y., Ferguson, D., Brown, J. (2011). 'Show us you know us': Using the Senses Framework to support the professional development of undergraduate nursing students. *Nurse Education in Practice* 11(6) 356-359

Ashburner, C., Meyer, J., Johnson, B. & Smith, C. (2004). Using Action research to address loss of personhood in a continuing care setting, *Illness Crisis and Loss*. **12**(1), pp. 23-37.

Avolio, B. J., Bass, B. M. (1995). Individualised consideration viewed at multiple levels of analysis: a multi-level framework for examining the diffusion of transformational leadership, *Leadership Quarterly*. 6(**2**), 199-218.

Baker, B. (2007). Old age in new age: The promise of transformative nursing homes. Nashville: Vanderbilt University Press.

Bamford-Wade, A., Moss, C. (2010). Transformational leadership and shared governance: an action study. *Journal of Nursing Management* 18(7), 815-821

Banks, P., Roxburgh, M., Kane, H., Lauder, W., Jones, M., Kydd, A., Atkinson, J. (2011). Flying Start NHS™: Easing the transition from student to registered health professional, *Journal of Clinical Nursing* 20(23-24), 3567-3576

Bass, B. M. (1995). Theory of transformational leadership redux *Leadership Quarterly* 6(**4**), 463-478

Bass, B.M., Avolio, B.J. (1994). *Improving organizational effectiveness through transformational leadership.* Thousand Oaks, California: Sage.

Bate, P., Mendel, P., Robert, G. (2008.) *Organizing for Quality: The improvement journeys of leading hospitals in Europe and the United States*. A Briefing Paper. London: The Nuffield Trust.

Bate, P., Robert, G., (2007). *Bringing user experience to healthcare improvement: the concepts, methods and practices of experience based design*. Oxford: Radcliffe Publishing.

Bate, S.P. & Robert, G., (2002). Knowledge management and communities of practice in the private sector: lessons for modernizing the National Health Service in England and Wales, *Public Administration,* **80**(4), pp. 643-663.

Berne, E. (1972). *What Do You Say After You Say Hello?* New York: Grove Press.

Berne, E. (1975). *What Do You Say After You Say Hello?* 2nd ed. London: Corgi.

Binnie, A. & Titchen, A., (1999). *Freedom to Practice Nursing* Edinburgh: Butterworth Heinemann.

Binnie, A., Titchen, A., (1999). *Freedom to Practice Nursing* Edinburgh: Butterworth Heinemann.

Bishop, E.C., Shepherd, M.L. (2011). Ethical Reflections: Examining Reflexivity Through the Narrative Paradigm, *Qualitative Health Research* 21(9), 1283-1294

Bluff, R., Holloway, I. (2008). The efficacy of midwifery role models, *Midwifery* 24(3), 301-309

Blumenthal, D.S. (2011). Is Community-Based Participatory Research possible? *American Journal of Preventative Medicine* 40(3), 386-389

Blumer, H. (1969). *Symbolic Interactionism: perspective and method.* Englewood Cliff, NJ: Prentice Hall.

Boog, B.W.M. (2003). The Emancipatory Character Of Action Research, its History and the Present State of the Art. *Journal of Community & Applied Social Psychology* 13(6), 426-438

Booth, A., Sutton, A. & Falzon, L., (2003). Working together: supporting projects through action learning, *Health Information and Libraries Journal*. **20** (4), pp. 225 – 231.

Borkan, J. (1999) Immersion/crystallization. In B. F. Crabtree & W. L. Miller (Eds.), *Doing Qualitative Research,*2nd ed., pp. 179-194. Thousand Oaks, CA: Sage.

Bradbury, H. & Lichtenstein, B. M. B., (2000). Relationality in organizational research: exploring the space in between. *Organisational Science*. **1**(1),5, pp.551-564.

Bradbury, H., Reason, P. (2003). Issues and Choice Points for Improving the Quality of Action Research. In Minkler, M., Wallerstein, N. (eds.) *Community-Based Participatory Research for Health*. San Francisco, CA: Jossey-Bass,

Brand, G., McMurray, A. (2009). Reflection on Photographs: Exploring First-Year Nursing Students' Perceptions of Older Adults, *Journal of Gerontological Nursing* 35(11), 30-35

Bridges, J., & Nicholson, C., (2008). Service improvement using patient narratives: engaging with the issues, *International Journal of Older People Nursing*. 3, 217-222.

Bridges, J., Gray, W., Box, G., Machin, S. (2008). Discovery Interviews: a mechanism for user involvement, *International Journal of Older People Nursing* 3(3), 206-210

Brown, J. (2006). *Student nurses' experience of learning to care for older people in enriched environments: a constructivist inquiry*, unpublished PhD Thesis. Sheffield: University of Sheffield.

Brown, J., Nolan, M. R., Davies, S. (2008a). Bringing caring and competence into focus in gerontological nursing: A longitudinal, multi-method study. *International Journal of Nursing Studies*, 45(5), 654-667.

Brown, J., Nolan, M. R., Davies, S., Nolan, J., Keady, J. (2008b). Transforming students' views of gerontological nursing: Realising the potential of 'enriched' environments of learning and care: A multi-method longitudinal study. *International Journal of Nursing Studies*, 45(8), 1214-1232.

Carter, C., Ruhe, M., Weyer, S., Litaker, D., Fry, R., Stange, K. (2007). An appreciative inquiry approach to practice improvement and transformative change in health care settings, *Quality Management in Health Care*. 16(3), 194-204.

Cerveo, R.M. (1985). Continuing professional education and behavioural change: a model for research and evaluation. *Journal of Continuing Education in Nursing* 16(3), 85-88.

Chambers, N., Clark, E., Smith, L., Harvey, G., Mciver, S., Benson, L. (2011) Use of action learning in a higher education setting to improve the quality of health care. *Journal of Management and Marketing in Healthcare* 4(1) 47-54

Charmaz, K. (2006). *Constructing Grounded Theory: a practical guide through qualitative analysis*. London: Sage.

Christensen, J. (2009). *FISH! Philosophy* [Online] Available at: http://www.charthouse.com/content.aspx?name=home2 (accessed 12.12.11)

Clark, P., (1996) Communication between provider and patient: values, biography, and empowerment in clinical practice, *Ageing and Society*. **16** (6), 747-774.

Clarke, A. (2006).Qualitative interviewing: encountering ethical issues and challenges, *Nurse Researcher* 13(4), 19-29.

Clark, T., Holmes, S. (2007). Fit for practice? An exploration of the development of newly qualified nurses using focus groups, *International Journal of Nursing Studies*. 44(7), 1210-1220.

Coghlan, D. & Brannick, T., (2005). *Doing Action Research in your own Organization*. 2nd edn, London: Sage Publications.

Coghlan, D., Brannick, T. (2010). *Doing action research in your organisation*. 2nd ed. London: Sage Publications

Concise Oxford Dictionary (2011). [Online] Available at: http://oxforddictionaries.com/ (accessed 5/12/11)

Cooperrider D. & Srivastva, S. (1987). Appreciative inquiry in organizational life. In: W. A. Pasmore, & R. W. Woodman. (eds) (10*Research in organizational change and development* **1,** pp.3-27 Greenwich, CT: JAI Press.

Cooperrider, D.L., Whitney, D., and Stavros, J.M., (2003). *The Appreciative Inquiry Handbook*. Bedford, OH: Lakeshore Communications.

Cooperrider, D.L., Whitney, D., Stavros, J.M. (2008). *Appreciative Inquiry Handbook: for leaders of change*. 2nd ed. Brunswick, Ohio: Berrett-Koehler.

Coyle, J., Williams, B., (2001). Valuing people as individuals: development of an instrument through a survey of person-centredness in secondary care, *Journal of Advanced Nursing*. 36 (3), pp.450-459.

Currie, K., Biggam, J., Palmer, J., Corcoran, T. (2011). Participants' engagement with and reactions to the use of on-line action learning sets to support advanced nursing role development, *Nurse Education Today* [Article in Press] doi:10.1016/j.nedt.2011.03.012

Davies, S., Nolan, M.R., Brown, J., Wilson, F. (1999). *Dignity on the Ward: Promoting Excellence in Care*. London: Help the Aged.

Dawood, M., Gallini, A. (2010). Using discovery interviews to understand patient experience. *Nursing Management* 17(1) 26-31

Dean, R., Proudfoot, R., Lindesay, J. (1993). The Quality of Interactions Schedule (QUIS): Development, Reliability and Use in the Evaluation of the Two Domus Units. *International Journal of Geriatric Psychiatry* 8(10), 819-826

Department of Health (2001a). *Essence of care – patient focused benchmarking for health care practitioners*. London: DoH.

Department of Health (2001b). *The National Service Framework for Older People*. London: Department of Health. [Online] Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066 (accessed 12/12/11)

Department of Health (2005). *Now I Feel Tall: What a patient led NHS feels like*. London: Department of Health

Department of Health (2006). *The Dignity Challenge*. London: Department of Health. [Online] Available at: http://www.dignityincare.org.uk/DignityCareCampaign/ (accessed 12/12/11)

Department of Health (2008a). *Confidence in Caring: A framework for best practice* London: Department of Health

Department of Health (2008b). *Darzi Report: High Quality Care for All: Next Stage Review, final report*. London: The Stationery Office. [Online] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825 (accessed 12/12/11)

Dewar B and Walker E (2004) Moving upstream together, Learning resources for leadership in partnership working, Queen Margaret University, Edinburgh

Dewar, B. (2010) Editorial: Appreciative Inquiry, *International Journal of Older People Nursing,* 5**,** 290-291.

Dewar, B., & Mackay, R., (2010). Appreciating compassionate care in acute care setting caring for older people, *International Journal of Older People Nursing*. 5, 299-308.

Dewar, B., & Sharp, C., (2006). Using Evidence: how action learning can support individual and organizational learning through action research, *Educational Action Research*, **14** (2), 153-159.

Dewar, B., Mackay, R., Smith, S., Pulli, S., Tocher, R., (2010). Use of emotional touchpoints as a method of tapping into the experience of receiving compassionate care in a hospital setting, *Journal of Nursing Research*. **15** (1), 29-41.

Dewar, B., Pullin, S. and Tocher, R., (2011). Compassion: can it be defined and measured? *Nursing Management* 17 (9) 30-35.

Douglas, K. (2010). Taking Action to Close the Nursing-Finance Gap: learning from Success. *Nursing Economics* 28(4), 270-272

Duchscher, J. E. B. (2009). Transition shock: the initial stage of role adaptation for newly graduated Registered Nurses, *Journal of Advanced Nursing*. 65(5), 1103-1113.

Ellis, L., Nolan, M.R. (2005). Illuminating continuing professional education: unpacking the black box. *International Journal of Nursing Studies*, 42(1), 97-106.

Evans, J., Boxer, E., Sanber, S. (2008). The Strengths and Weaknesses of Transitional Support: Programs for Newly Registered Nurses, *Australian Journal of Advanced Nursing*. 25(11), 6-22.

Faulkner, M., Davies, S., Nolan, M.R., Brown-Wilson, C. (2006). Development of the combined assessment of residential environments (CARE) profiles. *Journal of Advanced Nursing* 55(6), 664-677.

Finfgeld -Connett D (2008) Metasynthesis of caring in nursing, *Journal of Clinical Nursing* 17(2), 196–204

Firth-Cozens, J., Cornwell, J. (2009). *The Point of Care: Enabling compassionate care in acute hospital settings*. London: The King's Fund. [Online] Available at: http://www.kingsfund.org.uk/current_projects/the_point_of_care/compassion/ (accessed 12/12/11)

Fischy Music (2009). [Online] Available at: http://www.fischy.com/ (accessed 10/12/2011)

Fox, R., Henderson, A., Malko-Nyhan, K. (2005). 'They survive despite the organizational culture, not because of it': a longitudinal study of new staff perceptions of what constitutes support during the transition to an acute tertiary facility, *International Journal of Nursing Practice*. 11(5), 193-199.

Gergen, K. J., (1994). *Realities and Relationships: soundings in social construction*. Cambridge MA: Harvard University Press.

Gerrish, K. (2000). Still fumbling along? A comparative study of the newly qualified nurse's perception of the transition from student to qualified nurse, *Journal of Advanced Nursing*. 32(2), 473-480.

Gerrish, K., Lacey, A. (2010). (eds.) *The Research Process in Nursing* 6th Edition Oxford: Blackwell Publishing

Glaser, B. G. (1978). *Theoretical Sensitivity: advances in the methodology of grounded theory*. Mill Valley, California: The Sociology Press.

Glaser, B. G., Strauss, A. L. (1967). *The Discovery of Grounded Theory: strategies for qualitative research*. New York: Aldine de Gruyter.

Goleman, G., Boyatzis, R. (2008). Social Intelligence and the Biology of Leadership. *Harvard Business Review*. 1st September, 74-81.

Goleman, G., Boyatzis, R., Mckee, A. (2002). *The New Leaders: Transforming the Art of Leadership into the Science of Results*. London: Time Warner

Goodrich, J., Cornwell, J. (2008). *Seeing the person in the patient: The point of care review*. London: The King's Fund.

Grant, S., Humphries, M., (2006). Critical evaluation of appreciative inquiry, *Action Research* **4** (4), 401-418.

Gray, B. (2009). The emotional labour of nursing – Defining and managing emotions in nursing work. *Nurse Education Today* 29(2),168-175

Gray, B., Smith, P. (2009). Emotional labour and the clinical settings of nursing care: The perspectives of nurses in East London. *Nurse Education in Practice* 9(4), 253-261

Greenaway, R. (undated). Feedback Exercises and Links [Online] Available at: http://reviewing.co.uk/feedback.htm#making (accessed 10/12/2011)

Grundy, S. ,(1982). *Three Modes Of Action Research*. As cited in Kemmis, S. and McTaggert, R. (eds). (1988). The Action Research Reader (3rd ed). Geelong: Deakin University Press.

Guaspari, J., (1999). The hidden costs of customer satisfaction, *Quality Digest*. 2, 45-47.

Guba, E.G., Lincoln, Y.S. (1989). *Fourth Generation Evaluation*. Newbury Park: Sage.

Hardacre, J., Keep, J., (2003). From intent to impact: developing clinical leaders for service improvement, *Learning in Health and Social Care*. 2(3), 169 – 176.

Harvey G., Loftus-Hills A., Rycroft-Malone J., Titchen A., Kitson A., McCormack B. & Seers K. (2002). Getting evidence into practice: the role and function of facilitation. *Journal of Advanced Nursing* 37(6), 577–588.

HAS 2000 (1998). *"Not because they are old": An independent inquiry into the care of older people on acute wards in general hospitals*. London: Health Advisory Service.

Hearts and Minds (2010) [Online] Available at: http://www.heartsminds.org.uk/hearts-and-minds.html (accessed 10/12/2011)

Help the Aged (2008). *On Our Own Terms: The challenge of assessing dignity in care*. London: Help the Aged [Online] Available at: http://policy.helptheaged.org.uk (Accessed 13/12/11).

Heron, J. (1996). *Co-operative inquiry: research into the human condition*. London: Sage.

Heron, J., Reason, P. (2001). *The practice of co-operative inquiry: research with rather than on people*. In Handbook of action research: participative inquiry and practice, P. Reason and H. Bradbury, (eds), London: Sage. pp. 179-188.

Higgins, G., Spencer, R. L., Kane, R. (2010). A systematic review of the experiences and perceptions of the newly qualified nurse in the United Kingdom, *Nurse Education Today*. 30(6), 499-508.

Hockley, J., Dewar, B., and Watson, J., (2005). Promoting end of life care in nursing homes using an integrated care pathway for the last days of life, *Journal of Nursing Research*. **10**, pp. 135-152

Hockley, J., Froggatt, K. (2006). The development of palliative care knowledge in care homes for older people: the place of action research. *Palliative Medicine* 20(8), 835-843

Holloway, I., Wheeler, S. (2010). *Qualitative Research in Nursing and Health Care* 3rd edn. Oxford: Wiley-Blackwell.

Howatson-Jones, I.L. (2007). Dilemmas of focus group recruitment and implementation: a pilot perspective. *Nurse Researcher* 14(2), 7-17

IFAS (2008). *State Investment in Culture Change Toolkit*. Institute for the Future of Aging Services, Washington, DC. [Online] Available at: http://www.leadingage.org/uploadedFiles/Content/About/Center_for_Applied_Research/Publications_and_Products/State_Investment_Culture_Change_Toolkit.pdf (Accessed 13/12/11)

International Coach Federation [Online] Available at: http://www.coachfederation.org.uk/welcome/uk_icf_definition_of_coach_supervision.phtml (accessed 12/12/11)

Johnson, C., (1998). The essential principles of action learning, *Journal of Workplace Learning*. 10(6/7), 296 – 300.

Kavanagh, T., Stevens, B., Seers K., Sidami, S., & Watt-Watson, J., (2008). Examining appreciative inquiry as a knowledge translation intervention in pain management, *Canadian Journal of Nursing Research* 40 (2), 40-56.

Kerrison, S., Pollock, A. (2001). Complaints as accountability: the case of health care in the UK, *Public Law* Spring 33, 115

Koch, T., Kralik, D. (2006). *Participatory Action Research in Health Care*. Oxford, Blackwell Publishing

Kouzes, J.M., Posner, B.Z. (2005). *Student Leadership Practices Inventory*. 2nd ed. San Francisco: Jossey-Bass,

Kowalski, K., (2008). Appreciative inquiry, *Journal of Continuing Education in Nursing,* 39 (3), 104-104.

Lapworth, P., Sills, C., Fish, S. (2003).*Transactional Analysis Counselling*. Winslow: Oxford Press.

Lee, A.M., Poole, G. (2005). An Application of the Transactional Model to the Analysis of Chronic Illness Narratives, *Qualitative Health Research* 15(3), 346-364

Loads, D., (2009) Putting Ourselves in the Picture: *International Journal of Academic Development*, 14(1), 59-67.

Lorenz, L.S. (2011). A way into empathy: A 'case' of photo-elicitation in illness research, *Health* 15(3), 259-275

Lown, B.A., Rosen, J., Marttila, J. (2011). An Agenda for Improving Compassionate Care: A Survey Shows about Half of Patients Say Such Care is Missing. *Health Affairs* 30(9), 1772-1778

Maben, J. (2008). The art of caring: invisible and subordinated? A response to Juliet Corbin: 'Is caring a lost art in nursing?' *International Journal of Nursing Studies* 45(3), 335-358

Maben, J., Cornwell, J., Sweeney, K. (2009). In praise of compassion, *Journal of Research in Nursing* 15(1), 9-12

Maben. J., Latter, S., Macleod Clark, J. (2007). The sustainability of ideals, values and the nursing mandate: evidence from a longitudinal qualitative study, *Nursing Inquiry*. 14(2), 99-113.

Marlow, A., Spratt, C., Reilly, A. (2008) Collaborative action learning: a professional development model for educational innovation in nursing, *Nurse Education in Practice* 8(3), 184-189

Martin, C.J.H. (2011). Transactional analysis: A method of analysing communication, *British Journal of Midwifery*. 19(9), 587-593

McCance, I., McCormack, B., Dewing, J. (2011). An Exploration of Person-Centredness in Practice. *Online Journal of Issues in Nursing* 16(2) Manuscript 1.

McCann, T., Clark, E. (2005). Using unstructured interviews with participants who have schizophrenia, *Nurse Researcher* 13(1), 7-18.

McCormack, B., Dewing, J., Breslin, L., Coyne-Nevin, A., Kennedy, K., Manning, M., Peelo-Kilroe, L., Tobin, C. (2009). Practice development: realising active learning for sustainable change, *Contemporary Nurse* 32(1-2), 92-104

McCormack, B., Dewing, J., McCance, I. (2011). Developing Person-Centred Care: Addressing Contextual Challenges Through Practice Development. *Online Journal of Issues in Nursing* 16(2), Manuscript 3.

McCormack, B., Illman, A., Culling, J., Ryan, A. and O'Neill, S., (2002). Removing the chaos from the narrative: preparing clinical leaders for practice development, *Educational Action Research, 10(*3), pp. 335-351.

McCormack, B., Kitson, A., Harvey, G., Rycroft-Malone, J., Titchen, A. & Seers, K., (2002). Getting evidence into practice: the meaning of 'context', *Journal of Advanced Nursing.* **38** (1), pp. 94-104.

McCormack, B., McCance, I. (2010). *Person-centred nursing: theory and practice.* Chichester: Wiley-Blackwell

McGill, I., Brockbank, A. (2004). *The Action Learning Handbook*. London: Routledge, Falmer.

McNiff, J., Whitehead, J. (2011). *All you need to know about action research*. London: Sage Publications

Mead, G. H. (1934). *Mind, Self and Society: from the standpoint of a social behaviourist.* Chicago: University of Chicago.

Mead, G. H. (1964). *George Herbert Mead on Social Psychology.* Chicago: University of Chicago Press.

Meyer, J., (1999). Using qualitative methods in health related action research. In: Pope, C., & Mays, N., (eds.) *Qualitative research in health care 2nd edition,* London: BMJ Books.

Meyer, J. (2000). Qualitative research in healthcare: Using qualitative methods in health related action research, *British Medical Journal* 320(7228), 178 181.

Meyer, J. (2006). Action Research in Gerrish K, Lacey, A., Cormack, D (Eds) *The Research Process in Nursing*. Oxford: Blackwell Publishing

Meyer, J., Johnson, B., Proctor, S., Bryer, R., Rozmovits, L., (2003). Practitioner research: Exploring issues in relation to research capacity building, *Nursing Times Research*. 8(6), 407-417.

Murphy, F., Jones, S., Edwards, M., James, J., Mayer, A. (2009). The impact of nurse education on the caring behaviours of nursing students, *Nurse Education Today* 29(2), 254–264

Murphy, J., Tester, S., Hubbard, G., Downs, M., MacDonald, C., (2005). Enabling frail older people with a communication difficulty to express their views: the use of talking mats as an interview tool, *Health and Social Care in the Community*. 13 (2), 95-107.

NHS Lothian (2011*). Human Resources and Organisational Strategy* November 2008 – October 2011 Edinburgh: NHS Lothian

NHSScotland (2009). *Patients' Rights: A Public Consultation on a Patients' Rights Bill for users of the NHS in Scotland*. Edinburgh: Scottish Government [Online] Available at: http://www.scotland.gov.uk/Publications/2008/09/22091148/0 (accessed 19/12/11).

NHSScotland (2011). *Leading Better Care incorporating Releasing Time to Care*. [Online] Available at: http://www.evidenceintopractice.scot.nhs.uk/media/150149/lbc%20incorporating%20rtc%20report.pdf (accessed 5/12/11).

Nolan, M.R., Brown, J., Davies, S., Keady, J., Nolan, J. (2002). *Longitudinal Study of the Effectiveness of Educational Preparation to Meet the Needs of Older People and Their Carers: The Advancing Gerontological Education in Nursing (The AGEIN) Project*. ENB Research Highlights No. 48, London: English National Board for Nursing, Midwifery and Health Visiting

Nolan, M. R., Hanson, E., Magnusson, L., & Anderson, B., (2003). Gauging quality in constructivist research: the Aldre Vast Sjuharad model revisited, *Quality in Ageing – policy practice and research*. 4 (2), 22-27.

Nolan, M., Davies, S., Brown, J., Keady, J., Nolan, J. (2004). Beyond 'person-centred' care: a new vision for gerontological nursing. *International Journal of Older People Nursing*, 13(3a), 45-53.

Nolan, M., Davies, S., Brown, J., Nolan, J., Keady, J., (2006). *The Senses Framework: Improving Care for Older People Through a Relationship-Centred Approach* Getting Research Into Practice Series: University of Sheffield.

Nolan, M., Davies, S., Brown, J., Wilkinson, A., Warnes, A., McKee, K., Flannery, J., Stasi, K. (2008). The role of education and training in achieving change in care homes: a literature review, *Journal of Research in Nursing*. 13(5), 411-433.

Nolan, M., Hanson, E., Magnusson, L., Andersson, B. (2003). Gauging quality in constructivist research: The ÄldreVäst Sjuhärad model revisited, *Quality in Ageing – Policy, Practice and Research*. 4(2), 22-27.

Nolan, M.R. (1997). *Health and social care: what the future holds for nursing*. Keynote address at Third Royal College of Nursing Older Person European Conference and Exhibition: Harrogate.

Northouse, P. (2001). *Leadership theory and practice* 2nd ed., London: Sage Publications

Nursing and Midwifery Council (2006). *Advance Information to Programme Providers Regarding the NMC's Intention to Introduce Essential Skills Clusters for Pre-Registration Nursing Programmes*. NMC Circular 35/2006. NMC: London.

Nursing and Midwifery Council (2009*).Guidance for the Care of Older People*. London: Nursing and Midwifery Council [Online] Available at: http://www.nmc-uk.org/Documents/Guidance/Guidance-for-the-care-of-older-people.pdf (accessed 13/12/11)

O'Reilly, K. (2009). *Key Concepts in Ethnography*. London: Sage Publications

O'Shea, M., Kelly, B. (2007). The lived experiences of newly qualified nurses on clinical placement during the first six months following registration in the Republic of Ireland, *Journal of Clinical Nursing*. 16(8), 1534-1542.

Oliffe, J.L., Bottorff, J.L. (2007). Further Than the Eye Can See? Photo Elicitation and Research with Men. *Qualitative Health Research* 17(6), 850-858

Owen, R., Nolan, M.R., Venables, A., Curran, M., Behi, R. (1999). *Evaluation of the ENB Framework Higher Award*. Research Reports Series No. 12, London: English National Board for Nursing, Midwifery and Health Visiting.

Parahoo, K., (2006). *Nursing Research: Principles, Process and Issues*. 2nd ed. Basingstoke: Palgrave MacMillan

Parker, V.A. (2008). Connecting Relational Work and Workgroup Context in Caregiving Organizations. *The Journal of Applied Behavioural Science*. 38(3), 276-297.

Pellico, L. H., Brewer, C. S., Kovner, C. T. (2009). What newly licensed registered nurses have to say about their first experiences, *Nursing Outlook* 57(4), 94-203.

Pena, A. (2010). The Dreyfus model of clinical problem-solving skills acquisition: a critical perspective. *Medical Education Online* 15(10), 4846-4858

Petersson, P., Springett, J., Blomqvist, K. (2009). Telling stories from everyday practice, an opportunity to see a bigger pictures: a participatory action research project about developing discharge planning. *Health and Social Care in the Community* 17(6), 548-556

Polit, D.F., Beck, C.T. (2010). *Essentials of Nursing Research Methods, Appraising evidence For Nursing Practice*, 7th ed. Philadelphia: Williams and Wilkins, Lippincott.

Powell, A.E., Rushmer, R.K., Davies, H.T.O. (2009.) *A systematic narrative review of quality improvement models in health care*. Edinburgh: NHS Quality Improvement, Scotland.

Quality Assurance Agency (2010). *Graduates for the 21st Century* [Online] Available from: http://www.enhancementthemes.ac.uk/enhancement-themes/completed-enhancement-themes/graduates-for-the-21st-century (Accessed 13/12/11)

Rallis, S.F., Rossman, G.B. (2010). Caring Reflexivity. *International Journal of Qualitative Studies in Education* 23(4), 495 – 499

Rayner, D., Chisholm, H. & Appleby, H., (2002). Developing leadership through action learning, *Nursing Standard*. 16(29), 37-39.

RCN (2009). Research Ethics: Guidance for Nurses. London: RCN [Online] Available at http://www.rcn.org.uk/__data/assets/pdf_file/0007/388591/003138.pdf (accessed 8th December 2011)

Reason, P., Bradbury, H., (2001) Introduction. Inquiry and participation in search of a world worthy of human aspiration. In: P. Reason and H. Bradbury (Eds). (2001) *Handbook of Action Research* London: Sage

Reason, P., Torbert, W. R., (2001). Towards a transformational science: a further look at the scientific merits of action research, *Concepts and Transformations* 6(1), 1-37.

Reed, J., (2005). Using action research in nursing practice with older people: democratizing knowledge, *Journal of Clinical Nursing*, 14(5), 594-600.

Reed, J., (2007). *Appreciative Inquiry: research for change*. London: Sage: Thousand Oaks.

Reed, J. (2010). Appreciative Inquiry and older people- finding the literature, *International Journal of Older People Nursing,* 5(4), 292-8.

Reed, J., Pearson, P., Douglas, B., Swinburn, S., Wilding, H., (2002). Going Home from Hospital – an appreciative inquiry study, *Health and Social Care in the Community* 10(1), 36-45

Reivich, K., Shatté, A. (2002). *The Resilience Factor: 7 Keys to Finding your Inner Strength and Overcoming Life's Hurdles*. New York: Broadway Books.

Roger, P. J., Fraser, D., (2003). Appreciative Inquiry. In: H. Preskill & A T Coghlan (eds) *Using appreciative inquiry in evaluation*. San Francisco, CA: Jossey Bass

Ross, H., Clifford, K. (2002). Research as a catalyst for change: transition from student to registered nurse, *Journal of Clinical Nursing*. 11(4), 545-553.

Roxburgh, M., Lauder, W., Topping, K., Holland, K., Johnson, M., Watson, R. (2010). Early findings from an evaluation of a post-registration staff development programme: The Flying Start NHS Initiative in Scotland, UK, *Nurse Education in Practice*. 10(2), 76-81

Royal College of Nursing (2008). *Defending Dignity – Challenges and opportunities for nursing*. London: Royal College of Nursing. [Online] Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0011/166655/003257.pdf (Accessed 13/12/11)

Schmidt, L. A., (2003). Patients perceptions of nursing care in the hospital setting, *Journal of Advanced Nursing*. **44** (4),pp.393-399.

Scottish Executive (2005). *Better Outcomes for Older People: Framework for Joint Services. Edinburgh, Scottish Executive*. [Online] Available at: www.scotland.gov.uk/publications/2005/05/13101338/13397 (Accessed 13/12/11)

Scottish Executive (2006). *Research Framework for Health and Community Care* 2nd edition [Online] Available at: http://www.cso.scot.nhs.uk/publications/ResGov/Framework/RGFEdTwo.pdf [accessed 13/12/11]

Scottish Executive Health Department (2006a). *Delivering Health, Enabling Care*: *Professions' Contribution to Implementing Delivering for Health in Scotland.* Edinburgh: SEHD.

Scottish Executive Health Department (2006b). *Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland*. Edinburgh: SEHD.

Scottish Government (2009). *Delivering Quality through Leadership: NHSScotland Leadership Development Strategy*. Edinburgh: Scottish Government

Scottish Government (2010). *The Healthcare Quality Strategy for NHSScotland*. Edinburgh: Scottish Government. [Online] Available at http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf (accessed 5/12/11).

Scottish Government (undated). *Education Scotland: Approaches to Learning – Creativity* [Online] Available at http://www.ltscotland.org.uk/learningteachingandassessment/approaches/creativity/about/index.asp (accessed 10/12/2011)

Scottish Government Health Department (2007). *Better Health, Better Care*. Edinburgh: Scottish Government Health Department.

Scottish Government Health Department (2008). *Better Together Scotland's patient experience programme* Edinburgh: Scottish Government Health Department.

Seligman, M.E. P., (1991). *Learned Optimism*. New York: AA Knope.

Smith, S., & Shaw, C., (2007) The challenge of assessing and treating pain in dementia. *The Journal of Dementia Care*. 15(2), 28-30.

Smith, S., Dewar, B., Pullin, S., & Tocher R., (2010). Relationship centred outcomes focused on compassionate care for older people within in-patient care settings, *International Journal of Older People Nursing*. 5(2), 28-137.

Soh, K.L., Davidson, P.M., Leslie, G., Rahman, A.B.A. (2011). Action research studies in the intensive care setting: a systematic review. *International Journal of Nursing Studies* 48(2), 258-268

Stacey, G., Hardy, P. (2010). Challenging the shock of reality through digital storytelling, *Nurse Education in Practice* 11(2), 159-164

Stange, KC, Goodwin, M. A., Zyzanski, S.J. & Dietrich, A.J., (2003). Sustainability of a practice-individualized preventive service delivery intervention, *American Journal of Preventive Medicine* **25**, 296-300.

Storli, S.L., Lind, R. (2008).The meaning of follow-up in intensive care: patients' perspective. *Scandinavian Journal of Caring Science* 23(1), 45-56

Stronach, I., Garratt, D., Pearce, C., Piper, H. (2007). Reflexivity, the Picturing of Selves, the Forging of method. *Qualitative Inquiry* 13(2), 179-203

Suffolk Nurse Leaders Group (2011). Collaborative project to co-ordinate care for patients with dementia. *Nursing Management* 18(2), 27-31

Szczepura. A., Clay, D., Hyde, J., Nelson, S. Wild, D. (2008). *Models for providing improved care in residential care homes: A thematic literature review*. Coventry: A Joseph Rowntree Foundation Project by the University of the West of England.

The NHS Confederation (2008). *Compassion in healthcare: The missing dimension of healthcare reform?* London: The NHS Confederation.

The NHS Confederation and Mental Health Network (2007). *Time and trouble: towards proper and compassionate mental healthcare*. London: The NHS Confederation.

Thompson, N.C., Hunter, E.E., Murray, L., Ninci, L., Rolfs, E.M., Pallikkathayil, L. (2008). The Experience of Living with Chronic Mental Illness: A Photovoice Study. *Perspectives in Psychiatric Care* 44(1), 14-24

Tresolini, C.P., The Pew-Fetzer Task Force. (1994). Health Professions Education and Relationship-

Centred Care: A Report of the Pew-Fetzer Task Force on Advancing Psychosocial Education. San Francisco: Pew Health Professions Commission.

Van der Haar, D., & Hosking, D., (2004). Evaluating appreciative inquiry: a relational constructionist perspective, *Human Relations* 57(8), 1017-1036.

Van Manen, M., (1997). *Researching lived experience Human Science for an action sensitive pedagogy.* London: Althouse Press.

Vittrup, A.C., Davey, A. (2010). Problem based learning – 'Bringing everything together' – A strategy for Graduate Nurse Programs. *Nurse Education in Practice* 10(2), 88-95

von Dietze, E., Orb, A. (2000). Compassionate care: a moral dimension of nursing. *Nursing Inquiry* 7(3), 166-174

Walsh, M., Grant, G., Coleman, Z. (2008). Action Research – a Necessary Complement to Traditional Health Science? *Health Care Anal*. 16(2), 127-144

Walumbwa, F., Avolio, B., Gardner, W., Wernsing, T., Peterson, S. (2008). Authentic Leadership: Development and Validation of a Theory-Based Measure. *Journal of Management*, 34(1), 89-126.

Wasserman, I.C., & McNamee, S. (2010) Promoting compassionate care in the older person: a relational perspective, *International Journal of Older People Nursing,* 5 **(4)**, 309-316.

Waterman, H., Tillen, D., Dickson, R., de Koning, K. (2001). Action research: a systematic review and guidance for assessment *Health Technology Assessment* 5(23) 1-174

Watson, R., Deary, I., Lea, A. (1999). A longitudinal study into the perceptions of caring and nursing among student nurses, *Journal of Advanced Nursing* 29(5), 1228–1237.

Watson, R., Gardiner, E., Hogston, R., Gibson, H., Stimpson, A., Wrate, R., Deary, I. (2009). A longitudinal study of stress and psychological distress in nurses and nursing students, *Journal of Clinical Nursing*. 18(2), 270-278.

Whitehead, J. (2001). Newly qualified staff nurses' perceptions of the role transition, *British Journal of Nursing* 10(5), 330-339.

Whitehead, J., McNiff, J. (2006). *Action Research: Living Theory*. London: Sage Publications

Williams, B., 2002. Using collage art work as a common medium for communication in interprofessional workshops. *Journal of Interprofessional Care*, 16(1), 53-58.

Williamson, G.R., Prosser, S. (2002). Action research: politics, ethics and participation. *Journal of Advanced Nursing* 40(5), 587-593

Winter, R. & Munn-Giddings, C. (2001). *A handbook for action research in health and social care*. London: Routledge.

Winter, R. (2003). Buddhism and action research: towards an appropriate model of inquiry for the caring professions, *Educational Action Research* 11(1),141-160.

Yammarino, F, J., Dionne, S, D., Chun, J, U., Dansereau, F. (2005). Leadership and levels of analysis: a state-of-the-science review. *Leadership Quarterly* 16, 879-919

Youngsen, R. (2007). *People-centred Health Care. International Symposium on People-Centred Health Care: Reorientating Health Systems in the 21st Century*. Tokyo: The Tokyo International Forum, 25 November 2009.

Youngsen, R. (2008). *Compassion in healthcare: The missing dimension of healthcare reform? The NHS Confederation.* [Online] Available at: www.debatepapers.org.uk (Accessed 13/12/11).

8 Appendices

Appendix 1:

Approaches to Development Sites – Key Questions and Evidence

NHS Lothian / Edinburgh Napier University

Leadership in Compassionate Care Project

Invitation

Charge Nurses, from in-patient units within NHS Lothian, are invited to apply to become a Development Site as part of the Leadership in Compassionate Care Project

Background

The Leadership in Compassionate Care project is a collaborative venture between Napier University and NHS Lothian. The aim of the 3 year project is to ensure that compassionate nursing practice is integral to care within NHS Lothian and within the undergraduate nursing programme at Napier University.

The project has 4 key strands which are:

- Embedding the principles of Compassionate Care within the undergraduate curriculum at Napier University.
- Supporting newly qualified nurses during their first year in practice.
- Establishing NHS Lothian Centres of Excellence in Compassionate Care (Beacon Wards)
- Supporting development of leadership skills in Compassionate Care.

The Leadership in Compassionate Care project team consists of:

The Lead Nurse, Stephen Smith who has overall responsibility for the project, and 4 senior nurses. A wider group of nurses from NHS Lothian and lecturers from Napier University are also actively involved in taking this project forward.

More information about the project is available at the following web site: www.napier.ac.uk/fhlss/NMSC/compassionatecare/Pages/Home.aspx

Initial work with Beacon Wards

In the first phase of the leadership in compassionate care project, wards in NHS Lothian were invited to apply to become Beacon Wards in compassionate caring. Following a selection process, four wards were awarded Beacon status. The purpose of Beacon status was that the four wards would be able to demonstrate excellence in compassionate caring, with a view to sharing and spreading effective practice to other areas.

The Senior Nurses from the project worked with these four wards to understand what compassionate care looked like in these different care settings.

The aim was to systematically discover the best of what is and what has been. We wanted to focus on what is working, rather than what are the problems? A key principle for the project team is to work alongside people.

Key findings have emerged from this work and the next phase of the project involves identifying **Development Sites in Compassionate Care** where these findings can be developed further and a greater understanding achieved.

One of the charge nurses from the Beacon Ward summed up their involvement in the project by saying:

'It has been fantastic to have a truly patient focused project that has tried to capture what we do well and what we can do even better. I have found it truly inspirational. I have learnt to actively seek out feedback from patients and their families and this has been so rewarding. Time for the project hasn't really been an issue because we have worked any new things into our day to day practice. There has been a strong advantage to having the senior nurse work with us and help us to examine our culture and practices. It has been a great development opportunity for me and for the whole team.'

What does being a Development Site for Compassionate Care mean?

These sites will demonstrate a keen interest in developing compassionate, person- centred care within their areas and working with findings from the original Beacon Wards. There should be a commitment to supporting change and developing practice both at senior level and within the extended multidisciplinary team. Successful applicants will be supported by one of the senior project nurses, and will participate in two introductory study days and regular action learning sessions.

Being a development site means participants will be committed to wanting to examine current practice and to implement initiatives that will enhance practice to make it more compassionate for patients, their families and for staff.

A senior nurse will work with your team for a period of 7 months. The role of the senior nurse will be to work closely with the team to:

- Explore what is already understood from the beacon wards and look for this in the development sites
- Search for further evidence of compassionate care and how it is delivered within the development sites
- Enable the ward team to identify and try out ways of working that enhance compassionate, person – centred care
- Role model compassionate care
- Support staff to implement sustainable change
- Support staff to share their learning and development with other practitioners.

On completion of the 7-month period, the project team will negotiate with staff from the development site, how they would wish to remain involved in the project.

How do you become a Development Site?

The application process will be in 3 stages.

The application process outlined below has not been designed to judge the extent to which compassionate care is being delivered, rather it is designed to select sites that demonstrate a readiness to try out and develop compassionate, person-centred practices.

Stage one

This will involve the Charge Nurse of an NHS Lothian in-patient area submitting an abstract (see appendix 1 for content of abstract). In the first instance, it would be necessary for the Charge Nurse to discuss this application with their line manager. The abstract should be no more than 750 words and will identify how the ward team approaches and values change and how practice is developed. The abstract will outline what you consider compassionate care to be in your care setting. There will be a deadline of 2 weeks to complete this part of the process and all submissions will be E mailed to Billie Morrow by **Friday 7 November 2008** (Senior Nurse, Leadership in Compassionate Care Project) B.Morrow@napier.ac.uk

Stage two

A team from NHS Lothian and Napier University will review the abstracts. From the abstracts submitted, sites will then be short listed and asked to submit a portfolio that will provide a more detailed account / evidence of the activities highlighted in the original abstract (see appendix 2 for details of the portfolio content). The timeframe for this submission will be 4 weeks. Those wards that submitted a portfolio in the original application process and would like to resubmit would be invited to update their original portfolio. Deadline for submission of portfolios: **Friday 19 December 2008**.

Stage three

The portfolios will be reviewed by the NHS Lothian and Napier team. Eight sites will be shortlisted and visited by the team to enable a more in-depth understanding of the areas. Following this process, four sites will be selected as development sites.

This process will be completed by: **Friday 16 January 2009**. The Senior Nurses will commence work with the Development Sites in **February 2008.**

What happens if you are not selected to become a Development Site?

For those applicants who completed portfolios but were not selected to be a development site, opportunities to join the Leadership Strand of the Compassionate Care project will be available. This will ensure that members of your ward will be engaged in leadership development but will also be supported to take forward projects aimed at enhancing compassionate, person centred practice.

The process outlined above is not to judge the extent to which compassionate care is being delivered, rather it is designed to select sites that demonstrate a readiness to try out and develop compassionate, person-centred practices.

For further information please contact:

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Appendix 1 The abstract

The abstract must include the following details:

- Title: Abstract in support of application to become a Development Site for the Leadership in Compassionate Care Project
- Name of Charge Nurse
- Name and address of the ward/ care setting
- A telephone contact
- An E mail contact
- The date the abstract was written.

The abstract (750 words) should address the following questions:

- What does compassionate care look like in your care setting?
- Can you describe a change to practice that the ward team has initiated, which has enhanced care for patients / relatives in your setting?
- What did you learn from doing this?
- What would you do differently?
- What were the challenges and how did you approach them?
- How do you know this change has enhanced care?
- Are there other areas of practice you would like to develop in the future?
- What are they?
- Why do you want to develop this practice?

The abstract must be submitted by **Friday 7 November 2008** to Billie Morrow, Senior Nurse, Leadership in Compassionate Care Project

e-mail: B.Morrow@napier.ac.uk

Information and evidence required for completion of Development Site Portfolio.

To complete this portfolio, supporting relevant evidence should be provided. Evidence could take many forms and this is the decision of each applicant but could include: audits, ward information, ward policies, standards of care, patient stories, feedback from patients / relatives e.g cards & letters, photographs, complaints, ward meetings, accounts from staff and students, surveys and action plans.

Providing evidence that demonstrates involvement with patients, relatives and staff would be positive e.g. completed survey or patient story. The reviewers would be particularly keen to hear about how you get feedback from patients and relatives and what you do with this.

The portfolio is divided into three sections: caring environment, ward / team management and staff management.

Caring environment

Can you describe how your team provides compassionate, person centred care in day-to-day practice?

What challenges do you have when trying to provide person centred care (e.g lay out of the care setting, availability of rooms / quiet areas?

Please tell us about any initiatives / developments that have taken place on your ward that demonstrates compassionate care?

Can you demonstrate why these initiatives were implemented?

Have they been evaluated?

What ideas and plans does your team have, regarding developing compassionate care practices?

Ward / Team Management

What is your ward philosophy / operational policy?

Do you use a model of care, what is this and how is it used?

How do you work with complaints?

How does the team know about what is happening in NHS Lothian?

What patient information is provided and why? How is this evaluated?

Staff Management

Can you describe who is in your team?

Can you describe how your team works?

How does the team communicate about patient care issues?

How do staff (all members of the team) receive support?

How do staff (all members of the team) challenge one another?

How are staff (all members of the team) developed in your area?

How do you support students learning?

How are mentors supported in their role?

The portfolio must be submitted by:

Friday 19 December 2008.

Appendix 2: Using Patient Stories in NHS Lothian

Using Patient Stories in NHS Lothian

The purpose of this document is to define how the use of Patient Stories as a service evaluation tool will be managed in NHS Lothian. This is in order to protect patients, carers, and staff, and address issues surrounding how data will be generated, stored and presented.

What are Patient Stories?

Patient Stories, also known as patient narratives, is an established method of generating recorded interviews with patients about their experience of receiving care. They can be used as a tool to evaluate a healthcare service and are seen to promote patient involvement (Department of Health, 2004). The method is recognised as a powerful way of getting patients to identify areas for quality improvement and to find out which aspects of their care experience they particularly value. The content of each interview is led by the individual patient/client. Carer or staff stories can also be used.

Background to the use of Patient Stories

Over the past 7 years Patient Stories have been used as a tool in NHS Lothian on the Royal College of Nursing (RCN) Clinical Leadership Programme (CLP) and were governed under the licence of this programme.

The intention now is to be able to use Patient Stories in a wider range of programmes and clinically based activities. Also since the RCN programme is no longer running there is a need to define the governance processes including informed consent, data protection and quality control.

It is envisaged that Patient Stories will be used in the following situations in the future:

- By participants on formal leadership programmes and workshops
- By the organisation as part of a specific initiative e.g. Patient Stories Week
- As part of specific projects e.g. Leadership in Compassionate Care
- To generate audio material to use in teaching sessions
- As an integral part of improving and learning from the Patient Experience

The overall process of using Patient Stories is sponsored and supported by the Nurse Director in NHS Lothian. In all circumstances stories will only be undertaken by healthcare professionals who have had recognised training, (for example RCN CLP participants, staff who have attended needs-led workshops) or who have the support and assistance of staff such as clinical leaders/clinical leadership facilitators, who are experienced in story taking. Within NHS Lothian's Continuing Professional and Practice Development (CPPD) team, the Lead Practitioner for Clinical Leadership will act as a specific resource who can be contacted for advice and information and will aim to ensure overall quality and monitoring of the story taking.

Inclusion Criteria

Criteria for inclusion should be agreed according to the nature of the participating clinical area and are dependent on the patient's condition and his/her ability to give informed consent to the process. In terms of vulnerable groups such as children under 16, adults with learning disabilities and patients with mental illness, it is important not to exclude such patients. Their inclusion will be carried out in collaboration with families and carers, particularly around capacity to provide consent, and they will be given appropriate support.

In order to ensure a representative view and avoid the risk of bias in terms of perhaps including patients known to have a positive view, the aim is to select patients through some kind of random process based on the total numbers who are able to participate in a particular setting. The selection is undertaken by the person conducting the recording rather than by ward/departmental staff. It is recommended that at least 6 patients per area be selected.

Method

A quiet private area within or out with the ward area is required to ensure privacy and no disturbances during the story taking process. All patients are issued with an information leaflet (attached in Appendix 1) outlining the purpose and method of obtaining a patient story. It is made clear that their participation is voluntary and they have the right to withdraw from the process at any time. Anonymity is assured.

There are key skills required to undertake patient stories:

- Active listening and the ability to establish rapport with interviewees
- Ability to engage with patients and enable a sense of security
- Ability to ask open ended questions and not "lead patients down a particular path"(examples given in Appendix 2)
- An understanding of the context of quality improveme dnt
- Ability to actively listen to potentially stressful or difficult stories without passing judgement verbally or non-verbally
- Preparation and planning
- Consideration and communication with clinical teams who are involved in the patient's experience to ensure an understanding of the process, cooperation and support.

The process should encourage a natural discussion about care experiences, which can trigger significant memories and thoughts. Patients may become upset, angry or distressed when recalling specific incidents or experiences and information may be particularly sensitive. This requires professionalism and respect for individuals whilst maintaining a non-judgemental response.

Once the story is recorded, the patient is thanked for their participation and the interviewer then arranges to listen to the recording soon afterwards (within 48 hours where possible). A mind map is produced whilst listening to the story and themes identified. Where appropriate a colleague or facilitator then listens to the recording and adds to the mind map anything omitted or highlights in red any recurring or key themes or points of particular significance. Themes from several stories can then be collated, explored and action plans identified.

If the patient raises issues that are of cause for concern, the individual conducting the interview will discuss this with them, and with their agreement take this information to an appropriate individual such as Senior Charge Nurse, Clinical Nurse Manager or Patient Liaison Officer.

Data Management

Patient stories are collected using digital recorders (or tape recorders). The data collected may be handled in two ways; detailed transcription or audio review, which leads to mind mapping or other form of note taking. Most recordings will not be downloaded to computers nor transcribed; however, in some instances this may be appropriate. Where this is the case the resulting transcription will not include any patient identifiers and the transcript will be kept in a locked filing cabinet. Computers will only be those licensed by NHS Lothian and will be password protected.

Equipment required includes a digital recorder (or tape recorder and tapes), batteries and documentation to record the mind map when listening to the story. Recorders must be stored in a locked filing cabinet and are the responsibility of the professional undertaking the story at that time. The recordings (or tapes) must be deleted (or destroyed) once the mind maps are completed and all information has been recorded. Recordings will normally be deleted within six months.

Use of Findings

Clinical teams can then use this information to plan improved care pathways. The challenge is to then provide this information to key stakeholders within the organisation and contribute to the "bigger picture". Actions can be at a local level with an immediate effect or contribute to providing evidence for existing work such as Patient Liaison work examining complaints and communication issues. Articulating the impact is probably the biggest challenge when undertaking stories. Informing patients and interviewees, providing examples of actions and outcomes, within the areas involved, is also vital to the process. Identification of good practice and providing positive feedback to the clinical areas and also to the key stakeholders is essential and highly motivational for staff. Sharing good practice is encouraged and patients are then able to see how *their* story has contributed to improving the quality of service and care we provide.

Feedback and themes identified in the stories can be disseminated in written reports, conference presentations, written publications and letters to participants/staff/teams and patients involved.

For further information please contact:

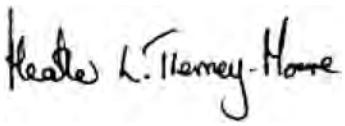
Sue Sloan, Lead Practitioner Clinical Leadership

CPPD Team, Education Centre, St John's Hospital

Tel: 01506 524416 (54416)

Mobile: 07740841626

Approved by:



Designation: Nurse Director

Date: 26 May 2008

Reference: NHS Modernisation Agency, Department of Health (2004) *Learning from patient and carer experience: A Guide to using Discovery Interviews to improve care*

Appendix 1 Patient Information

What are patient stories about?

You have been invited to take part in patient stories because

NHS Lothian staff are keen to hear from patients, clients and carers about what aspects of care they value and what aspects of care we could improve.

How long will it take?

The interview will take approximately one hour.

Will there be any other information about me?

The date of the interview and a code to identify your recording. All information and recordings will be anonymous. Confidentiality is of utmost importance.

What will happen if I do not understand the questions.

You will be asked open ended questions which are prompts so that you can tell us about whatever aspects of your care experience you wish to share.

There are no right or wrong answers.

For example:
Tell me more about....

What would I have to do?

Answer questions asked by the staff member so information can be obtained about your experience of

What are the benefits in taking part in patient stories?

NHS Lothian staff will be able to listen to your story, make improvements to service and also recognise and understand the aspects of care patients really do appreciate.

Where will the interview take place?

The interview will take place in a quiet area within the ward or hospital or health centre or at home

Appendix 1 Patient Information

What are the possible risks of taking part?

Sometimes patients may become upset or angry when telling their story. If at any time you wish to stop or withdraw from the interview you may do so. Your care will not be adversely affected in any way. Any recordings will be destroyed.

What will happen to the findings from my story?

The themes from the stories will be collated and action plans agreed to improve the quality of care.

Will this change the care I receive?

Taking part will not compromise your care. By increasing our understanding of what is important to you and by acknowledging any negative experiences, we can look at ways to improve and develop the care we deliver. We will also share examples of good practice.

Who is organising and sponsoring this work?

This work has been organised by NHS Lothian and is supported by the Nurse Director.

What if I want to talk it over with someone who is not involved in the patient stories

The date of the interview and a Please contact:
Juliet MacArthur,
Lead Practitioner-Research,
NHS Lothian
Tel: 0131 242 1752

Where will the interview take place?

The interview will take place in a quiet area within the ward or hospital or health centre or at home

Appendix 2

Using Patient stories in NHS Lothian

Examples of prompt questions for interviewing patients

These prompts are not in order and you may wish to add to or adapt them so they are more suitable for your patient group

- Tell me about when you became unwell
- Tell me about when you went into hospital/tell me about when you began to receive care at home
- What do you remember most?
- What was it like in the ward?
- Tell me about your care/operation/clinic appointment
- Is there anything significant or particularly memorable about your stay in hospital?
- Tell me about when you left the ward/clinic
- Was there anything that surprised/worried/upset/pleased you?
- Tell me more about....

NHS
Lothian

Patient Story Consent Form

*Please delete as appropriate

Have you read the information sheet? YES/NO*

Have you had an opportunity to ask questions and discuss

the process of story taking? YES/NO*

Have you received satisfactory answers to all your questions? YES/NO*

I hereby agree to participate in the patient stories on the understanding that I can withdraw this agreement at any time and that my current care and treatment will not be affected.

I understand that all the information gained will be anonymised and that information which is recorded or taped will be confidential.

After the interview the tapes will be listened to, themes from the stories will then be collated and explored, to identify areas of good practice and areas for development and improvement. The recorders/ tapes will be kept in a locked filing cabinet and only used under the supervision of an experienced healthcare professional.

I give my permission for the recordings/tapes to be used for teaching purposes within NHS Lothian.

Date _____

Signature or mark _____

Name (Block letters) _____

I confirm that I have explained to the patient/client the purpose and nature of the patient stories.

Date _____

Signature or mark _____

Name (Block letters) _____

Appendix 3: Quotes from Emotional Touchpoint stories and their link to action

'I think the patients would like to call everyone nurses. That is what the patients call staff. The idea of untrained staff – all the staff are trained. People talk about the trained and untrained. I am not sure about this.' (Relative)

- **Action:** Untrained' nurses to be referred to as auxiliary nurses by all members of the team

'I had nursed my husband for a number of years but I knew that the doctors and nurses could do things for him that were beyond me. The staff allowed me to continue caring for my husband; they would say to me "Let us know if you think he is in any pain", "Which side does he like to lie on best?" They did not try to separate me from my husband and they allowed the whole family to be there which was a great support and comfort for me.' (Relative)

- Action: Making sure that all patients and relatives are asked at admission and at other intervals throughout their stay what is important to them and recording this on the 'all about me sheet'

'One of the ladies died on here and I know that Mary was really close to her so I asked her if she would like to pay her last respects to the lady who had died. She went in and stood up over the bed and kissed her head and said God bless. It was a very special moment' (Staff member)

'Once mum had died we did think did Jessie – one of the other patients know about this. Jessie and Mum had struck up a friendship when they were in the ward together. I said to one of the nurses – *'oh can you tell Jessie that mum has died?'* – she looked at me, and had furrowed brows – I don't think she thought this was important. In the end we told Jessie that mum had died. Death happens to us all and it can be important to some people to know what has happened'. (Relative)

- **Action:** Having a staff discussion after someone has died, to decide which patients it would be appropriate to tell, and which patients to approach and offer an opportunity to pay their last respects

We really valued the continual updates that we received from staff, for example, 'He is much more comfortable this morning and telling us what to expect, not to be too alarmed about certain changes'. This made us feel more involved and prepared and therefore more at ease. Staff would often say to us 'Let us know if your father is in pain'. There was a real openness to share information.' (Relative).

- Action: Staff allocation system to patients reviewed so that more staff were involved as key nurse and that each staff member had a smaller number of patients to get to know well. This enabled staff to get to know family members better and build up relationships with them quicker.

'I felt out of my depth at night time - I had no experience of being in hospital overnight and there were to many differences from the day shift. New staff came on duty who needed time to get up to speed with Dad's latest situation, the lights were dimmed, the ward became quieter but because of that we became much more aware if there was an emergency being attended to. I felt unsure of what rule and regulations applied.

For example - Was it still OK to use the kitchen? Was there a vending machine for drinks/snacks in the building or if you went out of the building would you be able to get back in? Was it permissible to watch TV in the patients or relatives lounge at 3am? In some ways we could perhaps have done with a brochure to give us some information and to tell us what to expect' (Relative).

- **Action:** Development of an information pack with the relatives to help people to understand what it means to be a relative in the hospital at night

'You are always encouraged here to get involved with the bits and pieces that are going on. I feel grateful about the opportunities that are offered. Sometimes when it is busy you don't know what to do and you can find yourself wandering round.' (Student)

- **Action:**
- Staff and students prepared a list of handy things to do when you are feeling lost and don't know how to help. This included things like making sure all patients had a drink to hand and their buzzer and soaking someone's hands in warm water and cutting their fingernails. This list was attached to the student welcome pack.

'I asked this nurse what am I having for tea and she said she did not know which is silly cos she works here' (Patient)

'I like to cheer mum up when I come in. I help her with the menu. I like to try to vary it for her. She really liked what she had at lunch today but when I asked she couldn't remember what it was. I like to talk to her about food to try to get her interested because she has been off her food.' (Relative)

- **Actions:**
- Menu written up on white board each day so that staff, patients and families can see this. Positive response received from families about this as they now know what choices their relative had at mealtimes and has provided a discussion point for them at visiting.
- For people with a dementia the menu card is photocopied so that staff can share with the patient during the day what they have ordered to eat.

'We did not complain as we were very aware that we were on an emotional roller coaster and that our perceptions could have been inaccurate and our reactions may have been overreactions.' (Relative)

- **Actions:**
- Making a point of finding out how things are going for relatives by asking them directly on a regular basis.
- Each patient is allocated to a key member of staff to make this communication process easier.
- Carrying out patient and family stories using emotional touchpoints as a routine part of practice on the ward.

I felt that I was not caring for the patient who was a prisoner in a way that I would care for other patients. I was worried what other staff would think if I took an interest in him, they may think that I thought that the crime he committed was okay. It has been good to be able to talk about this. I feel really grateful as this has been a learning experience for me – I also feel determined to not make the same mistakes again. By that I mean being more comfy with the way I am and not so worried about what people say and think. (Staff member)

- **Action:** Weekly meetings each Thursday afternoon on the ward where the Chaplain explores with staff issues about caring. These meetings are confidential and staff have the opportunity to share how they feel about caring.

'I like it when the staff call me darling – I feel the staff treat me like family' (Patient)

'I don't like it when the staff call me dear it is condescending' (Patient)

- **Action:** All patients are asked when they are admitted if they would mind if staff ever refer to them using terms like honey, love or poppet and this is recorded in the all about me sheet.

'When she got her Rice Krispies™ at breakfast they were 'swimming in milk', this absolutely 'scunnered Mum eventually'. (Relative)

- **Action:** All patients offered a choice of how much milk they would like in their cereal in the morning. More choice at other times in relation to food e.g. salt, pepper and sugar at hand for those who want it.

'It's really good when people give you feedback about how things are. The other day one of the Consultants told me that I was very clear and concise in the multidisciplinary meetings. He felt that I came over with confidence and that I was doing well. This is my first staffing post' (Staff member)

- **Action:** Introduced feedback fortnight where staff invite 4 other members of staff to complete a short questionnaire about aspects that they do well and areas they could develop. This is planned to be carried out 3 times a year.

'The care is excellent here but the one thing I really worry about is making a mess of the bed during the night. I call out but I never know if the nurses have heard me and I worry that I will mess the bed. I have always been a clean and tidy person and this would be terrible. It would really upset me. The nurses say that I have not to worry and that they don't mind if they have to clean me up. But I really mind. It has never happened so far, the nurses always come but I worry.' (Patient)

- **Action:** The staff worked with the patient to find a solution. They thought of a hand bell to ring but the patient was worried if she rang this she would wake up fellow patients. One staff member came up with the idea of an intercom. This worked and the patient said "Oh I can't tell you what a difference this has made. I feel so relieved. I am not so well now so I might have to spend more time in bed away from where the nurses sometimes are. I feel so relieved thank you'.

'I wish I was not woken up for my medicines in the morning, don't know why this happens as I don't have medicines in the morning.' (Patient)

- **Action:** Recognising when it is not essential to give medicines out when people are asleep. This was presented at a staff meeting – staff discussed this and came to an understanding that although there was a medicine to be given at that time – the medicine should be moved to another time as to not disturb sleep.

'This has been the most organised placement I have ever had, your name's up on the board along with your Mentor and Co-mentor. They had books which are excellent, ready for me on my first shift, but before that I came in for a visit, it would have been good for me to have them then to read for preparation. The thoughts before being here don't match what it was really like, not that I really knew what to expect. I was intrigued to come and you take away what you want from a placement. The pack made up by here is excellent, it explains everyone's role and what to expect.' (Student)

- **Action:** Student portal information and unit booklet updated, with students advised to attend for an informal visit prior to allocation.

'Speaking with the doctors has left me bewildered. I have been told so many different things; I don't know what to believe. The doctors on this ward are nice but they just tell you what's happening and what they are doing. I really don't know what to ask them. I've been told Mum has Dementia with Lewy bodies, I don't know what that means. I went online to look it up, but I don't understand. Parkinson's disease has also been mentioned, I just don't know anymore.' (Relative)

- **Action:** Primary nurse and key worker meet with the relatives and patients following admission to collect a narrative using emotional touchpoints about their experience of care so far. They use this narrative in their contributions to the multidisciplinary patient reviews

'I feel wonderful when the Bank Nurse arrives on the ward and they have worked here before because they know a bit about the place. However, I feel grumpy when the Bank Nurse is not interested or motivated to work with us. They often end up standing about in the corridor when they could at least be talking with one of the patients' (Staff member)

- **Action:** A staff nurse worked with ward staff and along with feedback from Bank Nurses, an induction sheet for Bank staff was developed so that in the future other Bank staff would be given they came to the ward. This work was shared with Senior Managers of the Nurse Bank.

Appendix 4: Observation of interactions tool – Leadership in Compassionate Care Programme

(adapted from QUIS tool Dean, Proudfoot and Lindesay 1993)

The way in which you communicate to staff patients and families is a vitally important component of compassionate care. The quality of interaction audit tool is designed to help you evaluate the type and quality of communication that takes place on your unit/department or ward.

What is a quality of interaction audit (QUIS)?

This is a method of systematically observing and recording interactions whilst remaining a non-participant. It is a technique first developed for use in long term residential mental health settings, but the tool has undergone substantial revision has been adapted for more general use in residential and general hospital settings. It can be used as both a qualitative and quantitative tool to provide a measure of the quality of interaction between staff, patients and visitors. It is designed to develop the therapeutic and more sensitive communication within a ward or department. Initially it's use was to observe interactions between staff and patients but it has been adapted here to be used to observe interactions between staff/staff, staff/ patients and staff/relatives.

It should be used sensitively and discreetly with full knowledge of managers, staff, patients and relatives(if appropriate).

Key principles to consider in using this tool

Appreciation – appreciating the perspectives of all those involved in what you are observing is valuable. Jot down in one of the margins some questions related to what you have seen – e.g. checking out with staff why they acted in the way they did. It may be that you are able to pick up cues from patients and families about how they responded to particular interactions. This is important to record. Being aware of checking out assumptions you are making about what you see is important. In addition the act of appreciation is about analysing what worked well and why and trying to build on this in our action planning. This is a key element to the approach adopted here.

Relationship centredness – It is important to record patterns of communicating between staff, between patients and staff and between relatives and staff. Communication happens in the context of relationships. It is important to explore this in any discussions you have following the observation

Action – A key part of the process of feeding back observations is discussing learning and possible actions with staff. It may be that it is also appropriate to feedback and plan actions together with patients and families depending on the care setting. Actions should not just be considered in response to negative data findings but in response to how we can make what worked well happen more of the time.

How can the tool be used?

- As an introductory tool for highlighting good communication practice and areas for development
- As a management tool
- As a training tool
- Best used as part of a multi-method approach to quality improvement

The following practical guidelines (adapted from Fawcett 1996) will assist you in preparing and undertaking an observation

Guideline	Rationale
Preparing for Observation	
What is the focus of the observation e.g. medication administration, mealtimes, personal care-giving	It is not possible to observe everything within a multi-sensory environment. You need to choose a focus for your observation. You may be required to observe on a number of occasions (at different time periods) to build up a picture of what is happening in a workplace. You need to take into account the environment, verbal and non-verbal communication, actions, events & people
How will you document your findings?	It is helpful to develop a system for documenting your findings that enable you to capture data during the observation in a timely manner. Consider what abbreviations or codes you may use to document findings. Having large margins allow you to capture your thoughts during and after the observation. You will need to take note of things such as place/date/time. The template at the end of this guidance sheet may help in recording observations.
Gaining access to the site	You need to negotiate access to the site, think about us how often and how long you might want to observe practice. You also need to inform staff about the purpose of your observation and obtain consent where appropriate.
Preparing yourself	It is best to observe with a colleague in order to validate your findings and agree on key issues. When choosing a partner for observation, consider the need for an insider/outsider approach (i.e. if you are insider to the setting then perhaps someone from outside the setting would be most appropriate as a partner [and vice versa]). Consider having a 'practice observation' with a colleague, that way you can both observe the same thing and then compare notes about what you observed.
Undertaking an Observation	
Positioning yourself (+ other observer if required)	Think where the best advantage point is for you to observe practice. You need to take into consideration such things as how easy it is for you to observe what is happening without being 'in the way'.
Time	As you are developing your observation skills you may find that you can only spend 15-20 minutes observing practice at a time as a high level of concentration is required. This observation tool is designed to be completed in 20 minutes.
Recording data	Try to capture as much data as possible. Ensure notes are clear and concise. It may be that you want to record what is happening and assign the codes later. Try to be as clear as you can with your description so that it is easier to ascribe codes later.
After the Observation	
Review your notes	Write any additional comments as soon as possible after the observation period as well as any questions you are posing about what you have observed. Compare notes with the other observer to develop a greater understanding about what was happening.
Review the process	This can be done as an individual or group activity. What worked well during the observation? What things could you improve upon? What did you learn about observation skills and techniques? What impact did your own value judgements have on what you observed?
Feeding back	When the observation is finished you (the observers) should firstly clarify with individual team members anything you are unsure of. You should also discuss with staff specific aspects of the observation data that you want to further clarify or gain a deeper understanding of. Prepare to feedback an overall score and also key themes that emerged. Present the key themes as tentative open to discussion and refinement
Analysis and action planning	You may choose to do this after one observation or after a number. The process should involve developing an understanding of what worked well. What supported the positive social interactions to happen? How could they happen more of the time? What action do we need to take forward?

Rating the interactions

When rating the *quality* of the interaction, bear in mind:

- Consistency
- Your agreed consistency with your colleagues
- Your discretion when rating each part of a multiple interaction. Use common sense but give a fair picture
- Negative interactions even as part of a 'better' whole should be identified. A sharp instruction or command, belittling, or inappropriate behaviours or endearments stick in the mind of staff, patients and relatives.
- Discuss your thoughts with your colleagues, some activities or events just need extra thought
- Rate straight away
- Write any additional comments as soon as possible after the observation period as well as any questions you are posing about what you have observed

Equipment

- Watch with second hand
- Observation sheets – usually at least 5 sheets per person per observation (enclosed within the portfolio)

Observation time periods

This tool can be used at any time but may be useful during:

- Early morning for personal care
- Handover
- Doctors rounds
- Lunchtime
- Early evening with visitors present – for noise/ busyness
- Late evening

Each observation is to be 20 minutes in duration.

Interactions to record

All *staff/patient/relative* interactions to be recorded during the period of observation.

Feedback and presentation of the results

When the observation is finished you (the observers) should firstly clarify with individual team members anything you are unsure of. You should also discuss with staff specific aspects of the observation data that you want to further clarify or gain a deeper understanding of. Start by asking them open questions. This will help you gain insight into the practice context and minimise the risk of you making false assumptions about what you saw.

Immediate feedback is important and it is crucial to feedback both positive and negative aspects of what was observed.

It is useful to give a written summary including the nature of the interactions that worked well and those that need to be considered for development. Within this summary it is useful to give simple percentages of the quality of interactions e.g. 20% of observation were positively social (n=20), 70% were basic care interactions (n=70), 5% were neutral interaction (n=5) and 5% were negative interaction (n=5).

Developing action

Work with staff to consider:

- How they feel about the feedback?
- What they would like to discuss more deeply?
- What they have learnt?
- What helps the things that worked well to happen?
- How could these things be supported to happen more of the time?

For negative interactions – what might be going on that causes this to happen? What would the reverse of the negative interaction look like? How could this be supported to happen more of the time? What actions would they like to take forward and how might they do this?

Coding categories

The coding categories for observation are:

Positive social (PS) – interpersonal communication demonstrating empathy, support, explanation, socialisation.

These interactions:

- Show warmth, are respectful and sensitive
- Are enhancing, providing people with feelings of safety and significance
- Are enabling and can assist individuals to make choices and be in control
- **Neutral: (N)** – brief interactions that are carried out but without elements of social, psychological, and emotional support as above. It is the conversation necessary to get the task done.

These interactions:

- Neither undermine nor enhance people
- Are either part of carrying out care tasks adequately in order to get the job done or
- Involve a request or information exchange without any of the features of Positive Social interactions

Negative Communication (NC) – communication which is disregarding of the staff, patient or family members' dignity and respect.

These interactions:

- Lack warmth or respect
- Undermine feelings of safety and significance
- Are insensitive and can be disempowering

In addition to the codes above it is important to record whether the interaction is **verbal (V)** or **nonverbal (NV)** and

Who the interaction is between staff/staff (SS), staff/patient (SP) or staff/relative/visitor (SR)

Observation of Interactions – summary of codes

Positive social (PS)- interpersonal communication demonstrating empathy, respect, support, explanation, socialisation.	Neutral (N)- brief interactions that are carried out but without elements of social, psychological, and emotional support as in positive social. It is the conversation necessary to get the task done	Negative Communication (NC) – communication which is disregarding of the staff, patient or family members' dignity and respect.
• Caring conversations e.g. what sort of night did you have, how do you feel this morning, what would make you more comfortable • Showing interest in and knowledge of the patient as a person • Encouragement and comfort during care tasks that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients, staff and families • Explaining, offering information e.g. medications • Appropriate use of smiling, laughing, personal touch and empathy • Welcoming patients, visitors and other staff onto the ward • Introducing yourself to others • Engaging in conversations that check things out with others • Negotiating conversations • Ascertaining the views of others • Giving praise • Using tools to enhance communication • Involving people in decisions • Supporting people to ask questions • Asking questions	• Brief verbal explanations and encouragement, but only that the necessary to carry out the task • Fleeting task orientated conversation • No questions about feelings or questions to elicit how another person feels • Fleeting comments to check out things – is that okay? • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Lacks caring or empathy but not necessarily overtly rude • People's opinions are not ascertained • Lack of explanations • Talking to a colleague at the bedside without including the patient • Giving minimal responses to questions by others • Not recognising underlying concerns or issues	• Ignoring, undermining, use of child-like language • Being told to wait for medication or attention without explanation or comfort • Told to do something e.g. button dress without discussion, explanation or help offered • Being told can't have something e.g. a cup of tea without good reason/ explanation • Being rude and unfriendly • ✣Bedside hand over not including the patient • Being referred to as a label – student, bed number, boarder, feeder. • Being angry with or scolding people

Date _____ **Time** _____ **Area/Ward** _____ **Event (if appropriate)**_____

Observer: _____ **Overall Score** _____ **Positive Social,** _____ **Neutral,** _____ **Negative.**

Interaction Description of what happened	Code: PS, N or NC	Verbal / Non-Verbal	Between?	Questions/Comments

Leadership in Compassionate Care Programme – ObservationDate 15/7/10Time 0820-0845
Observation event: Breakfast Observers names: XXXXXXX Ward: XXXXXX

Overall score xx% positive social interaction xx% neutral and xx% Negative
(Only sample of interactions represented here).

Interaction Description of what happened	Code: PS, N or NC	Verbal / Non-Verbal	Between?	Questions/Comments
Staff nurse says 'Remember to buzz me my name is XXX' as she leaves the patient	PS	V	S-P	How often do we remind patients of our name? Maybe it is good to do this more than just say at the start of a shift
Conversation happens around the bedside as nurse is checking medications – I like to pick my own fruit (staff)	PS	V	S-P	This conversation was happening while the nurse was looking out the tablets and checking them against the prescription – is this hard to do when the patient is talking to you? Should we make patients more aware that it would be helpful to have minimal conversation during medication administration?
I am not fit enough to do that anymore (Patient)				

Leadership in Compassionate Care Programme – ObservationDate 15/7/10Time 0820-0845 Observation event: Breakfast Observers names: XXXXXXX Ward: XXXXXX

Overall score xx% positive social interaction xx% neutral and xx% Negative (Only sample of interactions represented here).

Interaction Description of what happened	Code: PS, N or NC	Verbal / Non-Verbal	Between?	Questions/Comments
Nurses making a bed and talk to each other – no patient is by the bed. Social conversation about whether they are working the weekend or not	N	V	SS	This seemed appropriate given there was no patient there. If the patient is there how do you include them in your social conversation?
Making beds while patient eating breakfast – no conversation	NC/N	VV	SP	Was it necessary to make the beds during breakfasts on this particular morning? Was the patient asked if this would be okay? Would the patient feel comfortable to say it was not okay? When asked the nurse about talking to the patient while making bed she said she preferred not to do this as the patient had their mouth full of food. More
Relative arrived on ward – staff said hello and asked her how she was	PS	V	SR	How easy is it to genuinely ask how the relative is? What happens if they go into a lengthy conversation about how they are feeling and you don't necessarily have the time to listen at that moment?

Interaction Description of what happened	Code: PS, N or NC	Verbal / Non-Verbal	Between?	Questions/Comments
Ignoring a patient that is calling out for assistance. (following discussion with staff the patient calls out a lot of the time, the person has a cognitive impairment and staff were working hard at trying to find attend to needs and support other patients on the ward)	NC/N	NV	SP	What is an appropriate way to respond when a patient calls out for nurses nearly all of the time? Staff talked about how they new by the tone of his voice if things were different for him and although it might look as if they were ignoring him they were looking in the room always as they were passing. NC moved to N

QUIS originally developed by Dean, Proudfoot and Lindesay (1993). The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry* Vol * pp 819-826.

QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University. Available at: **http://www.staff.city.ac.uk/~jacky/dignity/resource.htm**

QUIS tool developed further after consultation with Health Improvement Scotland, with specific reference to Inspection of services for older people in acute hospitals in NHSScotland, Observation recording guidance for inspectors, Person Centred Care:

Care which demonstrates compassion, dignity, privacy, clear communication and shared decision making

Appendix 5: Exit Interview Schedule

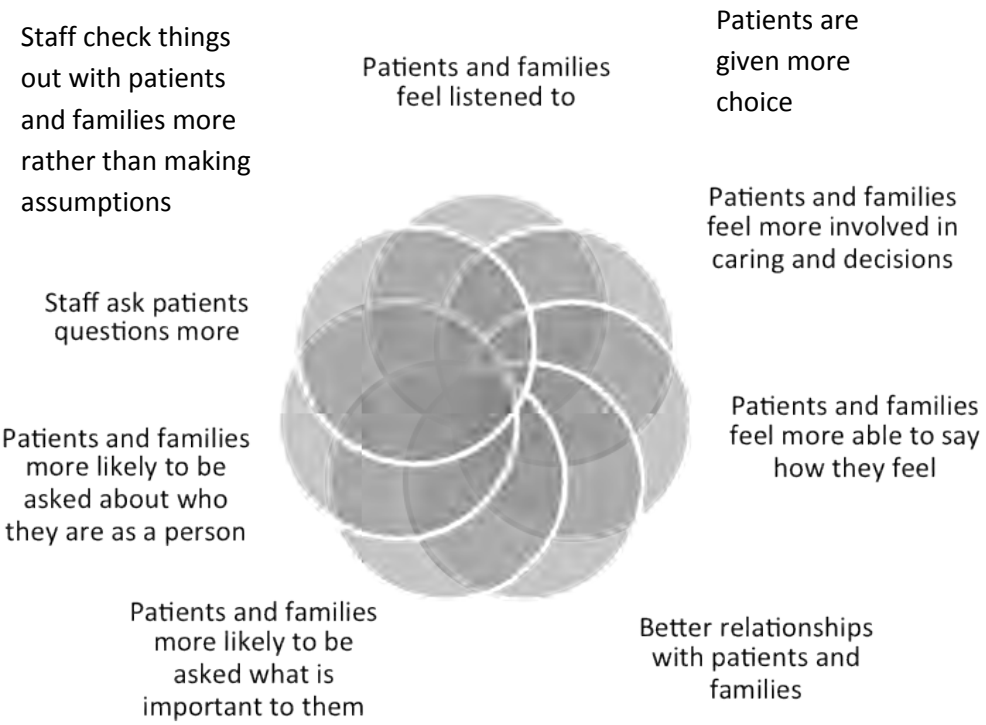
Evaluation Questions (October 2010)

Looking back over the programme:

1. What has it felt like to be involved?
2. Can you tell me a bit about a time when you felt your opinions were listened to and valued in this programme?
3. Can you tell us one good or successful story from the process.....and one not so good, or a disappointment?
4. What improvements have you seen? Can you give an example?
5. Tell me a bit about thing you have learnt about yourself through participating in the programme.
6. As a result of taking part in the programme, what has it made you think about?
7. What, if anything, are you going to do differently as a result of taking part in the programme?
8. Tell me about what you have learnt about the team while taking part in the programme?
9. Is there anything you think we should have done differently?
10. What do you think will happen now? In what way will things continue?
11. How would you describe what you and others have been doing to someone who did not know about the programme?

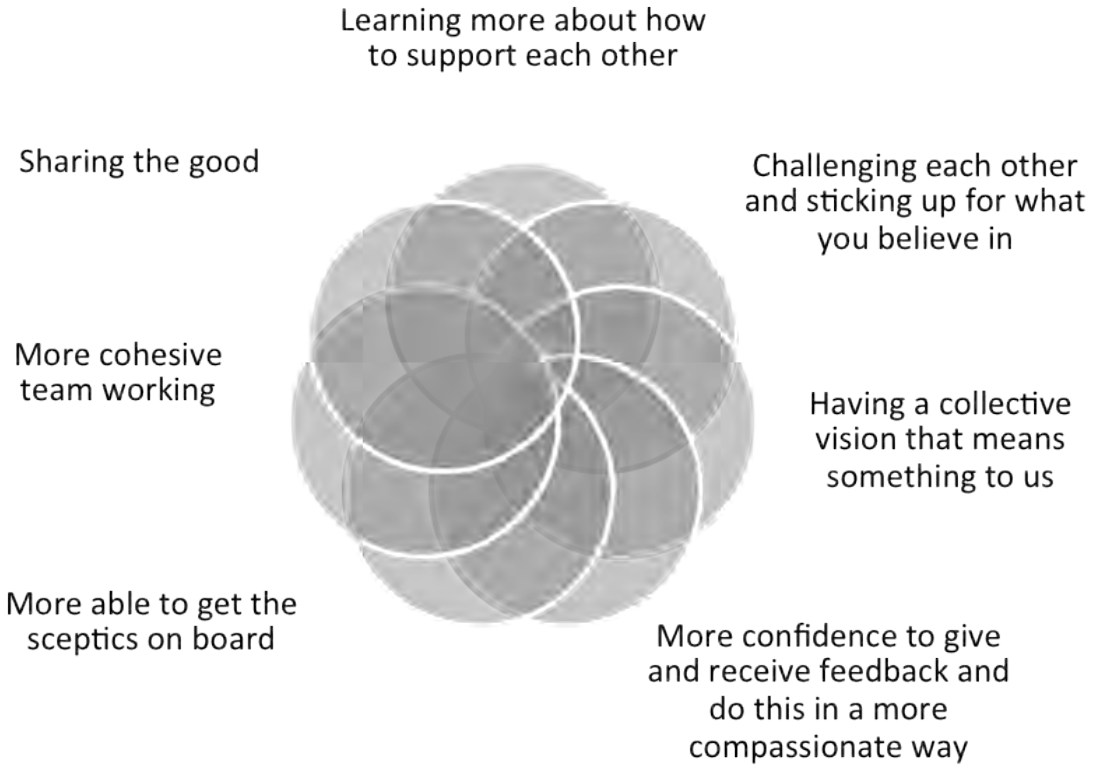
Appendix 6: Themes from exit interviews

Differences to patients and families as perceived by the nurse

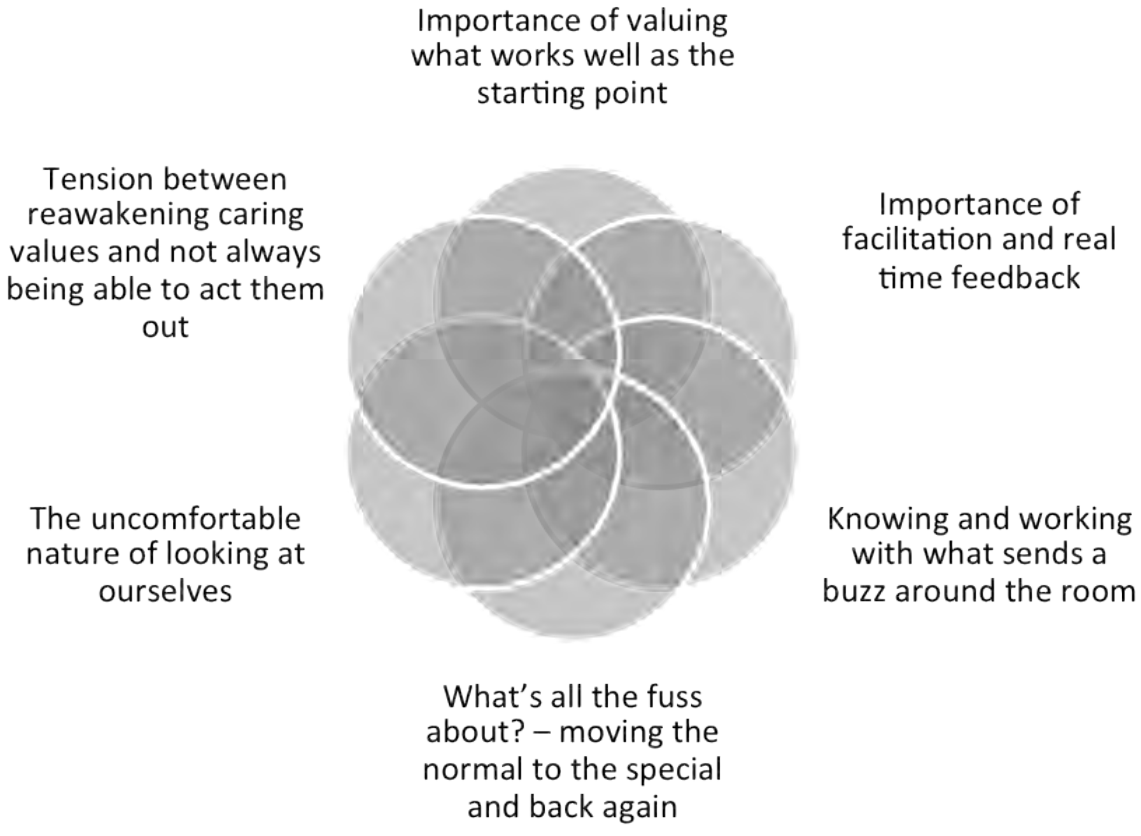


Differences to staff as individuals as perceived by staff

Differences to the team as perceived by staff



Process points



Appendix 7: Discussion and action about positive care practice

Quote from patient staff or family member about what works well in relation to caring	Positive caring practice statement	Staff commentary	Agreed Action
'We were privileged in many ways when visiting my husband in the last few days of his life. Basic things like being given permission to use the kitchen meant we could make tea and coffee or microwave a meal. The relative's lounge included a sofa bed and a shower so I didn't have to go home and we could be at my husband's bedside 24 hours a day. This was especially important to me.'	Learning about the little things that matter to people and adapting existing policy is important. For one relative knowing that she could be on the ward 24 hours a day if necessary was important	People are not supposed to use the kitchen – some staff let them do this and others don't but you can't criticise those that don't because they are just doing what is being asked of them.	Charge nurse to find out what managers perspective on this policy is. Charge nurse finds out that there is a special fridge stocked with food in the hospital for relatives at night. This was not widely known and was subsequently put in the new guidance sheet staff and relatives developed together to give information to relatives. Tea and coffee facilities were put into relative's room so that they did not have to go in the kitchen.

Appendix 8: Examples of Improving Experience Briefings:

Title: Using Beliefs and Values clarification to improve understanding of ward culture

Summary:

Simon Pullin, Senior Nurse with the Leadership in Compassionate Care Project used a values clarification exercise (Warfield & Manley 1990; Manley 1992) to get to the heart ward culture. This method was used to understand staffs beliefs and values of issues relating to compassionate care.

How it was before:

Active processes for understanding staffs beliefs and values were not explicit

How I did it:

- Organised to meet with groups of staff
- Groups were varied and included therapists ward clerks, students, nurses etc.
- Explanation of beliefs and values given
- Series of questions asked of group. Then discussed as a team
- Worked with the group to help explore issues further
- Discussion recorded, then written up and fed back
- Themes compiled from collective analysis

How it's improved:

- A way of developing relationships with the team
- Staff valued having space and time to talk about care "Really good (doing B&V) to be able to take time to think and talk like this"
- Identified strengths of the team
- Identified areas of development
- Provoked thought and reflection from staff : "Was useful (doing B&V)made me think more about why I am here"
- How I feel about what I have done:
- Developed a better understanding of the area
- Felt able to work with staff to identify what was good and what could be done better.
- Nervous in doing this exercise to make it a good experience for staff
- Good to receive feedback as to how staff enjoyed the opportunity

Further Information

References/ Websites etc

Warfield C; Manley K (1990) Developing a new philosophy in the NDU Nursing Standard 4(41) 27-30

Manley K (1992) Quality Assurance: The Pathway to Excellence in Nursing (Chapter 7) In Bryzinska G & Jolley

Contacts: Simon Pullin, Corstorphine Hospital, 136 Cortorphine Road, Edinburgh EH12 6TT, Tel: 0131 459 7215

Email: simon.pullin@nhslothian.scot.nhs.uk; s.pullin@napier.ac.uk

Improving experience briefing

Title: Using emotional touchpoints to learn about the experience of receiving care

Summary: Belinda Dewar and Richard Mackay, Charge Nurse on ward 50 Western General Hospital, and member of the Leadership in Compassionate Care Project, are supporting staff to use emotional touchpoints (Bate and Robert 2007) as way of learning about the patient and family experience of being in hospital and using this to help staff recognise and celebrate positive care practices and develop the service.

How it was before: Patients were asked informally on the ward how things were going for them and the ward issued a postal questionnaire to former patients on a yearly basis. Patients often said the care was really good and gave thankyou cards but we did not know why it was good. We often got a poor response from the survey and the comments were again very general. When we tried to use patient stories on the ward we found that patients described what had happened but rarely told us how they actually felt.

How we did it:

- Develop up a pack of emotional touchpoints in the patient/relative journey e.g. coming into hospital, mealtimes, personal care, going for tests
- Develop up a bank of both positive and negative emotional words e.g. powerless, happy, included, numb
- Invite patients/relatives to take part in sharing their experience
- Explain how we plan to do this – through an informal discussion lasting about 30 minutes and provide written information
- Ask them to provide informed consent 24 hours before the discussion takes place
- At a time that is suitable for the patient or relative ask the patient to select the touchpoints that are relevant to them in their patient experience and invite them to include any additional touchpoints that we have not already identified (one relative though being here at night was a key touchpoint for her so this was added)
- Taking each touchpoint in turn, ask the patient/family to select an emotional word that sums up for them how they felt about the particular experience of for example – coming into hospital, or going for tests. The patient may select a number of emotive words. From the example above the patient selected worried and glad in relation to the experience of going for tests.
- Ask the patient/family why they felt that emotion. A relative said for example that they felt out of their depth being on the ward at night as they did not know the routine and what they coul and could not do. They also felt privileged as they were given the space on the ward and support from the nurses to laugh, cry and talk with their family about what a lovely life their father had had.
- When a negative point is raised ask the patient/relative what they think we can do to improve things and if appropriate ask if they would like to be involved in this (for example in the above example the family member is helping to develop an information sheet to support families who are on the ward at night)
- Following the interview – type up the notes from what the patient/family have said.
- Give the notes back to the patient/family member to read through and ask them if this is an accurate recording of what they said and if they are happy for us to share this with staff on the ward
- Share with staff and ask staff to tell us what they have learnt from reading the story and if there are any actions we would like to take forward

How it's improved practice:

- Staff more at ease about hearing negative aspects of a patient/family experience as the method does not directly focus on blaming the service
- Better relationships developed with patient and family members
- Seeking feedback that is based on the persons emotional response to a situation cannot be disputed

- Patient and family member can be involved in shaping the service
- Actions taken forward are based on real and meaningful evidence – i.e. the voice of the patient/family
- Staff feel moved and motivated to have another look at what we do
- Has helped us to challenge assumptions about what we think the patient/family feels and wants

How we feel about what I have done:

Using emotional touchpoints has been a powerful experience for us on ward 50. The touchpoints are easy to use and help to keep a clear focus to the patient story. It is really hard not to be driven to action from the story so it has meant that change and development take a smoother ride. Hearing the positive things about practice has been a real insight – we often don't know the small things that matter so much to the patient and perhaps we take for granted. This quote below from a relative told us something that we do on the ward that is positive that we did not really know about:

'My mum needed the loo and I told somebody – they said this was not a problem and asked me to wait outside. I could hear them outside the room and they were chatting away to mum at her level – they were having a laugh together and sharing things. I felt proud as the staff had probably heard what she was saying so many times already but they reacted as if they had heard what she was saying for the first time. This felt good.'

Further Information

References

Bate P and Robert G (2007) Toward more user centric OD: Lessons from the field of experience based design and a case study Jourla of Applied Behavioural Science 43,41 **http://jab.sagepub.com/cgi/content/abstract/43/1/41**

Contacts:

Richard Mackay, ward 50 Western General Hospital, Crewe Road, Edinburgh, **Richard.mackay@luht.scot.nhs;**

Belinda Dewar, Senior Nurse, Leadership in Compassionate Care Project**, b.dewar@napier.ac.uk.**

Improving Experience Briefing

Using the Senses Framework to enhance student placements

Summary: Pat McGeever, Charge Nurse at Roslynlee Hospital took part in the Leading into the Future Programme and used the Senses Framework (Nolan et al 2006) to structure student's engagement with all the ward staff during their placement and as a way to seek feedback on the learning environment.

How it was before: Students were often seen as 'just another pair of hands'.

How I did it:

- I met with the students on their first day of placement and discussed my own experience of working in older people's services (positive and negative) and my vision for the ward.
- I explained the Senses Framework and outlined what I hoped it would achieve for patients, relatives, staff and students.
- I asked the students to keep a reflective diary, specifically focussing on when they felt the 'Senses' were being met for them – I wanted to know when things were going well.
- I gave them a questionnaire that looks at the Senses in the ward environment and asks what 3 things they would change in the ward. One thing they highlighted was that our meal times were too noisy, with more interaction amongst the staff than with the patients.
- I created a new buddy system for students – as well as a registered nurse mentor they also had a nursing assistant buddy.

How it's improved:

- Sense of Belonging – writing the students' names up on the staff board (for patients and relatives) made them feel part of the team
- Sense of Continuity – they told me that there was a difference in the way they had been taught to administer a depot injection at Napier compared to what they were seeing in practice. This led to review of ward practice and the students were supported to administer in the way they had been taught.
- Sense of Achievement – the students' mentor at Napier reported that during reflection sessions these students talked a great deal about the Senses Framework and how enthusiastic they were about the placement with a strong focus on what they were achieving.
- Sense of Purpose – the students worked closely with the occupational therapist to develop a way of gathering 'life stories' for our patients that helps us to get to know them more as individuals. This made a significant contribution to our ways of working that will remain long after the students have left.

How I feel about what I have done:

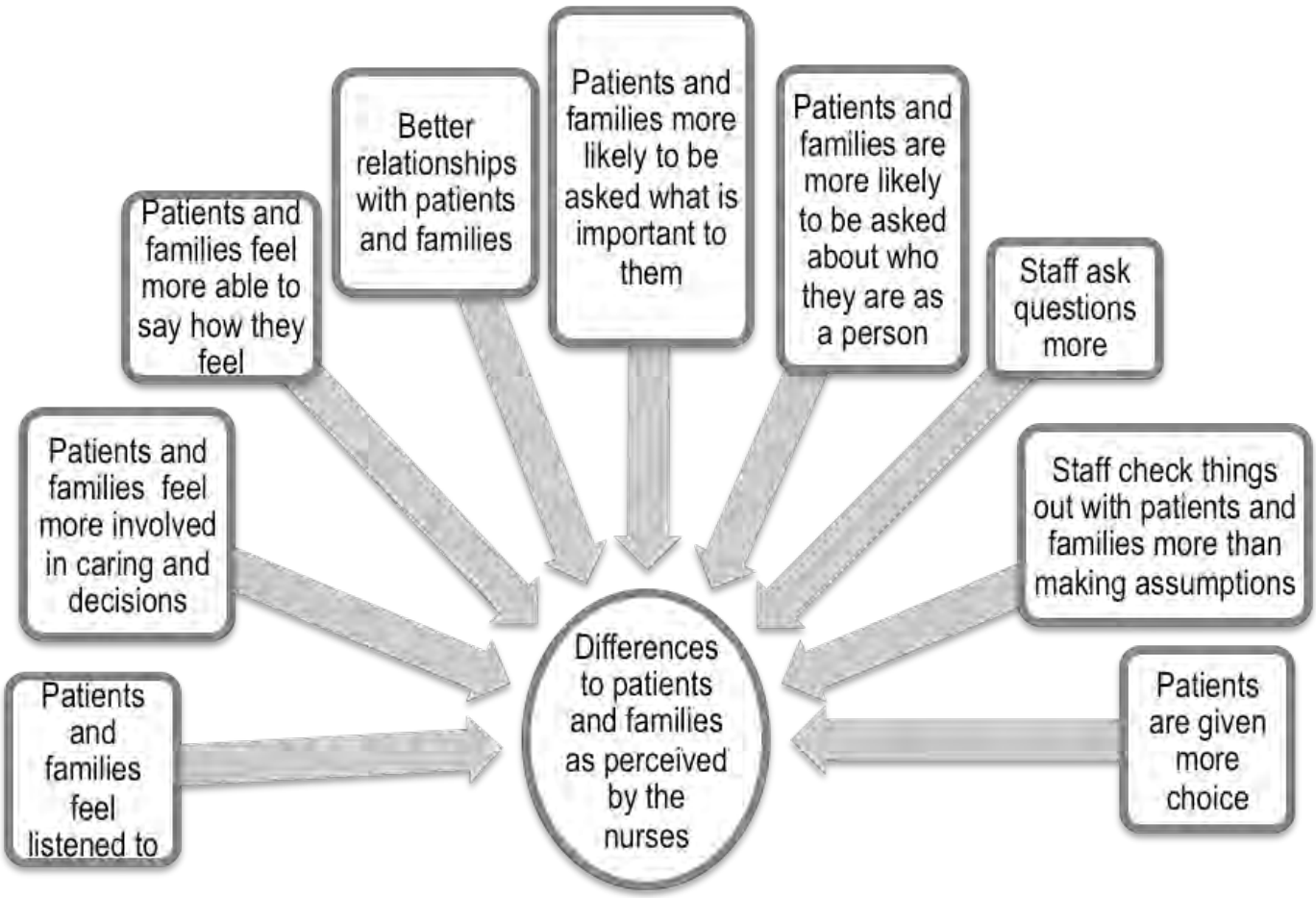
When I heard about the Senses Framework it just connected with me and the light went on! Taking the Senses forward in my ward has made me feel refreshed and rejuvenated. Spending time with the students on the first day setting the scene was the key thing – spend an hour telling them my story and journey in nursing paid dividends. The other great thing is that all the team wanted to come on board because the Senses helped remind us of all the values we came into nursing for. It was good to see the students leaving happy – one of them is even presenting about her experience on my ward at an RCN National Student Conference!

Further Information

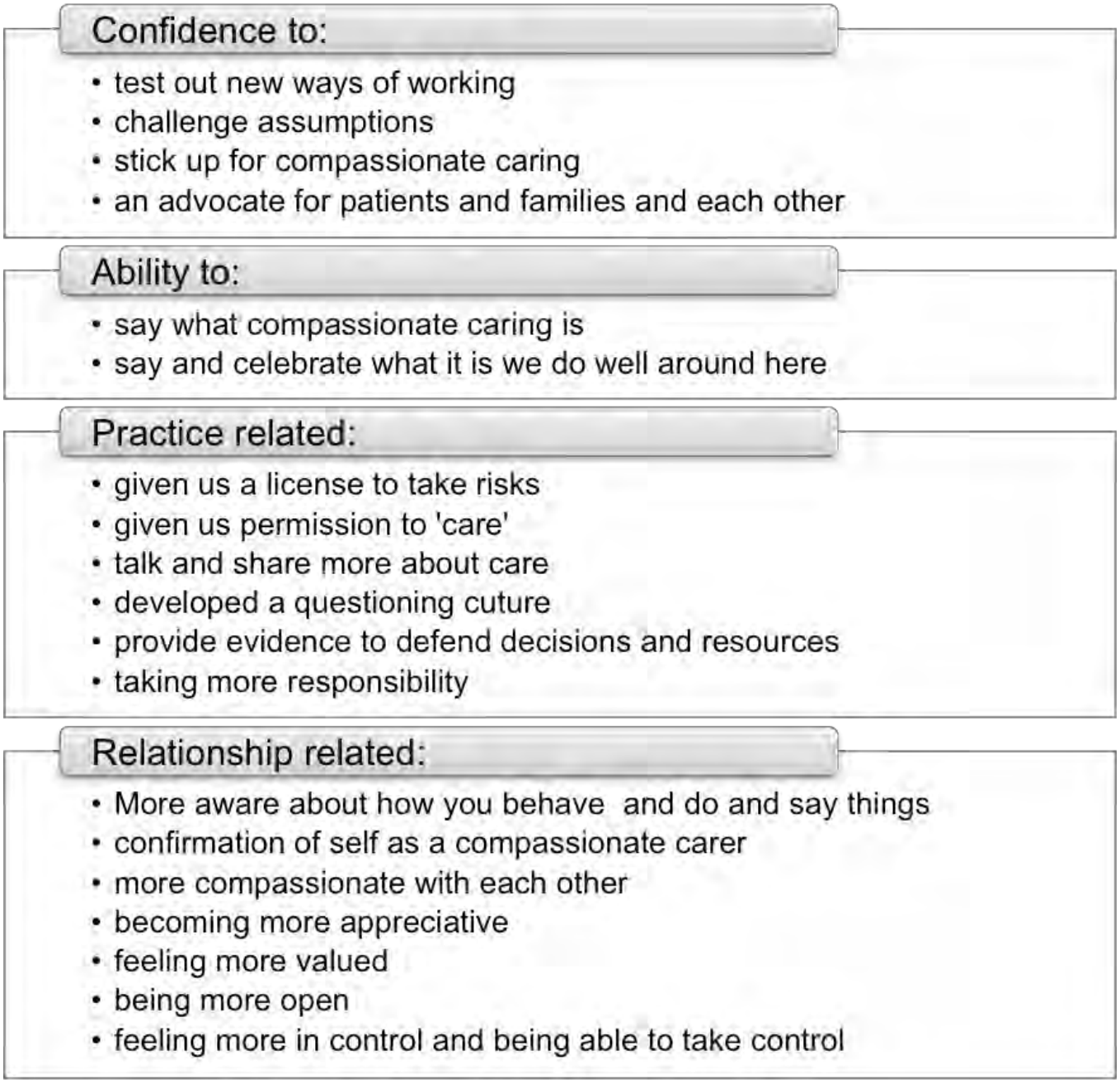
Nolan, M., Brown J., Davies, S., Nolan, J., Keady, J. (2006) The Senses Framework: Improving Care for Older People through a Relationship-Centred Approach GRIP: University of Sheffield.

Contacts: Pat McGeever, Charge Nurse, Roslynlee Hospital, Roslin, Midlothian, EH25 9QE, 0131 536 7600,
patricia.mcgeever@nhslothian.scot.nhs.uk

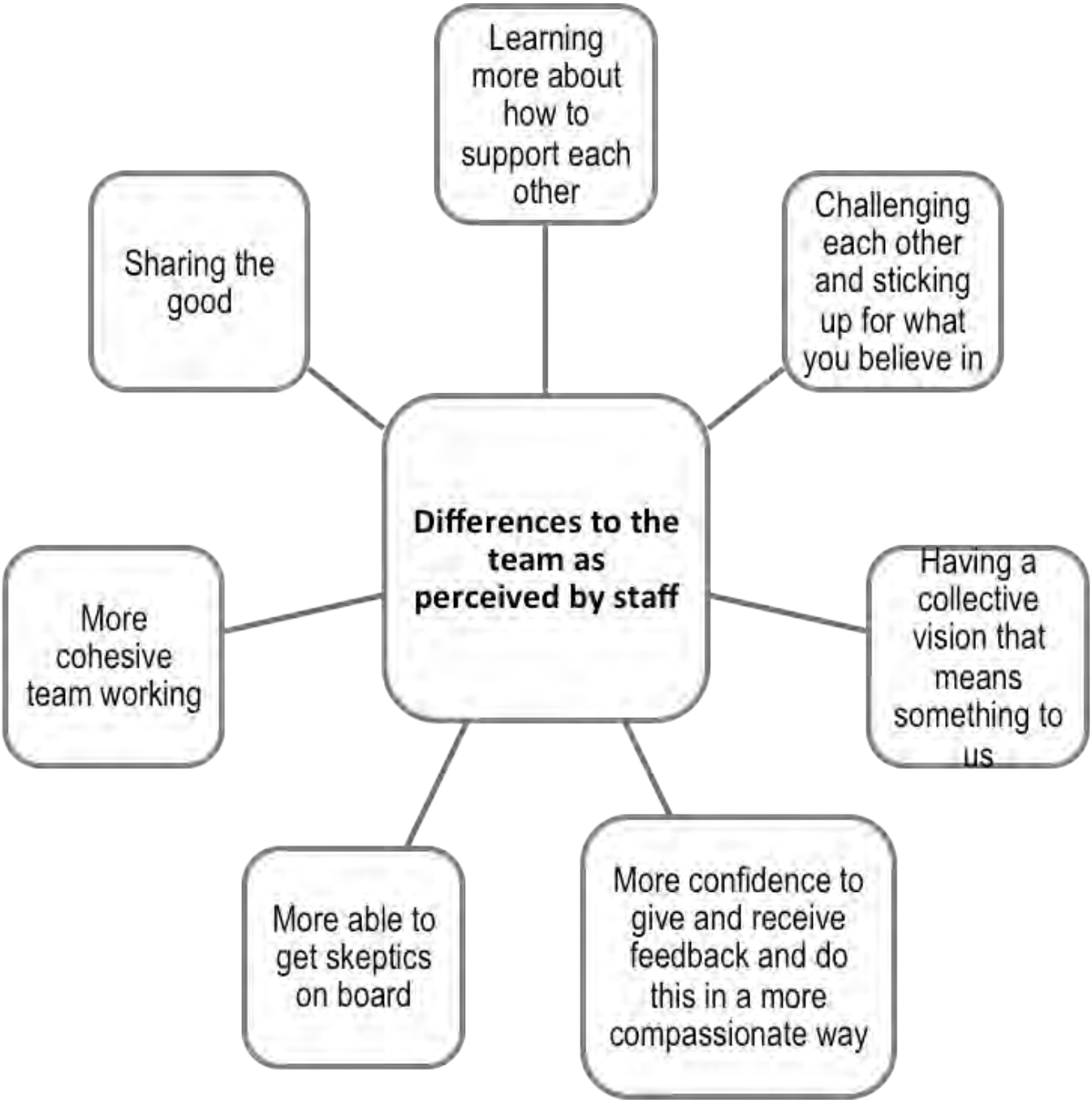
Appendix 9a. Differences to patients and families as perceived by the nurses



Appendix 9b. Differences to staff as individuals as perceived by staff



Appendix 9c Differences to team as perceived by staff



Appendix 10: Final Analytic Framework for Compassionate Care Model

1. Caring Conversations **Discussing, sharing, debating and learning how care is provided, amongst staff, including patients and relatives and the way in which we converse and talk about caring practices**
1.1 Being proud and firm sticking to the principles of person centeredness
1.2 Caring for and about each other
1.3 Thinking and talking about how we do things and how we make it even better
1.4 Recognising and sharing our own emotion
1.5 Collective decision making based on the needs of patients/family and staff
1.6 Being kept in the loop
1.7 Safe to express your opinion and ask questions
1.8 Consciously being curious
1.9 Using language that promotes a shared understanding

2. Flexible person centered risk taking

Making and justifying decisions about care in respect of context and working creatively with patient, family and staff choice and best practice

2.1 Personal sharing
2.2 Confidence to challenge the way things are done
2.3 Considering the dilemmas of giving and receiving person centred care
2.4 Valuing the professional knows best
2.5 Knowing when to use banter/humour/play
2.6 Use of language to reflect the individual as a person

3. Feedback

Giving and receiving of focused and specific feedback about experiences of care is important in developing compassionate caring practice

3.1 I am glad you are on today because.....
3.2 Hearing and accepting praise
3.3 Feeling safe to ask
3.4 Taking the time to ask

4. Knowing you, Knowing me

Developing mutual relationships and knowing the persons priorities, enables negotiation of how compassionate care is given

4.1 Knowing how people are feeling acting and responding
4.2 Knowing the little things that matter
4.3 Knowing the person and using that to influence the way care is given/received
4.4 Making a connection and clicking

5. Involving, valuing and transparency

Creating an environment throughout the organisation where staff, patients and their families actively influence and participate in the way things are done

5.1 A deliberate welcome or a smile costs nothing
5.2 Spotting the opportunities and knowing the possibilities
5.3 Being open and real about expectations
5.4 Sharing/co creating the way things are done (links with first) e.g. patient booklets
5.5 Systems to enable and share this happening

6. Creating spaces that work

The environment

6.1 Knowing and respecting a space that works for me
6.2 Having my space and somewhere to go
6.3 Working together to make the most of our environment

Worked examples can be found on next page

Worked Examples for each component of the Compassionate Care Model

1. Caring Conversations

Discussing, sharing, debating and learning how care is provided, amongst staff, patients and relatives and the way in which we talk about caring practices

1.1 Caring for and about each other

I enjoy the company from the patients, I help Janet who is in the bed next to me, and she is confused. She wanders about the room and the ward. She goes into other peoples lockers and takes things. Mary in the other bed gets annoyed by her. I tell her she can't help it and to leave her be. She calls on the nurses to stop her from taking things, she shouts at her to go out of her space. The nurses are very good with Janet, they remind her where she is and that her husband will be in at visiting time, they give her magazines to read and put some music on to try and pass the time for her. The nurses had to move Mary into a side room because Janet was driving her mad. The nurses kept asking me if I was ok with Janet, I always say of course I am ok we get on well together. **[Patient comment]**

On this placement I found that, at breaks, staff genuinely wanted to get to know you by talking to you. Staff are allocated to work in three teams, however they also work together across all teams to help each other and that feels really good. The staff on this ward knows how to work together and have a great sense of humour. **[Student nurse comment]**

1.1 Caring for and about each other continued

I feel supported on here – sometimes you just don't feel yourself and others cut you some slack. I was particularly low at one time and had some personal things going on in my life – staff were great they didn't push to find out how I was all the time, I just knew they were there for me because they would do little things to help me out. **[Staff comment]**

It is staff mealtimes too. If I have been out with my wife I bring her back about 6.30 pm. There is no point in getting back for 6 pm as staff are on their breaks. We all need a break. By 6.30 the girls are finished and they can help put my wife back to bed. **[Relative comment]**

There is something around that patients care for staff also, It was quite nice being shown around the grounds by a patient, he obviously loved certain parts and it was good to see what he enjoyed. Not sure why he showed me round may have been that he wanted some company on his walk, some patients will come up and introduce themselves when you first start, that does make you feel welcome. They are a part of the team and ward as well. **[Student comment]**

There was a walkabout visit on the ward where the Chief Executive Team were coming to look around and give some feedback from what they saw. One of the consultants joined us on this visit and he was very supportive particularly in relation to challenges nurses face on the ward. It felt as if he was really there to defend our case. He talked about the increasing numbers of patients with dementia and the challenges of this and the need for training in this area to support staff. **[Staff comment]**

2. Flexible person centered risk taking

Making and justifying decisions about care in respect of context and working creatively with patient choice, staff experience and best practice

2.2 Confidence to challenge the way things are done

Sometimes I have seen gaps in curtains or people exposed. I will always say to them to do something about it. **[Staff comment]**

One of the patients was given a cup of tea and a biscuit. The biscuit was not on a plate it was laid beside the cup on the bedside table. The patient said looking down at the biscuit– 'this wouldn't happen at home you know I would serve this on a plate **[Patient comment]**

A decision was being made to try to implement initiatives to save money. One of the other wards were going to cut one of their night staff, so they were going from 4 nurses down to 3. I said that I was concerned about this because of the impact this would have on patient care. The other ward were going ahead with this anyway. I made a decision to try to monitor the impact that this had on our ward – like if one of our members of staff had to go to this ward to cover for breaks or if they were one down and we had to give them one of our staff to cover for the night. I wanted to document how often this was happening so we could present this back to management. **[Staff comment]**

Towards midnight we had changed Ann's position – and instead of the night before when it was every 2 hours – the family were very much saying to us and them – she looks so comfortable is it okay that we leave her for now – I said of course it is – she's comfortable. If she is uncomfortable we would know. The family were really feeling that they were involved with her care. About 12 o'clock Ann was becoming a bit distressed so I gave her a bit of morphine and I said to them this might be a sign of change and the end might not be too far away but we will see how things settle down. We gave it a wee bit of time. They came out to me again and said she was not settling so we were able to give her a wee bit more morphine and I did say that this was possibly coming close to the time. I remember I didn't leave the room after this. They looked like they were terrified. So we just sat together. When she was coming towards the end and I wanted them both to have a hand to hold – I said let's just disconnect the drip it won't make any difference at this stage and they held her hand. I suppose the drip can be a symbol of hope – it's hard. The lady's breathing changed she was starting to gasp and everything – with some people I feel they want you to go – but I felt they were giving me permission to stay. I just sort of hugged them and they held her hand. They were sobbing. Then one of them really started to take the lead with things – it was when she said can we take the oxygen off – and I said yes it was okay. It's hard, the noise of the oxygen and she had such a small face – the mask enveloped her face– they wanted to take it off. It was not natural to have it on. I said its okay we just sat there and she passed away. It could have been one of these experiences that was a horrible experience for them but they wanted to see it all. All I could do was to support them though this and explain that this was normal. **[Staff comment]**

continued overleaf

2.2 Confidence to challenge the way things are done continued

Once mum had died we did think did Jessie – one of the other patients in the bay should know about this. Mum had moved out of the bay a couple of days before she died but had struck up a eal friendship with Jessie. We felt it was important that Jessie knew she had died. I said to one of the nurses – oh can you tell Jessie that mum has died – she looked at me, and had furrowed brows – I don't think she thought this was important or was a bit puzzled by our request. In the end we told Jessie that mum had died. Death happens to us all and it can be important to some people to know what has happened. **[Relative comment]**

It's hard to challenge – staff challenge quite a bit about tasks that are not done but it is harder to challenge when it is about attitudes and values – these are more personal and people may get upset. It's also more difficult to have concrete examples. I find that it is good to watch others at work and then try to feedback immediately. The other day one of the care assistants was very gruff with some relatives that had come in a bit early for visiting. She said to them that it was not visiting time yet and walked off. I spoke to the relatives and found out a bit more about them. They had travelled a long distance to get here. I facilitated early visiting for them. I spoke to the care assistant about her approach – it wasn't so much that she said it was not visiting time yet – which was correct it was the way she said it. She did not react well to this. But it was interesting the next week one of those visitors had not been able to come to the ward since then because they had been ill – the CA commented that it was good that they had been able to visit that day **[Staff comment**]

So I went to ask the doctors on the ward what I should do, they said there's nothing you can do, he has been referred to another specialty and we just have to wait for them to come. However this didn't seem right to me so I decided to ring the ward where he would have gone (had there been a bed) to ask them what I should do. I found them very helpful. First they offered me advice on how to nurse the patient and then they said they would ask the consultant to come and as soon as possible to see the patient, they also said just to ring if I had any further concerns... Although I felt out of my depth I felt I had done my best to get information and help for both the patient and his wife **[Staff comment]**

3. Feedback

Staff, patients and families giving and receiving specific feedback about their experience of care.

3.3 Feeling safe to ask and give feedback

I try to find out if I have done okay – I put it across in a jokey way so just like if I have given them a shower I try to ask them was it okay did you enjoy that – if they stay quiet I might think it has not been so good so I might say how would you like your shower tomorrow **[Staff comment]**

We had been given a higher chair for me. I have arthritis and it was easier for me in the higher chair to just sit with my husband comfortably. On one occasion, somebody must have come into the room and removed the chair. It's difficult – there were possibly lots of rules and regulations that we are not necessarily aware of and you are never sure when you are overstepping the mark and if someone is having to act on somebody else's instructions? We did not feel able to say anything as we are well aware of the constraints within the health service. **[Relative comment]**

Thinking about her going home wherever that new home is – I feel optimistic hopeful and encouraged that we are going on a new journey. I also feel in control and that if a home is not suitable I will be able to say because people ask me what I think. **[Relative comment]**

I feel embarrassed asking for feedback – I associate feedback with the negative and I feel bad when I am in a position of hearing negative feedback. I probably go red in the face when I hear negative feedback – I don't like this – I hate turning beetroot when I am embarrassed. It feels as if there is a bit of a risk in seeking feedback but I know it is my responsibility to do this. **[Student comment]**

I feel I have a greater self awareness of my own feeling s in relation to feedback that may get in the way of me actively seeking this out. **[Staff comment]**

I have felt comfortable to say to my mentor or other staff what I need to know and I am okay to tell them what I have done or haven't done. **[Student comment]**

4. Knowing you, knowing me

Developing mutual relationships and knowing the persons priorities, to enable negotiation in the way things are done around here.

4.4 Helping others to connect

It's good to have male nurses working on the ward. The male nurses are just great, they've have kept me sane many times, it's good to make that connection. I think male friendships are important **[Male Patient comment]**

It makes a difference if you try to find out something about the person. There is a man in bay 2 and even although it's hard to talk to him – I've managed to have a wee bit of a conversation with him – he likes Hearts – I told him what the Hearts score was yesterday. I look in the notes or speak to the relatives to try to find something– this man had a hearts strip – so I knew. It's good to have common ground to work with. I always try to do this. I've never come across a time when I couldn't make some connection. **[Staff comment]**

I always try to find out something about the nurse who comes to work with us from the nurse bank– where she has worked before, what she likes doing, even if I just make sure I make some of the beds with her in the morning. I feel it is time well spent to just get to know something about her – it must be hard being on different wards all the time. **[Staff comment]**

My daughter had painted my husband's toenails with blue, glittery nail polish the night before we came to hospital. Of course the nurses noticed and asked about it, I felt they got a little insight into their father daughter relationship. They saw a bit of the 'person' my husband was. They showed real interest, they cared, which is why I sent the letter after the funeral telling.

5. Involving, valuing and transparency

Creating an environment throughout the organisation where staff, patients and families actively influence and participate in the way things are done around here

5.5 Systems to enable involving valuing and transparency

For a new member of staff who is to become a key worker, the team all contribute to creating a vision of what care looks like, airing different reasons for ways of working and explaining how a care plan was agreed. At the same time, including new information that adds to the patient's likes and dislikes and personal biography, building the picture of the person **[Observation]**

We have changed our documentation – we need to find out what is normal and individual for the patient so we can work with them to plan care that means something to both of us. We had a lady in the other day – she is normally breathless but can get about her house without too much trouble and has an electric buggy for outside – and this is what she would like to get back to. So often you see in the care plan the goal is to relieve breathlessness – but we are not going to be able to do this here. No wonder the care plans are not filled in if they don't really reflect what is actually going to happen. **[Staff comment]**

We have put up a white board on the ward for people to write up the menu for lunch and tea that day. This came from a comment by a patient that she could not remember what she had ordered the day before from the menu and also comments by a patient's relative that it would be nice to know what on the menu so they could talk about this when they came in to visit. Some staff on the ward were reluctant to write the menu up on the board – feeling that this was an extra task, were not sure why they were doing it and that having the menu board made it feel like a care home rather than an acute medical ward. When it was discussed the reasons why it was useful to have this – people seemed to get it and were happy to do it. The problem is that unless we keep on reminding people why and sharing positive comments about what people value about having the menu board then it might not be done because people don't understand why. **[Staff comment]**

It's really hard to pass any information on the ward. People don't seem to read things – we have a communication folder that is often not read. We have been thinking about trying to spread the word by thinking about the things staff do read. Each morning for instance they read the diary so we have started putting stuff in there so it will be read. It's good because it's not just about practical things like could everyone put in their request for off duty by the end of the week but we have put in things like a patient who went home 2 weeks ago with a huge package of care – is doing really well. **[Staff comment]**

On this ward staff work together very well and so communication is very good. For example when they say they are going to do something in 4 hours you can always go and do something in that time. If you don't know when it will happen then you are constantly waiting and time goes slowly. Managing expectations is important. **[Staff comment]**

Appendix 10a:

Caring conversation questions (staff questionnaire: draft)

Ques. 1

I feel supported on here, I was particularly low at one time and had some personal things going on in my life – staff were great they didn't push to find out how I was all the time, I just knew they were there for me because they would do little things to help me out.

To what extent do you feel supported like this in your area?

Not supported 1 2 3 4 5 6 7 8 9 10 Completely supported

Ques. 2

There was a walkabout visit on the ward where the chief executive team were coming to look around and give some feedback. One of the consultants joined us on this visit and he was very supportive particularly in relation to challenges nurses face on the ward and the need for training and support.

To what extent would your team support each other like this?

Not supported 1 2 3 4 5 6 7 8 9 10 Complewtely supported

Ques. 3

We often have situations where patients are reluctant to do things for themselves. We had a patient who could walk herself to the toilet but if you were in the room she would not do anything for herself. As a team we talked about the frustration we felt and how we could try and make things better. What seemed to help was if we sat down and had a discussion with the patient about what they wanted and what we wanted. We struck a deal – this really worked – It was like tough love.

To what extent do you feel your team negotiate care like this with patients?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely

Ques. 4

Since the compassionate care project started I have been trying to look at things with a different eye. Noticing what people do from day to day, I never really saw this before. It's not just about accepting things as they appear.

To what extent are you able to ask questions about the way things are done?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely

Ques. 5

I did feel frustrated at times looking after the lady. She was dying and in a lot of pain. It was difficult because she did not like getting turned but sometimes you had no choice because she had made a mess and we needed to clean things up. I felt so guilty and helpless because I did what I could but felt this just wasn't enough. Talking with others helped – as it made me realise I was not the only one feeling this way.

To what extent are you able to share how you feel with members of your ward team?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely

Ques. 6

Consultant said to a patient who had just found out that she had cancer in her lung that they were going to treat it very aggressively. When asked how she felt, she said that the doctor had used the word aggressive and that had made her think it was bad. She had not thought that the word aggressive was a positive approach to her treatment that was meant to bring about some hope.

To what extent are you using language that patients understand?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely

Ques. 7

I prepared myself to talk to the relatives by reading the notes and the report and went through it with one of the consultants also to ensure I was saying the right things.

To what extent do you feel prepared to say the right thing?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely

Ques. 8

During bed making the staff nurse was telling the charge nurse and the patient about planning to travel through Thailand. The patient mentioned that she had lived in Thailand for 4 and half years. Although the staff nurse and charge nurse were having this conversation, they included the patient.

To what extent do you feel you include patients in social conversations?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely

Ques. 9

One of the staff nurses went up to a patient who had a degree of cognitive impairment and said good morning Elizabeth. The lady said that she could call her Beth if she wanted. The staff nurse asked if she would like the name above her bed changed from Elizabeth to Beth so that we all knew this – the patient said 'no I don't think so I think it is a bit childish to have the names above the bed because I know who I am'. The staff nurse and the patient laughed together.

To what extent do you feel you support patients to express their opinion?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely

Ques. 10

Doctor came onto the ward the other day and stated "I'll take the alcoholic back and we'll give you a stroke" that's unacceptable behavior"

To what extent do you feel able to challenge things that don't respect people as individuals?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely able

Ques. 11

One of the lady's on the ward was in her last few hours of life. There were so many family members involved in this lady's care and they all had their own idea about things. I said to the doctor that the family are really concerned, can we think about how we can make her as comfortable as possible? We all went into the doctors room and spoke about it. They came out feeling more confident that everything was going to be done to keep her comfortable, I felt we were all working towards the same objective.

To what extent do you feel you can bring staff and families together to make collective decisions?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely able

Ques. 12

There was a discussion at a multidisciplinary meeting about a patient who was about to be discharged home and needed a complex package of care. The occupational therapist and the physiotherapist had a detailed discussion about a recent home visit. The consultant then said – the thing the lady is most worried about is whether her new wheelchair will get through the front door, can we relieve this fear?

To what extent do you feel collective decisions are based on needs of patient and relatives?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely

Appendix 11:

Questions to ask when using the image and positive care practice slides

What did you get from looking at these images and statements?

What is the value (if any) of this way of communicating ideas and messages?

What images and statements stood out for you and why?

What has it made you think about?

Is there anything you would do or think differently about after having looked at this?

If you get them to talk about one particular image (jot down the image and statement discussed)

What was the focus of the discussion?

What was their interpretation of what it is saying for them and their practice?

Does this practice (from the positive statement) happen most of the time?

If no – What could help it to happen more?

Is there anything you would do or think differently about after having looked at this?

Appendix 12a: Examples of differing data collection methods

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Ref: SS/vm/Letters/StudyDay24/04/09

30 March 2009

Dear Staff Nurse

LEADERSHIP IN COMPASSIONATE CARE PROJECT
STUDY DAY FOR NEWLY QUALIFIED NURSES -
WEDNESDAY 3RD JUNE 2009

In order to support you in your continued development from student nurse to staff nurse we would like to invite you to attend a study day we have planned to support Newly Qualified Nurses working in NHS Lothian. The study day will take place on:

Wednesday, 3rd June 2009 and will be held in the Castle Room, Edinburgh Napier University, Craighouse Campus, Craighouse Road, Edinburgh, EH10 5LG

The programme starts at 09.30 and finishes at 16.00 hrs. Unfortunately we are unable to reserve parking spaces within the Napier Campus for the number of participants who will attend this study day.

At the study day, Theresa Fyfe The Director of the Royal College of Nursing in Scotland will give a motivational presentation about her nursing experiences and her vision for nursing. There will be a unique opportunity for newly qualified practitioners to ask Theresa questions following her presentation.

Fischy Music performers will also be demonstrating how their musical approach enables children, and those who work with them, to communicate, explore and understand emotions and spirituality through music. The aim of this session is to explore the value of using different approaches to communicate compassionately with those in our care.

continued overleaf

The aim of the day is to provide you with support and inspire you in your new role as a Staff Nurse. For those of you who attended previous study days, the content for this day will be different and we would encourage you to come along.

We will be holding focus groups at the study day as part of the Evaluation of the Leadership in Compassionate Care Project: The experiences of newly-qualified (less than one year) staff nurses. You are under no obligation to take part in these groups but should you wish to access an information letter and consent form it is available on our web pages in the Supporting newly qualified staff nurses page, please see link below. http://www.napier.ac.uk/fhlss/NMSC/compassionatecare/Pages/Home.aspx Information letters and consent forms will also be available on the day.

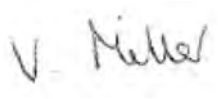
In order to attend this study day you need to negotiate attendance with your Line Manager directly.

It is not possible for us to guarantee that you will be released to attend this programme as your Manager has to ensure that the needs of the service are met. Managers across NHS Lothian will be informed of this study day. There is no cost for attending; however we would ask you to book in order to plan catering arrangements.

If you require further information about the day, please contact **Stephen Smith, ste.smith@napier.ac.uk Tel: 0131-455-5675.**

Potential participants should contact Val Miller, vf.miller@napier.ac.uk or June McGregor, j.mcgregor@napier.ac.uk Tel: 0131-455-5633/5674 to book a place. Places will be allocated on a first come basis.

With best wishes.



for Stephen Smith
Lead Nurse
Leadership in Compassionate Care Project

Appendix 12b: Examples of differing data collection methods

Newly Qualified Nurses Study Day

Leadership in Compassionate Care Project

Programme for 14 January 2009

Venue: Room G44, Comely Bank Campus, Napier University, Crewe Rd. South, Edinburgh, EH4 2LD

0930	Welcome & Introduction to the day	Stephen Smith
0940	Evaluation focus groups Information and consent	Dorothy Horsburgh
0950	Motivational presentation followed by Q & A session	Interim Director of Nursing NHS Lothian
1050	Coffee	
1120	Mindfulness	Elizabeth Douglas
1230	Lunch	
1315	Presentation from newly qualified nurses – experiences of working through flying start programme	Catherine & Grainne
Staff Nurses ward 50, WGH		
1400	Group discussions / Focus groups	Group Facilitators
1515	Compassion in practice – Feedback from ward taking part in leadership strand	Isobel & Sharon Ward 4, WGH
1545	Evaluation	
1600	End of day	

Learning outcomes for study day

1. In response to hearing the experiences of others, consider issues of personal motivation and achievement.
2. Develop an enhanced understanding of care and compassion
3. Consider the opportunities and challenges (both personal and organisational) to providing care that is compassionate within your practice setting
4. Identify methods and actions that enable progression through the Flying Start programme

Appendix 12c: Examples of differing data collection methods

EDINBURGH NAPIER UNIVERSITY

FACULTY OF HEALTH, LIFE & SOCIAL SCIENCES

School of Nursing, Midwifery & Social Care

Leadership in Compassionate Care Project

NQ Study Day – 24 April 2009

Evaluation Form

It is important that we continually check out with you how you are feeling about the study days and if there are any changes we need to make. We would really appreciate it if you could spend a few minutes at the end of today completing this form.

What I enjoyed most about today's experience?

What is the most significant thing you have learnt as a result of today's experience?

Is there anything you might think differently about after today's experience?

Is there anything that could have been done differently?

Are there any other general comments that you would like to make?

Appendix 12d: Example of Results of Evaluation From Data Collection

EDINBURGH NAPIER UNIVERSITY

FACULTY OF HEALTH, LIFE & SOCIAL SCIENCES

School of Nursing, Midwifery & Social Care

Leadership in Compassionate Care Project

NQ Study Day – 24 April 2009

Evaluation Form

It is important that we continually check out with you how you are feeling about the study days and if there are any changes we need to make. We would really appreciate it if you could spend a few minutes at the end of today completing this form.

What I enjoyed most about today's experience?

- Interactions, especially the clown doctors and Charlotte's story.
- All of the presentations.
- Focus group – chance to feed back.
- The presentations/focus group.
- Meeting up with student colleagues.
- Seeing friends again and having fun with learning.
- Flying start info and compassionate care info. Inspirational speaker was very good.
- The whole day was very positive, inspiring.
- The whole study day was good. Really enjoyed the XXXXXX presentation.
- Charlotte's inspirational talk.
- Meeting with new people. Encouraged to be positive.
- The ability to be honest about our experiences and Flying start nurses experiences.
- Elderflower/clowning around and the inspirational speaker.
- The opportunity to be silly!
- Everyone relaxed and enjoyed themselves.
- How everyone got on and also the clown doctors.
- Charlotte's talk.
- The fun element and relaxed atmosphere.
- Time out to see the bigger picture again. To consider why I'm doing nursing, what kind of nurse I want to be. In a fun, interesting, varied day.
- Hearing from the clown doctors and Elderflowers, the fantastic work they do.
- Very inspirational sessions.
- In finding out that what I am feeling and doing is the same for everyone.
- The mix of learning.
- Focus group discussion.
- Charlotte's discussion about her adventure sailing. I loved it.
- I loved interacting with the clown people.

What is the most significant thing you have learnt as a result of today's experience?

- More information about flying start.
- We all have the same worries.
- Importance of eye contact during clowning and relevance to nursing practice.
- Buddy systems.
- Communication – verbal and non-verbal. To make light of mistakes!
- Making a mistake is not the end of the world but a good learning experience.
- Flying start info.
- Small steps can make things achievable.
- Good communication is vital. Have fun, don't take things too seriously.
- Making mistakes is not always a negative experience.
- Not alone!
- That we are well supported. That we all feel the same in our first posts.
- More about flying start and other newly qualified experiences.
- The importance of being approachable, use of non-verbal communication.
- Making mistakes, not to be too hard on yourself. Flying start.
- Flying start. The clown doctors and the work they do.
- Seeing how empowering it is to face up to challenges.
- Flying start in relation to development and how beneficial it can be for my role and progression.
- Re-inspired both in terms of flying start – encouraged to persist despite the negativity, and in terms of being positive and conscientious in sometimes negative environments.
- Eye contact, and being an available nurse that patients/relatives actually want to talk to and feel they can approach.
- Don't be too hard on myself.
- How my vulnerability can sometimes help me communicate better with patients.
- Flying start explained. Seeing things from another's perspective.
- Positive thinking and self-awareness.
- That flying start is a useful tool.
- Is there anything you might think differently about after today's experience?
- I will get started on flying start. Making mistakes is human.
- To take things one step at a time and not be too intimidated by what you think people expect of you.
- More positive attitude to flying start.
- Reflecting on practice doesn't just come from within.
- No.
- Too long with clown doctors, could have done with more time on transition from student to S/N.
- Realise that you don't have to be perfect all of the time.
- No, big surprise.
- Sharing experiences and having some fun with colleagues and patients can be very beneficial.
- Be more positive.
- That it is ok to make mistakes and am very encouraged by the flying start nurses experiences and look forward to doing it myself.
- The way I communicate with patients and relatives.
- The importance of being approachable, use of non-verbal communication.
- Can have fun while working.
- You can have some fun when working and to be able to interact with different people.
- Making mistakes is ok and I might be seen as normal and human for them.
- The fun element but only when appropriate.
- New view of flying start. Much more positive.
- That it's not always easy being a newly qualified nurse but we can learn a lot from challenging situations to improve patient care.
- Flying start.
- Not to make judgements about people you don't know. Would never have thought that Charlotte had sailed round in that little boat by looking at her!!
- I'll do flying start.

Is there anything that could have been done differently?

- I came without expectations and have been very pleasantly surprised by the content.
- Is there any write-up/summary of things that came up in other groups – maybe on web-site? I'll look as it may have already been done for last day.
- Don't know.
- Slightly less time with clowns.
- Smaller group.
- No. (n=11)

Are there any other general comments that you would like to make?

- Really enjoyed this study day
- Thank you very much indeed.
- Heating!
- I myself think laughter is a good healing process it was good to see the clowns and how they care for people through laughter, music and touch.
- Good day for newly qualified staff.
- Ideas and "permission" to do things differently.
- Bit cold.
- Think it's great to have these days for newly qualified staff. It provides insight into how a newly qualified nurse should progress as well as offering support.
- Clown doctors were brilliant. Totally inspiring. Talk by Maggie and Fiona on flying start also so helpful and so encouraging. Thank you.
- Another really enjoyable and inspirational day.
- Very varied programme which was good. Learning through activities was also beneficial.
- It would be useful to have some mental health input.
- Well organised day. Thank you.
- I enjoyed the day and found it helpful.
- No (n=3)

Appendix 13: Participation Information Sheet – Student / Lecturer

NHS Lothian

NAPIER UNIVERSITY EDINBURGH

School of Nursing and Midwifery & Social Care

Participant Information Sheet – Student/ Lecturer

Development of compassionate care in undergraduate education and practice

NHS Lothian and Napier University would like to invite you to take part in a research study taking place from January 2008 to November 2008. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and talk to others about it if you wish.

Part 1 tells you the purpose of this research and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study.

Part 1

What is the Purpose of the research study?

The purpose of this research study is to find out what things affect the delivery of compassionate care to patients and what could be done to help to improve and support compassionate care so that it is embedded as an integral part of nursing. We will also ask you about your experience of learning/teaching compassionate care within the undergraduate curriculum. "Compassionate care" is often associated with words such as – caring, empathy, human touch, and sensitivity. In this study we want to learn more about what it is, what it feels like and how to support people to ensure that it is a core part of all of our work.

Why are we inviting you to take part?

You have been invited to take part in this study because you are either a student or lecturer at Napier University. You may have experience of delivering compassionate care, and may be learning or educating about compassionate care and it is important that we hear your views.

Do you have to take part?

It is up to you to decide whether or not you take part in any part of this research, and you would be free to leave the project at any time without giving a reason. This would not affect any aspect of your work or learning.

What will happen to you if you take part?

You will be interviewed by our researchers within a focus group about your experiences of engaging in and learning/teaching compassionate care. Each participant will be asked to take part in one focus group only and you will be given a choice of dates/ times that you can choose from. Focus groups will comprise of student or lecturers.

We expect that discussions will take from 30 minutes to 1 hour at any one time. We will ask your permission to tape record these discussions. You can withdraw from the study at any time.

Expenses and Payments

No expenses or payments will be made. Focus groups will be arranged during a time when you will be at university for another reason (e.g. class).

What could be the risks or disadvantages of taking part?

We will be discussing issues about your experiences of engaging in and learning/teaching compassionate care. As part of this we will be discussing participants' views on what affect care

and caring has had for you as an individual. Some participants could find that this causes upset or distress. We want to make sure this research works well for you and will do our best to support all participants. This could include any assistance or comfort you might need or want to help you during our discussions, as well as someone to talk to afterwards. We will check with you if you need anything to help you take part and ensure that this support is provided.

What could be the benefits of taking part?

This is a joint study between NHS Lothian and Napier University. Whilst we cannot promise that taking part will help you directly, the information we get from this research will help to improve care and enhance the education programmes for student nurses in relation to compassionate care. We have found in other projects that staff and patients have reported that they have learnt a great deal from taking part in this type of study.

What happens when the research stops?

This is the first phase of the study which will be completed by October 2008. Further research will then be planned and taken forward based on the findings of the first phase.

At the end of our study we will share the findings and our recommendations. The results of the research will also be published – please see Part 2 for further information. The detailed information (data) from the research will be kept at Napier University offices for 5 years by Dr. Jayne Donaldson (Chief Investigator). Then all of this information will be confidentially destroyed.

Will my taking part in the research be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2. The meetings will be taking place in the University – so others are likely to know you will be taking part, however all information we obtain will be treated in confidence and personal references and identifying information will be removed.

If the information in Part 1 has interested you and you want to take part in the research, please read the additional information in Part 2 before making any decision.

Part 2

What will happen if you don't want to carry on with the study?

You will be able to pull out of the research at any time. This will not affect any aspects of your work or study.

What if there is a problem?

If you have a concern about any aspect of this research, please contact the Chief Investigator who will do her best to answer your questions (see contact details below).

If at any stage you would like to talk about participating in the research to someone independent of the study then you can contact Dr Catriona Kennedy (see contact details below).

Will your taking part in the research be kept confidential?

All information collected during this research will be held in the chief investigator's office at Napier University. Dr Jayne Donaldson as the Chief Investigator will act as the custodian of this information and will ensure that it is kept in a confidential and secure way, in accordance with the Data Protection Act, 1998.

Interviews will be recorded by researchers in two ways :

1. Audio recording

Audio recordings will be made. We will also get your written permission to audio record any meeting with you before recording begins. Audio recordings will be kept as described above.

2. Written notes

We may take written notes whilst discussions are held to guide our conversations and record what people say.

The researcher will feed back to you, at the end of any discussion, their understanding of the main points that have been covered. You will be asked if this is accurate and if there is anything that you would like to add or be omitted.

Information from audio recordings and notes will be entered onto a secure (password protected) computer system. All information being entered will be coded; no names and addresses will be entered with this information. Your position will be identified: for example, if we use a quote from you we would put the words 'student 1' or 'lecturer 3' beside this. No personal data will be divulged.

If you do give your name and contact details this information will be held in a separate computer file on a secure (password protected) computer system. Written information such as consent forms will be held in locked cabinets in Napier University research offices. These will only be accessed by the researchers.

You can view copies of any information held on you at any time on request. These requests should be made to Dr. Jayne Donaldson. All information will be kept securely for 5 years then destroyed confidentially.

We will not share any personal information that you have given us with any other organisations except in the following very exceptional circumstances. If information is disclosed by you which leads us to believe that someone is at significant risk of harm or abuse, information may be passed to relevant authorities. You would be informed of this.

What will happen to the results of the research?

The results of this research will be published and shared with participants and other individuals and organisations involved with or who have an interest in the research. Participants will not be identified within any reports produced. The results will also be used to inform future service and educational developments.

Who has reviewed the research study?

The research has been looked at by an independent group of people, called a Research Ethics Committee. This research has been reviewed and given favourable opinion by Napier University Research Ethics Committee.

Thank you for taking the time to read this information

Contact details

Dr Jayne Donaldson (Chief Investigator) by telephone on 0131 455 5697 or email j.donaldson@napier.ac.uk or by post at School of Nursing, Midwifery and Social Care, Napier University, 74 Canaan Lane, Edinburgh, EH9 2TB.

Dr Catriona Kennedy (Independent contact) by telephone on 0131 455 5620 or email c.kennedy@napier.ac.uk or by post at School of Nursing, Midwifery and Social Care, Napier University, 74 Canaan Lane, Edinburgh, EH9 2TB.

Appendix 14: Focus Group Invitation

NHS Lothian

NAPIER UNIVERSITY EDINBURGH

Monday 8 December 2008

Dear Student

Leadership in Compassionate Care Project

Napier University / NHS Lothian

We would like to invite you to take part in a focus group discussion at lunch time, 12 – 1pm on Tuesday 9th December 2008 at Comely Bank Campus, room to be confirmed. A light lunch will be provided.

A detailed information letter about the focus group is available on WebCT.

The purpose of this research study is to find out what things affect the delivery of compassionate care to patients and what could be done to help to improve and support compassionate care so that it is embedded as an integral part of nursing. We will also ask you about your experience of learning compassionate care within the undergraduate curriculum. "Compassionate care" is often associated with words such as – caring, empathy, human touch, and sensitivity. In this study we want to learn more about what it is, what it feels like and how to support people to ensure that it is a core part of all of our work.

You will be interviewed by our researchers within a focus group about your experiences of engaging in and learning about compassionate care. Each participant will be asked to take part in one focus group only, each focus group will be audio recorded.

You will be provided with an information letter about the research and we will ask you to sign a consent form if you are willing to participate.

You are under no obligation to participate in this research.

Kind regards

Stephen Smith
Lead Nurse
Leadership in Compassionate Care Project
Napier University / NHS Lothian Leadership in Compassionate Care Project
Napier University
Canaan Lane
Edinburgh
EH9 2TB

T. 0131 455 5675
E. ste.smith@napier.ac.uk

Appendix 15: Consent Form

NHS Lothian

NAPIER UNIVERSITY EDINBURGH

School of Nursing and Midwifery & Social Care

Date : Participant ID number:

CONSENT FORM: student/lecturer (delete as appropriate)

Title of Project:

Development of compassionate care in undergraduate education

and practice: phase 1

Name of Researcher: _____

1. I confirm that I have read and understand the Participant Information for the above research study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without aspects of my study/work or legal rights being affected. ☐
3. I agree to interviews / meetings being audio recorded. ☐
4. I agree to take part in the above research study. ☐

Name of Participant _____ Date _____ Signature _____

Name of Person consent _____ Date _____ Signature taking _____

Please sign both copies and retain one for yourself and give the other to the researcher

Appendix 16: Student Focus Group questions

1. In your experience are there any particular examples of compassion that you can share that help to define compassionate care?

2. In your experience as a student nurse can you think of any examples of compassionate care that you have received personally either in clinical practice or as a student within the university?

3. In your experience so far are there any modules within the undergraduate programme where compassionate care is evident or included?

4. "In a world of stretched resources compassionate care and empathy come cheap" What are your views on this comment made by a former patient?

5. Can you suggest any measures that could be put in place

Appendix 17: Lecturer Focus Group Questions

1. "In a world of stretched resources compassionate care and empathy come cheap" What are your views on this comment made by a former patient?

2. In your experience are there any particular examples of compassion that you can share that help to define compassionate care?

3. Could you describe any modules taught within the undergraduate programme, where compassionate care is particularly evident?

4. Can you suggest ways in which compassionate care (or definition) could be made more explicit within the UG programme?

5. Can compassionate care be taught?

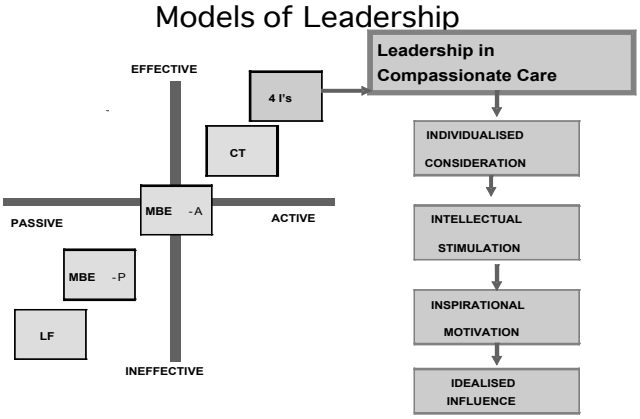
Quote: "I am a student nurse and we are taught these fundamental skills. This project is a slap in the face for nurses and universities if they do not know how to deliver compassionate care." (Student nurse, UK)

6. Are there ways that we as facilitators of learning can

a) enhance and encourage compassionate nursing practice

b) impact on student experience to promote a compassionate person centred experience?

Appendix 18: Mapping to the 4 'I's' of the Bass and Avolio (1994) Model to Leadership in Compassionate



Models of Leadership: Adapted from Bass and Avolio (1994)

The model represents a continuum of leadership with transformational leadership attributes (the 4I's) being defined in terms of leader's behaviours and the effect of these on the followers. Here followers are motivated to do more than originally expected and feel trust, loyalty, respect and admiration toward the leader (Yammarino et al. 2005). Bass (1995) points out that transformational leadership does not replace transactional, it builds upon it; one cannot necessarily exist without the other. Transformational leadership, according to Avolio and Bass (1995) is more internally driven (where they redefine or drive change based upon their vision of a more satisfactory outcome/solution) whereas transactional is more externally driven (the leader works within the rules and desires of the organisation).

Non-Leadership	Transactiona	Tranformation 4 I's
LF = laissez-faire	MBE-P =Management by Exception Passive	Individualised Consideration
	MBE-A = Management by Exception Active	Intellectual Stimulation
	CT = Constructive Transaction	Inspirational Motivation
	CT = Constructive Transaction	Idealised Influence

Appendix 19: Ground rules for ways of working

Agreed Ways of Working

- Take risks and challenge
- Be supportive and sensitive to each other's needs
- All take responsibility to move things to action
- Be honest and real
- Respect for each other as we are all equal in the group
- Not to take things too personally
- Make coming to the group a priority
- Make a difference
- Have fun
- All that's said and done within the group is confidential. All need to agree what would leave the room in terms of actions.
- Work in partnership with each other
- Appreciative feedback – consider how this is given and received and not to make immediate assumptions without checking it out with the person
- Keep an eye throughout sessions as to how other people are doing

Appendix 20: Themes from Restorative Space Sessions

25.08.10

- What aspects of my job do I have control over and can do something about?
- How do we maintain our own beings when we feel that our more creative and innovate ways of working are being squashed
- Something about managing the expectations that others have of us and how to learn to say 'No' in a confident and articulate reasons behind decision
- There is something about developing trust and developing a more honest and open attitude and thinking about how we work with those who are less able/willing to demonstrate these attributes
- Identifying where we can go for support/help and what this might look like

29.09.10

- Questioning the culture
- Reinventing ourselves Participating in decision making
- Feeding back constructively on how decision are working (or not)
- Creatively freeing ourselves from perceived constraints
- Taking risks

27.10.10

- The creation of a 'space' to reflect on individual and collective practice but also to consider ways forward to enhance and progress practice.
- Creating and sustaining opportunities of being able to have open and honest dialogue with individuals.
- Importance of being supported and, when appropriate being able to ask for guidance which is acknowledged as being real due to challenges in everyday practice and not seen as being a failure.
- Leadership opportunities and how leaders influence and shape the workplace culture.
- Considering ways in which to formalise leadership development opportunities within the university

24.11.10

- What are the opportunities are available to us and others, to formally develop leadership skills and attributes and use them in practice?
- To be able to have an honest and open dialogue with colleagues and managers about practice.
- The opportunity to reflect on practice, both as an individual and with colleagues.
- In order to achieve the above we need time and a space to be able to successfully achieve this. There was a suggestion that staff should be able to prioritise such sessions and that the creation of such a space was endorsed by management and colleagues.
- Support, and on occasions guidance is necessary to enable the creation of 'reflective spaces'.
- It was suggested that the above key themes could be influencing in bringing about a cultural change within the organisation.
- There was a sense of some disappointment at the numbers attending the sessions on a regular basis but there was a 'real' understanding on the part of the participants and the facilitators as to why people were unable to commit to attending every workshop. The teaching timetable, meetings being called at short notice and individuals' workload (predictable and unpredictable) being three of the reasons identified as to why this occurred.

Appendix 21: Personal Attributes Questionnaire

NHS Lothian

Edinburgh Napier University
School of Nursing, Midwifery and Social Care
Leadership in Compassionate Care Project
Personal Attributes Questionnaire

Edinburgh Napier UNIVERSITY

Q1. Which best describes your current position?

- Registered Nurse / Registered Midwife saf ❑
- Mentor – Registered Nurse / Rewgistered Midwife ❑
- Manager – Registered Nurse / Registered Midwife ❑
- Senior Manager – Registered Nurse / Registered Midwife ❑
- Nursing / Midwifery Academic ❑
- Student Nurse /Student Midwife ❑
- Service user ❑
- Carer ❑
- Other ❑

Q2. If you answered 'other', please insert your current position below

---

Q3. If you are a registered nurse or midwife, please indicate the fields of practice in which you have recent clinical experience (tick all that apply).

- Adult nursing ❑
- Child health nursing ❑
- Mental health nursing ❑
- Learning disabilities nursing ❑
- Midwifery ❑

OR

If you are a student, please indicate which programme you are undertaking.

- Adult nursing ❑
- Child health nursing ❑
- Mental health nursing ❑
- Learning disabilities nursing ❑
- Midwifery ❑

Q4. Your gender: Male ❑ Female ❑

Q5. For each of the personal attributes below, please indicate how relevant you think each one is to the selection of prospective applicants to nursing or midwifery programmes.

a. A good listener

Strongly agree	Agree	Not sure	Disagree	Strongly disagree
❑	❑	❑	❑	❑

b. Able to communicate with people from a wide range of backgrounds

Strongly agree	Agree	Not sure	Disagree	Strongly disagree
❑	❑	❑	❑	❑

c. A good team worker

Strongly agree	Agree	Not sure	Disagree	Strongly disagree
❑	❑	❑	❑	❑

d. Patient, tactful and non-judgemental

Strongly agree	Agree	Not sure	Disagree	Strongly disagree
❑	❑	❑	❑	❑

e. Honest and trustworthy

Strongly agree	Agree	Not sure	Disagree	Strongly disagree
❑	❑	❑	❑	❑

f. Able to demonstrate a sensitive and compassionate approach to people

Strongly agree	Agree	Not sure	Disagree	Strongly disagree
❑	❑	❑	❑	❑

g. Able to draw on knowledge and experience

Strongly agree	Agree	Not sure	Disagree	Strongly disagree
❑	❑	❑	❑	❑

h. Able to remain calm in potentially stressful or distressing situations

Strongly agree	Agree	Not sure	Disagree	Strongly disagree
❑	❑	❑	❑	❑

i. **Observant and able to act on your own initiative within your level of responsibility**

Strongly agree ❑ Agree ❑ Not sure ❑ Disagree ❑ Strongly disagree ❑

j. **Recognise the need to seek and act on guidance**

Strongly agree ❑ Agree ❑ Not sure ❑ Disagree ❑ Strongly disagree ❑

k. **Willing to take responsibility within your own level of expertise, knowledge and experience**

Strongly agree ❑ Agree ❑ Not sure ❑ Disagree ❑ Strongly disagree ❑

l. **Able to reflect on your own and others' practice**

Strongly agree ❑ Agree ❑ Not sure ❑ Disagree ❑ Strongly disagree ❑

m. **Confident to make decisions**

Strongly agree ❑ Agree ❑ Not sure ❑ Disagree ❑ Strongly disagree ❑

n. **Able to multitask**

Strongly agree ❑ Agree ❑ Not sure ❑ Disagree ❑ Strongly disagree ❑

o. **Patient and cheerful with a good sense of humour**

Strongly agree ❑ Agree ❑ Not sure ❑ Disagree ❑ Strongly disagree ❑

p. **Able to teach and encourage people to develop their skills**

Strongly agree ❑ Agree ❑ Not sure ❑ Disagree ❑ Strongly disagree ❑

q. **Good basic IT skills – confident use of e-mail & internet**

Strongly agree ❑ Agree ❑ Not sure ❑ Disagree ❑ Strongly disagree ❑

r. **Numeracy (to a specified level)**

Strongly agree ❑ Agree ❑ Not sure ❑ Disagree ❑ Strongly disagree ❑

s. Literacy (to a specified level)

Strongly agree ❑ Agree ❑ Not sure ❑ Disagree ❑ Strongly disagree ❑

t. Able to demonstrate use of reasoning and articulate transferable skills

Strongly agree ❑ Agree ❑ Not sure ❑ Disagree ❑ Strongly disagree ❑

u. Able to show insight and motivation into chosen field of practice

Strongly agree ❑ Agree ❑ Not sure ❑ Disagree ❑ Strongly disagree ❑

v. Able to commit to a full time course

Strongly agree ❑ Agree ❑ Not sure ❑ Disagree ❑ Strongly disagree ❑

w. Being of 'Good health and good character' (NMC, 2008)

Strongly agree ❑ Agree ❑ Not sure ❑ Disagree ❑ Strongly disagree ❑

Q6. Do you think these personal attributes are equally important in recruitment to all fields of nursing and midwifery practice?

Yes ❑ Not sure ❑ No ❑

Q7. If you answered 'No' or 'Not sure' to Q6, please provide your reasons below:

Q8. Can you suggest other personal attributes that would be important to take into account in the selection of nursing and midwifery students?

Q9. If you have any other comments to contribute, please enter them below.

Thank you for participating in our survey

Anne Waugh, George Petrie, Fiona MacKinnon,
Connie McLuckie and Mandy Gentleman

Appendix 22: Evaluation

Within each of the study days for Newly Qualified Practitioner programme the LCCP team shared experiences and examples from the LCCP programme. The premise of this was to encourage exploration, reflection and discussion of participants practice and learning from others.

Each of the study days were themed and focussed on a particular element of compassionate care. For example in the third year the themes for each of the study days were:

- Hearing the experiences of patients, families and staff and taking action
- Being appreciative
- Involving and valuing
- Use of evidence from observations and stories
- Knowing you, knowing me

The LCCP team used a variety of approaches to engage participants in these sessions that included:

- Providing an overview of the LCCP programme and examples from practice along with the opportunity for discussion
- Workshops on the practical use of hearing peoples experiences of care using emotional touch points. This workshop included demonstrations of how this is done along with participants trying if out for themselves
- Exploring real issues through acting out scenarios and asking participants in groups to consider how they felt, what they thought was going on. Then asking the characters questions to identify what was good and how could it be different.
- Using creative activities such as collage to explore participant's experiences of being newly qualified.
- Exploring the use of other methods used within the LCCP programme such as beliefs and values clarification and observation
- Facilitated discussion groups on the challenges of being newly qualified and how to move to action in these challenges
- Presentation and question and answer sessions from staff within the senior nurse's areas in their experiences of being newly qualified and how they have overcome this.

Appendix 23: Evaluation Questions (October 2010)

Looking back over the programme:

1. What has it felt like to be involved?
2. Can you tell me a bit about a time when you felt your opinions were listened to and valued in this programme?
3. Can you tell us one good or successful story from the process.....and one not so good, or a disappointment?
4. What improvements have you seen? Can you give an example?
5. Tell me a bit about thing you have learnt about yourself through participating in the programme.
6. As a result of taking part in the programme, what has it made you think about?
7. What, if anything, are you going to do differently as a result of taking part in the programme?
8. Tell me about what you have learnt about the team while taking part in the programme?
9. Is there anything you think we should have done differently?
10. What do you think will happen now? In what way will things continue?
11. How would you describe what you and others have been doing to someone who did not know about the programme?

Appendix 24: Table of Observations, Activity Observed and Frequency

Phase/Ward	What was observed	Number of observations
Beacon Phase		
Ward 1	Mealtime Medicine round Care giving Meetings Night shift Visiting time	2 2 1 2 1 1
Ward 2	Meetings Handover	3 2
Ward 3 – 204	Handover Communication Team Effectiveness Nurses station Privacy and Dignity Visiting time	2 2 1 1 1
Ward 4	Mealtimes Medicine round Nurses station	1 1 2
Development Site		
Ward 1	Day room Handover	1 1
Ward 2		
Ward 3	Mealtime Visiting time Meetings	2 1 1
Ward 4 – RFU		
Development Unit		
Unit 1	Mealtime Review	2 1
Unit 2	Patient clerking in	3
Unit 3	Ward round Admission	1 1
Unit 4	Care giving Mealtimes Visiting times	3 3 1
Unit 5	Reception/Clinical	2

Beacon: Ward 1 (Ward 50) Ward 2 (Ellen's Glen) Ward 3 (204) Ward 4 (101)

Development Sites: Ward 1 (Craiglea) Ward 2 (Loanhead) Ward 3 (CCA) Ward 4 (RFU)

Development Units: Unit 1 (CHP) Unit 2 (Medical day/Discharge) Unit 3 (Neuro) Unit 4 (Surgery) Unit5 (Maternity)

Appendix 25: Summary of Data Collection Episodes per Beacon Ward, Development Site, Development Units

Phase / Ward	Stories			Obs	Beliefs and Values		Beliefs and Values		RCN DVD		Exit
	Pts	Rel	Staff	No. of obs	P	S	P	S	P	S	
Beacon											
Ward 1	12	10	13	9	25	8	25	8			17
Ward 2	2	3	6	6	30	9	25	9			22
Ward 3	7	6	8	5	42	12	38	7			
Ward 4	4		5	4	15	4	15	4			7
Development Site											
Unit 1	7	7	8	3	97	16	40	5			15
Unit 2			4	3	5	2	5	4			
Unit 3	14	4	12	2	12	3	20	3	4	1	
Unit 4	12	8	7	7	32	6	32	6			25
Unit 5	5	2	10	2	4	1	10	1			
Total	78	49	107	52	319	80	269	69	46	7	140

Beacon: Ward 1 (Ward 50) Ward 2 (Ellen's Glen) Ward 3 (204) Ward 4 (101)

Development Sites: Ward 1 (Craiglea) Ward 2 (Loanhead) Ward 3 (CAA) Ward 4 (RFU)

Development Units: Unit 1 (CHP) Unit 2 (Medical day/Discharge) Unit 3 (Neuro) Unit 4 (Surgery) Unit5 (Maternity)

Key: P = Number of participants, S= Sessions held

Wordle™ result of entire final report

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