

Embedding compassionate care in local  
NHS practice: a realistic evaluation of the  
Leadership in Compassionate Care  
Programme

Juliet Claire MacArthur

A thesis submitted in partial fulfilment of the  
requirements of Edinburgh Napier University, for the  
award of Doctor of Philosophy

May 2014

## Acknowledgements

Undertaking and completing this PhD would not have been possible without the support of many people. I am particularly grateful to my three supervisors: Professor Morag Gray, Professor Heather Wilkinson and Dr Gerri Matthews-Smith. Our supervision sessions have been stimulating, with appropriate challenge when I have needed it and always with a great deal of support.

I give my thanks to all the participants in this study. I appreciate the time they gave me and their openness during interviews. I am especially grateful to the Leadership in Compassionate Care Team for their willingness to share emerging thoughts and ideas about compassionate care in practice.

I would like to acknowledge the funding provided by the Centre for Integrated Healthcare Research and NHS Lothian's Research and Development Office for the fees for my studies. I have also appreciated the study leave and support given to me by the various managers I have had over the course of this period, including Mary Parkhouse, Melanie Johnson and Sarah Ballard-Smith.

My family have been a very important source of support and a welcome distraction. I thank Tom for having faith in me, his genuine intellectual interest in the concept of compassion and his regular texts and emails to tell me when the latest debate or news item on compassion were on Radio 4 and Radio 5 Live. Seamus and Fergal have grown up with this PhD and have encouraged me to keep going, particularly when they have challenged me to do my own 'homework' when I have suggested they should be doing theirs. I hope that they will feel that my regular absence from my motherly duties have been worth it.

I would like to thank my colleagues and friends for their ongoing interest over the many years that I have been conducting this research. In particular I have appreciated the support from Michael Brown, Thanos Karatzias, Sue Sloan, Janet Corcoran, Gordon Hill and Liz Adamson. Thanks also to Mandy Allison for her encouragement all the way through. Studying at the weekends was thankfully punctuated with wonderful walks round Arthur's Seat with Jane

Kinnear and gave me the opportunity to focus and chat about the other aspects of my life.

Finally, I would like to give special thanks to Barbara Sharman at Letham House for providing the most wonderful hospitality and setting for the writing retreats that became my main opportunity for analysis and writing. I also enjoyed and benefitted from the academic stimulation of other writers including Heather Wilkinson, Ailsa Cook, Catherine-Rose Stocks-Rankin, Claire Lighthowler and Jo Alexjuk.

## **Dedication**

This PhD is dedicated to Simon Pullin who was a Senior Nurse on the Leadership in Compassionate Care Programme from December 2007 until his untimely death in July 2011. It was a privilege both to know him and to seek his views and experiences as part of this research study.

## **Abstract**

This thesis offers an original contribution to knowledge through providing a rigorous longitudinal examination of a complex intervention known as the 'Leadership in Compassionate Care Programme' (LCC) which was designed to embed compassionate care within local NHS practice in a large Health Board in Scotland. To date there has been little research into the impact of dedicated programmes aimed at enhancing compassionate care on an organisational basis. Through the use of Pawson and Tilley's (1997) realistic evaluation framework this study takes the form of a critical exploration of what did and did not support a sustained focus on compassionate care within the participating settings. The findings have important implications for both policy and practice, and the thesis culminates in a series of recommendations for healthcare organisations at macro, meso and micro levels.

Concern about the delivery of compassionate care in the NHS has become a major focus of political, public and professional debate during the last ten years. There has been long standing recognition of the clinical and financial pressures within the NHS; however, the scandal of poor care in Mid Staffordshire NHS Trust brought the issue of compassionate nursing practice into sharp focus. This study makes reference to the findings of the original Francis Inquiry (2010) and subsequent recommendations (Francis 2013) and there is no doubt that the current and future landscape of compassionate care is very different to the one encountered at the outset of this inquiry in 2007.

This longitudinal qualitative study provides insight into nurses' experiences as they engaged with the LCC Programme and it provides an important understanding of how best to recognise and support existing good practice and achieve sustainable improvements. Data collection was conducted over three years and primarily involved 46 semi-structured interviews with 33 key participants. This led to the development of eight detailed case studies of participating wards and the generation of an analytic framework based on 'level of adoption' of the LCC Programme. The eventual synthesis of findings across all eight study sites permitted the development of a conceptual model

for strengthening organisational capacity for the delivery of compassionate care. The 'compassionate core' of this model recognises compassionate care as focussed on meeting the needs of patients, of relatives *and* of staff. My findings point to the fact that embedding and sustaining compassionate care demands a strategic vision and investment in a local infrastructure that supports relationship-centred care, practice development, and effective leadership at all levels.

## Contents

Acknowledgements.....	ii
Dedication.....	iii
Abstract.....	iv
Contents .....	vi
List of Tables .....	ix
List of Figures .....	xi
Chapter One: Introduction.....	1
1.1 Background.....	1
1.2 Aim of the LCC Programme .....	2
1.3 The changing landscape of compassionate care.....	3
1.4 Rationale for investigation.....	5
1.5 The Leadership in Compassionate Care Programme.....	7
1.6 This study .....	15
1.7 Contribution to new knowledge .....	16
1.8 Insider-outsider researcher .....	16
1.9 Reflexivity .....	18
1.10 Chapter overview .....	19
Chapter Two: Context.....	22
2.1 Why worry about compassion? .....	22
2.2 Historical perspective.....	23
2.3 Evidence on patient experience .....	24
2.4 More recent cause for concern.....	26
2.5 The period 2007 – early 2009 .....	27
2.6 The period late 2009 – 2011 .....	36
2.7 The period 2012 - present.....	44
2.8 Conclusion .....	46
Chapter Three: Literature Review.....	47
3.1 Analysing Compassion.....	47
3.2 Scope of the literature review .....	49
3.3 Compassion: emotion and/or virtue?.....	50
3.4 Definitions of compassion .....	50
3.5 Models of compassion .....	51

3.6 Compassion and suffering .....	53
3.7 Compassion and pain for the compassionate.....	55
3.8 Compassion and pity.....	56
3.9 Compassion as a global trait? .....	58
3.10 Compassion, empathy and sympathy .....	59
3.11 Motivation for compassion.....	65
3.12 Demonstrating compassion in professional practice.....	67
3.13 Compassion – innate characteristic or taught skill? .....	68
3.14 Fostering a culture of compassion.....	69
3.15 Compassion and relationships .....	70
3.16 Compassion and therapeutic benefits .....	73
3.17 Compassion and end of life care .....	74
3.18 Compassion and ‘presence’ .....	75
3.19 Compassion and ethical decision-making .....	76
3.20 Compassion fatigue .....	77
3.21 Compassion and emotional labour .....	79
3.22 Synthesis of literature review on compassion.....	80
3.23 Gaps in the literature.....	82
3.24 Research questions .....	83
<b>Chapter 4: Methods .....</b>	<b>84</b>
4.1 Introduction .....	84
4.2 Evaluation research .....	85
4.3 Initial Quasi-experimental Design.....	86
4.4 Seeking an Alternative Research Design .....	89
4.5 Realistic Evaluation.....	90
4.6 Use of realistic evaluation in healthcare .....	102
4.7 How to conduct realistic evaluation .....	104
4.8 Realistic evaluation and the Leadership in Compassionate Care Programme.....	108
4.9 Research Design .....	111
4.10 Ethical considerations .....	119
4.11 Data Collection.....	123
4.12 Analysis .....	125
4.13 Rigour .....	132
<b>Chapter Five: Findings Part 1 .....</b>	<b>135</b>
5.1 Introduction.....	135
5.2 Understanding the Context .....	138
5.3 Recognition and Expression of Compassionate Care.....	149

5.4 Reflections on the context of the LCC Programme.....	164
Chapter Six: Findings Part 2 .....	166
6.1 Introduction .....	166
6.2 Analytic framework.....	167
6.3 Critical examination of the Beacon Wards and Development Sites .....	171
6.4 Lessons Learned .....	254
6.5 Synthesis of findings within the realistic evaluation framework.....	270
Chapter Seven: Discussion.....	286
7.1 Introduction .....	286
7.2 Importance of this study .....	286
7.3 Key messages .....	288
7.4 Literature on compassionate care .....	291
7.5 Embedding compassionate care .....	295
7.6 Summary .....	312
7.7 Strengths and limitations.....	313
7.8 Reflections on role as insider-outsider researcher.....	316
7.9 Ethical considerations .....	316
7.10 Areas for future research .....	317
7.11 Conclusion .....	318
Chapter Eight: Recommendations .....	322
8.1 Policy recommendations .....	322
8.2 Practice recommendations.....	324
8.3 Priority recommendations .....	327
References.....	329
Appendix 1 Literature Review – Search Strategy.....	358
Appendix 2: Interview Schedules .....	359
Appendix 3: Subject Information Sheet.....	363
Appendix 4: Consent Form .....	368
Appendix 5: Conference and Seminar Presentations .....	369



## List of Tables

	<b>Page</b>
Table 1: The application of the 4-D Cycle of Appreciative Inquiry in the LCC Programme.	10
Table 2: Practice development techniques used in the LCC Programme and number of participants.	12-13
Table 3: Classification system for examining compassion/empathy (Kunyk & Olson, 2000).	60
Table 4: Comparisons between sympathy, empathy and compassion.	63
Table 5: Graber & Mitcham (2004) Preliminary model of affective clinician/patient interactions	68
Table 6: Kenneth B Schwartz Centre's three categories that contribute to a Compassionate Patient-Caregiver Relationship (adapted from Sanghavi 2006)	71-72
Table 7: Nurse's potential responses to work stress (McHolm 2006).	78
Table 8: Tentative Quasi-experimental design for impact evaluation	87
Table 9: 'Folk theories' informing the realistic evaluation research design	95-96
Table 10: Mapping the essential features of social programmes to the rationale for the LCC Programme.	110
Table 11: Types of data collection methods used within the study and their link to CMO configurations	113
Table 12: Study sample including number of interviews and pseudonym	118-119
Table 13: Relationship between research questions, primary code and concepts associated with Realistic Evaluation.	128
Table 14: Examples of secondary, tertiary and quaternary codes arising from Phase One analysis within primary code of 'Expressions of Compassionate Care'; secondary code 'Definitions'; and tertiary code 'Beacon Stakeholder'	130
Table 15: Dimensions for examining rigour in qualitative research	132

Table 16:	Summary of key context and characteristics of each Beacon Ward and Development Site	137
Table 17	Examples of perceived changes in the Nursing Profession	141-142
Table 18:	'Level of adoption' of the LCC Programme by the Beacon Wards and Development Sites	169
Table 19:	Outcome Matrix for Ward A	173
Table 20:	Outcome Matrix for Ward B	181
Table 21:	Outcome Matrix for Ward C	190
Table 22:	Outcome Matrix for Ward D	201
Table 23:	Outcome Matrix for Ward E	210
Table 24:	Outcome Matrix for Ward F	221
Table 25:	Outcome Matrix for Ward G	232
Table 26:	Outcome Matrix for Ward H	243
Table 27:	Conjectured CMO configurations for the LCC Programme	271
Table 28:	Refined CMO configurations for the LCC Programme	285

## List of Figures

		<b>Page</b>
Figure 1:	Phases of the Beacon Strand indicating the specialties involved	8
Figure 2:	Leadership in Compassionate Care Programme Themes (with indication of number of sub themes)	14
Figure 3:	Schulz et al.'s Model of Compassionate Care (2007, p.9)	52
Figure 4:	Basic ingredients of realist social explanation (Pawson and Tilley 1997 p.72)	102
Figure 5:	Focus of inquiry in each of three phases of data collection	114
Figure 6:	Profile of stakeholder sample groups within each phase of data collection.	116
Figure 7:	Initiatives linked with the Leadership in Compassionate Care Programme	125
Figure 8:	Key areas of change affecting the Nursing Profession in the past 10 years	140
Figure 9:	Description of complexity of care by one Charge Nurse	145
Figure 10:	Five core elements of compassionate care from each stakeholder group	153
Figure 11	Model of Compassionate Care based on the definitions of the different stakeholder groups	154
Figure 12	Shift in regularity from $R^1$ to $R^2$ which illustrates outcomes of a social programme	170
Figure 13:	Realistic Evaluation Summary - Ward A	178
Figure 14:	Realistic Evaluation Summary - Ward B	187
Figure 15:	Realistic Evaluation Summary - Ward C	195
Figure 16:	Realistic Evaluation Summary - Ward D	205
Figure 17:	Realistic Evaluation Summary - Ward E	208
Figure 18:	Realistic Evaluation Summary - Ward F	228
Figure 19:	Realistic Evaluation Summary - Ward G	239
Figure 20:	Realistic Evaluation Summary - Ward H	253

Figure 21:	The Stakeholders' Model for a Compassionate Care Programme	257
Figure 22:	Staff perceptions of the facilitation skills of the LCC Senior Nurses	264
Figure 23:	Promoting and limiting factors within the context that influenced the level of adoption within the Beacon Wards and Development Sites	274
Figure 24	Underlying and programme mechanisms impacting on the level of adoption of the LCC Programme	278
Figure 25	Principal outcome domains for each stakeholder group following implementation of LCC Programme	283
Figure 26:	Four essential elements for embedding compassionate care in NHS practice	291
Figure 27:	Key elements of compassionate care for patients, relatives and staff – the 'Compassionate Core'	296
Figure 28:	Relational practice and relational inquiry as the dynamic influencing compassionate care.	300
Figure 29:	Strategic factors influencing the delivery of compassionate care	304
Figure 30:	Practice development components within the model of building organisational capacity to embed compassionate care.	309
Figure 31:	Conceptual model of enabling factors to enhance organisational capacity to deliver compassionate care.	312

# Chapter One: Introduction

## 1.1 Background

This study involves critical examination and evaluation of the impact of a high profile research and practice development initiative known as the 'Leadership in Compassionate Care' (LCC) Programme that has been undertaken in Scotland jointly by Edinburgh Napier University and NHS Lothian (2012)<sup>1</sup>. This unique Programme has been based on a partnership approach between practice and education, with a strong focus on nursing care, but delivered within a multi-professional context in a complex NHS organisation. It was funded by a benefactor for three years and initiated in late 2007. The Programme is ongoing, although this study relates to the discrete activity between February 2008 and May 2011. The context is inpatient facilities in NHS Lothian, one of the 15 Health Boards in Scotland. Whilst the findings are of significance nationally and internationally, they are based on implementation within a single health domain and so are not necessarily generalisable.

My research adopted Pawson and Tilley's (1997) realistic evaluation framework as its underpinning methodology and was a longitudinal qualitative study with data collection carried out concurrently with the implementation of the LCC Programme itself. Realistic evaluation (Pawson & Tilley 1997) is a type of theory-driven research which places emphasis on understanding the context within which an intervention is taking place. The approach is based around the concept of 'social programmes', which Pawson and Tilley (1997) recognised as initiatives that seek to change existing processes and involves the interplay between the individual and the institution within which they operate. Rather than seeking an answer to the question of whether a programme has 'worked' (or not), realistic evaluation is designed to provide detailed answers to the question of '*why* a programme works, for *whom* and in *what* circumstances?'<sup>2</sup>

---

<sup>1</sup> Details of the Leadership in Compassionate Care Programme can be found on the Edinburgh Napier University Website  
<http://www.napier.ac.uk/fhlss/nmsc/compassionatecare/Pages/Home.aspx>

<sup>2</sup> A full discussion of realistic evaluation (Pawson & Tilley, 1997) is presented in Section 4.5.

Both the LCC Programme and my own research have come at a time when the issue of compassionate care has become a vital matter in the United Kingdom and beyond. Within the UK the Francis Inquiry (2010 and 2013) and more recent Keogh Review (2013) have brought the issue of compassionate care to the heart of the questions surrounding quality, safety and effectiveness in the NHS. This makes the aims and findings of my study all the more relevant to current debates. The overall aims of this study were to:

1. Develop an understanding of the concept and expression of compassionate care within the participating services.
2. Critically analyse the impact of the LCC Programme within the NHS organisation.
3. Examine the interplay of context and process that are seen to influence the programme outcomes in order to understand *why* the Leadership in Compassionate Care Programme works, for *whom* and in *what* circumstances.

This introductory chapter examines the aim of the LCC Programme before exploring the changing landscape of compassionate care in the intervening years between the inception of the Programme in 2007 and the present day (July 2013). There has been a demonstrable shift in focus towards the concept of compassion in the wider healthcare sphere than could possibly have been imagined at the outset and this serves as an important contextual issue to the whole study. As will be discussed throughout this work the influence of the Mid Staffordshire scandal and subsequent inquiries by Lord Francis (2010 & 2013) have been particularly influential.<sup>3</sup> Having outlined my rationale for undertaking this investigation I will overview the LCC Programme itself, including its underpinning theoretical principles and operational delivery. Before concluding with the chapter overview I will reflect on my own role as researcher in this study, which has been characterised as an ‘insider-outsider’ (Corbin-Dwyer & Buckle, 2009).

## **1.2 Aim of the LCC Programme**

The aim of the LCC Programme was to ‘to embed compassionate care as an integral aspect of all nursing practice and education in NHS Lothian and

---

<sup>3</sup> The background details about the Mid Staffordshire inquiry are detailed in Section 2.5.2.

beyond' (Edinburgh Napier University & NHS Lothian, 2012, p.14). A LCC Team was appointed to deliver the Programme and this included a Lead Nurse in Compassionate Care and four Senior Nurses<sup>4</sup>. The Programme involved four strands:

- **Establishing Beacon Wards** that would showcase excellence in compassionate care.
- **Facilitating the development of leadership skills.** This strand would offer leadership development opportunities to key individuals.
- **The undergraduate curricula.** A priority was to influence education through embedding relationship-centred compassionate practice in the nursing and midwifery programmes.
- **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.

(Edinburgh Napier University & NHS Lothian, 2012 p.15)

The LCC Programme was itself conducted as a research study and followed three key theoretical principles in its design: action research, relationship-centred care and appreciative inquiry. My study focuses primarily on the Beacon Strand, although given the nature of the Programme there are inter-relationships with the other components. A more detailed description of the LCC Programme and its underpinning theoretical framework will be presented in Section 1.5.

### **1.3 The changing landscape of compassionate care**

At the inception of the Programme in 2007 the term 'compassion' was not being widely used within the UK nursing / healthcare arena, although 'dignity' was emerging as key concept for the expression of concern around practice, particularly in the care of older people (Agnew, 2007; Reed and McCormack, 2007; Webster, 2007) and the focus of a number of early initiatives (Department of Health, 2007; Healthcare Commission, 2007a; Cass, 2008). It is important to stress that the impetus for the LCC Programme was not a suggestion that compassion was absent from care delivery in NHS Lothian,

---

<sup>4</sup> In order to preserve the anonymity of the Lead Nurse they were identified as one of the Senior Nurses in the findings.

rather a recognition that, within the prevailing context of healthcare delivery, feedback from patients had indicated that compassionate care could not always be taken for granted. The background to and manifestations of these concerns both locally, nationally and internationally along with the responses will be explored in detail in Chapter Two.

A comprehensive literature review surrounding the concept of compassion and compassionate care up to the point of early periods of data collection in 2008-2009 will be presented in Chapter Three. Where relevant the more recent literature will be included within the discussion in Chapter Six.

Prior to the initiation of the LCC Programme compassion was barely mentioned in key strategic documents in the UK such as *Delivering Care, Enabling Health* (Scottish Executive Health Department, 2006a), *Rights, Relationships and Recovery* (Scottish Executive Health Department, 2006b) and *Now I Feel Tall* (Department of Health, 2005). However, what is noteworthy as a contextual factor to this study is how the landscape of compassion has changed in subsequent years in that compassionate care has become integral to the aspirations and commitments for healthcare delivery across the UK. This emerged from 2008 onwards in key strategic health documents such as *NHS Next Stage Review* (Department of Health, 2008a), *NHS Constitution for England* (Department of Health, 2009) and *Healthcare Quality Strategy for NHSScotland* (Scottish Government 2010a) and has been sustained thereafter.

As will be discussed in Chapter Two the impact of the Mid Staffordshire Inquiry and publication of the two inquiries by Lord Francis (Francis 2010 and 2013) along with other high profile reports (for example Patients Association, 2009, 2010 & 2011) have played a major contribution to elevating the issue of compassion to the national agenda for the public, politicians, the profession, higher education and the media.

The consultation document *Delivering Dignity* (Local Government Association, NHS Confederation, Age UK, 2012a) went as far as to recommend that healthcare organisations should work to recruit staff that have the compassionate values needed to provide dignified care as well as the clinical



and technical skills<sup>5</sup>. Furthermore it stipulated that hospitals should evaluate compassion as well as technical skills in their appraisals of staff performance. The final report (Local Government Association, NHS Confederation, Age UK, 2012b) made 37 recommendations emphasising the issue of personal responsibility as well as focusing on the role of universities in instilling compassionate values in undergraduate programmes. It also recommended that all care organisations should introduce facilitated practice-based development programmes to ensure that staff have the confidence, support and skills needed to deliver care.

Recent policy directives have included the Commissioning Board for the Chief Nursing Officer in England *Compassion in Practice: Nursing, Midwifery and Care Staff: Our Vision and Strategy* (Department of Health, 2012) and the report of the Willis Commission *Quality with Compassion: the future of nursing education* (Royal College of Nursing, 2012). The *Compassion in Practice* vision centres around the '6Cs': 'care, compassion, competence, communication, courage and commitment' (Department of Health, 2012 p.11) and are driving nursing strategy in England. In Scotland the focus has been somewhat different with the emphasis being a wider national 'Person Centred Health and Care Programme' that was launched in November 2012. The high level strategic aim of this Programme is that by 2015, health and care services will be centred on people, as demonstrated by improvements in care experience, staff experience and in co-production (NHS Education for Scotland, 2012).

#### **1.4 Rationale for investigation**

My motivation to undertake this study came in 2007 when I became aware of the LCC Programme during its planning stages, although I was not directly involved in the process. I was particularly drawn to the choice of term 'compassion' (which was proving to be controversial locally) and it stimulated my interest in exploring its true meaning and manifestation in the context of contemporary healthcare delivery, which I recognised as being rapidly changing with challenging clinical environments. My own experience over the

---

<sup>5</sup> Members of the LCC Team were amongst the health and social care experts invited to give oral evidence to the Commission on Improving Dignity in Care in 2011.

previous 15 years in professional roles in practice and research development within the NHS had led to a long standing awareness and interest in the influence of organisational context on the actual delivery of nursing care, and the potential interplay between macro, meso and micro forces influencing the culture of care delivery.

My existing knowledge of the practice development literature, particularly that of the former Royal College of Nursing (RCN) Institute, pointed to the fact that one-off changes in practice are not the same as a sustained systematic development of practice that focuses on achieving cultural changes in practice settings (McCormack and Garbett, 2003). The model of practice development that came from RCN Institute known as the Promoting Action on Research Implementation in Health Services (PARIHS) Framework focused on achieving increased effectiveness in patient-centred care through the interplay and interdependence of three key factors:

- *Evidence* (research evidence, clinical experience and patient preferences)
- *Context* (culture, leadership and measurement)
- *Facilitation* (characteristics, role and style)

Kitson, Harvey and McCormack (1998)

Kitson, Harvey and McCormack (1998) position these three elements on a low to high continuum. Through their research they demonstrated that the most successful implementation occurs when evidence is scientifically robust ('high' evidence), the context is receptive to change with sympathetic cultures, appropriate monitoring and feedback systems and strong leadership ('high' context) and when there is appropriate facilitation of change using the skills of external and internal facilitators ('high' facilitation).

The emerging plan for the LCC Programme at this stage was based on a model of facilitation and was to be targeted, in the first instance, at Centres of Excellence; areas that could be assumed to have 'high' context (these became known as the Beacon Wards). The missing ingredient was the evidence on compassion; how was it manifest?, what were patient's preferences and experiences?; and how might this be captured to be taken forward to support

care development in settings that were in a different place on the continuum described by Kitson, Harvey and McCormack (1998)? This was an essential component of the LCC Team's research and practice development activities within the Beacon Wards.

It was evident, therefore, that the LCC Programme presented the opportunity for a systematic enquiry into the concept of compassion within a complex organisation. This was mirrored with the realisation that there was a clear challenge for those who had commissioned the project and those employed to deliver it to be able to demonstrate the impact of the investment. My initial engagement with the key stakeholders at this time (June-July 2007) involved the exploration of possibilities for evaluation, with an emphasis on the impact within the clinical settings involved.

### **1.5 The Leadership in Compassionate Care Programme**

As previously stated this study focuses primarily on the Beacon Strand of the LCC Programme that was implemented in three phases between 2008 - 2010. Each phase involved selection of a number of wards and departments that had put themselves forward for inclusion and ultimately led to 33 clinical settings across NHS Lothian being directly involved. These wards and departments were from a broad range of specialities and sites, including acute and community hospitals (Figure 1 overleaf). The Senior Nurses worked in each of the settings for between 7-9 months. In the LCC Phases 1 and 2<sup>6</sup> they worked on an individual ward, whereas in Phase 3 they worked across a Unit, potentially involving 4-5 wards. All participating wards and departments had elected to take part, rather than being put forward as 'failing' wards.

The goals of the Beacon Wards included:

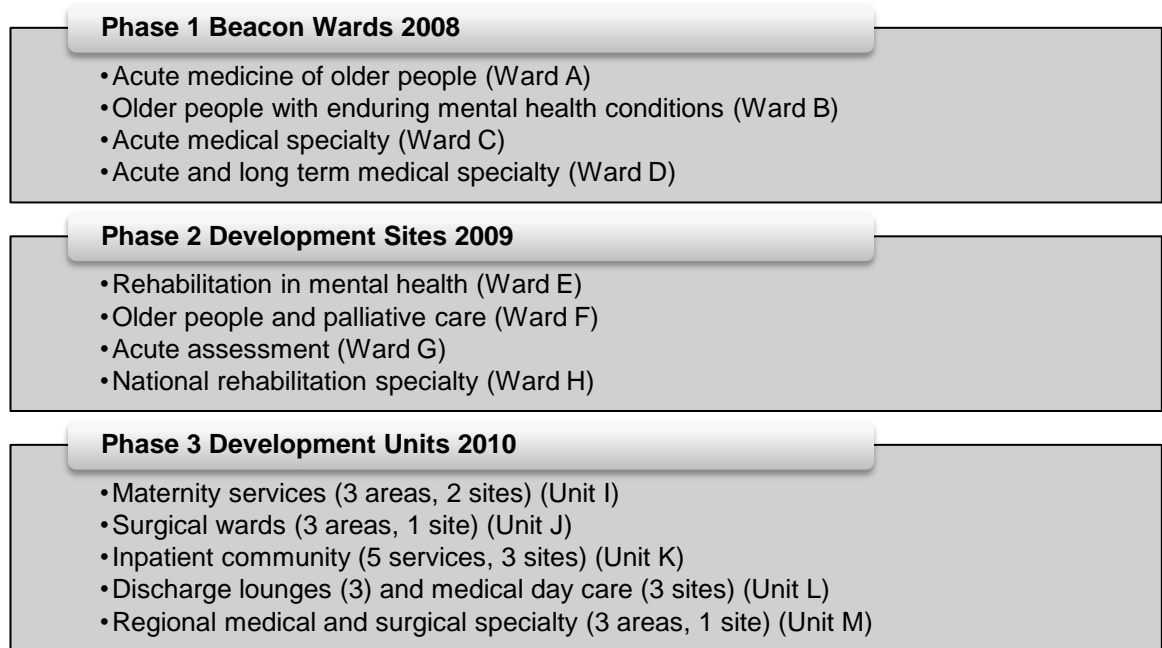
- Developing an understanding of compassionate care from the perspective of patients, families and staff;
- Developing key principles for compassionate nursing practice;
- Testing out and evaluating interventions that enhance compassionate care;

---

<sup>6</sup> The terms 'LCC Phase 1' and 'LCC Phase 2' etc. are used to distinguish the phasing of the LCC Programme from the phasing of my own study which are referred to as 'Phase One', 'Phase Two' etc.

- Developing best practice statements for compassionate care;  
(Edinburgh Napier University & NHS Lothian, 2012 p.19).

**Figure 1: Phases of the Beacon Strand indicating the specialties involved.**



### **1.5.1 Theoretical principles and approaches of the LCC Programme**

The LCC Programme followed three key theoretical principles: action research, appreciative inquiry and relationship-centred care. It involved engagement with a wide range of participants including patients, relatives, NHS staff, lecturers and student nurses (Smith et al., 2010; Dewar, Pullin & Tocher, 2011; Edinburgh Napier University & NHS Lothian, 2012).

#### **1.5.1.1 Action research**

Meyer (2000) describes action research as a style of research rather than an explicit method that focuses on the generation of solutions to practical problems and empowering those involved in it to improve practice. It is a cyclical process that involves an ongoing series of cycles that include problem identification, planning, action (implementation of change and monitoring) and evaluation that may lead to the identification of new problems, planning, action and evaluation (Waterman et al., 2001). The generation of knowledge and action directly useful to practice and the empowerment of people at a deeper level were important to the LCC Programme since one of the outcomes was to develop strategies that enhance compassionate caring that practitioners

themselves had ownership of and were able to develop themselves (Edinburgh Napier University & NHS Lothian, 2012 p.21-22).

#### **1.5.1.2 Appreciative inquiry**

The processes employed within the LCC Programme were based on an underpinning philosophy of appreciative inquiry (AI) (Cooperrider et al., 2008). Traditionally action research mainly focuses on problem-solving approaches, which may start by accentuating limitations rather than possibilities. In contrast AI focuses on the positive elements of both individuals and the organisation itself ('the positive core'), and there is evidence that this can result in effective and sustainable change (Cooperrider et al., 2008). AI is based on a 4-D Cycle involving 'Discovery' (what is), 'Dream' (what might be), 'Design' (what could be) and 'Destiny' (what can be). The Senior Nurses acted, therefore, as action researchers with an appreciative stance. Dewar and Mackay (2010) report that this meant working with staff, patients and families to understand compassionate care in the clinical areas, to systematically discover what was happening by actively being curious and understanding and affirming different points of view. The Senior Nurses' questions focused on what was working well rather than what were the problems. They did, however, emphasise that problems or negative comments were not ignored, but rather were responded to through considering possibilities rather than dwelling on the problem (Edinburgh Napier University & NHS Lothian, 2012 p.22). Table 1 overleaf illustrates the phases of the AI 4-D cycle within the LCC Programme and the interventions adopted during each cycle.

**Table 1: The application of the 4-D Cycle of Appreciative Inquiry in the LCC Programme**

<b>Phase</b>	<b>Interventions</b>
1. Discovery	<p>‘What is working well round here?’</p> <ul style="list-style-type: none"> <li>➤ Structured participant observation</li> <li>➤ Informal participant observation</li> <li>➤ Staff and student stories</li> <li>➤ Photo elicitation with staff, patients and families</li> <li>➤ Patient and family stories</li> </ul>
2. Dream	<p>‘What would be the ideal caring environment?’</p> <ul style="list-style-type: none"> <li>➤ Feedback sessions with staff</li> <li>➤ Beliefs and values group interviews with staff</li> </ul>
3. Design	<p>‘What do we have to do to achieve our ideal? Test this out and evaluate the activity’</p> <ul style="list-style-type: none"> <li>➤ Group discussions with staff to generate provocative statements</li> <li>➤ Development of actions</li> <li>➤ Field notes and interviews to monitor impact of any development activity</li> </ul>
4. Destiny	<p>‘What has worked well and how can people be supported to develop further?’</p> <ul style="list-style-type: none"> <li>➤ One to one interviews with staff</li> <li>➤ Development of action plans</li> <li>➤ Analysis of charge nurse tape recordings submitted on monthly basis, containing reflections on process of change.</li> </ul>

(Dewar & Mackay, 2010)

### **1.5.1.3 Relationship-centred care**

Relationships are viewed as being fundamental to teamwork, leadership and care delivery. Tresolini (1994) developed the concept of relationship-centred care in the USA in response to his recognition that the nature and quality of relationships were central to healthcare and the broader healthcare delivery system. Relationship-centred care (RCC) is viewed as a way in which healthcare settings value, act on and sustain relationships that form the context and basis of care. Beach and Inui (2006) from the Relationship-Centred Care Research Network at the John Hopkins University School of Medicine define RCC as ‘care in which all participants appreciate the importance of their relationships with one another’ (p.53). They go on to outline

four founding principles: (1) that relationships in healthcare ought to include the personhood of all participants; (2) that affect and emotions are important components of these relationships; (3) that all healthcare relationships occur in the context of reciprocal influences; and (4) that the formation and maintenance of genuine relationships in healthcare is morally valuable (Beach & Inui, 2006 p.53).

Attention to the relationships between professionals, patients and relatives has been the focus of considerable research in recent years. In the UK Nolan et al. (2006) undertook a number of research studies that led to the development and publication of the Senses Framework. Focus on relationships based on the six Senses<sup>7</sup> have been linked to 'enriched' environments of care, and have also been demonstrated to be important for student nurses and other staff (Brown et al., 2008a; Andrew et al., 2011). Within the LCC Programme relationship-centred care permeated all aspects of the work, and the Senses Framework became a core element of the Leadership Programme.

### **1.5.2 Practice Development**

Through facilitation processes the LCC Team utilised a range of innovative practice development techniques within each phase and setting as a means of examining practice and exploring experiences. These techniques are summarised in Table 2 overleaf and their use will be referred to in Chapter Five: Findings Part 2 with regard to where they were used, how they were accepted and the outcomes that were achieved in the Beacon Wards and Development Sites as a result.

---

<sup>7</sup> The six Senses are Sense of Security; Sense of Belonging, Sense of Purpose, Sense of Continuity, Sense of Achievement, Sense of Significance (Nolan et al. 2006).

**Table 2: Practice development techniques used in the LCC Programme and number of participants**

Type of practice development intervention	Reference(s)	Description in the LCC Programme Final Report <sup>8</sup>	Number of participants (where stated in Final Report)
Beliefs and values clarification	Pullin (2009)	p.38-39	319
Image work 'photo elicitation'	Brand & McMurray (2009), Lorenz (2011)	p.39-41	Not stated
Feedback Sheets – 'Dog & Rose'	Developed locally	p.41-42	Not stated
'Dog' = what could we do better?			
'Rose' = what did we do well?			
Emotional touchpoints <sup>9</sup>	Bate & Roberts (2007)	p.43-46	78 patients
	Mackay & Dewar (2009a)		49 relatives
			107 staff
Formal and information observation	Workplace Culture and Critical Analysis Tool (WCCAT) (McCormack et al., 2009)	p.46-47	52 episodes
	Quality Interaction Schedule (Dean et al., 1993)		
Action learning	McGill & Brockbank (2004)	p.47-49	Not stated
Focus groups using RCN Dignity DVD	RCN (2009)	p.49-50	46
Real time feedback to staff		p.50-51	Not stated

<sup>8</sup> Edinburgh Napier University & NHS Lothian (2012)

<sup>9</sup> Emotional touchpoints is a technique developed by Bate and Roberts (2007) whereby participants are invited to think about key 'points' or experiences of the health care 'journey' (for example admission, discharge, visiting time, night time). These might be predetermined by the person conducting the interview or chosen by the participant. They are then presented with a series of words expressing various emotions, both positive and negative, and asked to select those that best describe their experience or feeling about the various 'points' that have been identified. Having selected the words they are then asked to discuss or describe their rationale for selection and this forms the basis of the construction of a narrative which is then written up by the interviewer and given back to the participant as soon as possible. Within the LCC Programme emotional touchpoints were used with patients, relatives, staff and students.



**Table 2 (continued): Practice development techniques used in the LCC Programme and number of participants**

Type of practice development intervention	Reference(s)	Description in the LCC Programme Final Report <sup>10</sup>	Number of participants (where stated in Final Report)
Positive practice statements	Mackay & Dewar (2009b)  Dewar, Pullin & Tocher (2011)	p.51-53	Not stated
Facilitating (and evaluating) action projects		p.53-57	Not stated

The LCC Team’s facilitation led to the identification and implementation of a wide range of actions and work-based projects aimed at improving the experience of all those involved in the receipt and delivery of care (Edinburgh Napier University & NHS Lothian 2012 p.56; Dewar and Mackay 2010). Whilst the focus of the LCC Programme during the first three years was in a comparatively small number of clinical settings the overall aim of the Programme was to embed compassionate care throughout the organisation.

### **1.5.3 Complex intervention**

The LCC Programme should be seen as a complex intervention, something that is most often associated with clinical studies. Shiell, Hawe and Gold (2008), however, recognise that health researchers also use the notion of complexity to indicate the problems faced in evaluating many non-drug interventions. They highlight the fact that, although rarely delineated, complexity has two meanings. In the first it is a property of the intervention, and in the second it is a property of the system in which the intervention is implemented. This perspective fits exactly with the nature of the LCC Programme with the combination of the three underpinning theoretical frameworks and its implementation in three phases. The complexity of the intervention was also based on the combination of context (different specialities at each stage of implementation) and processes (the four strands

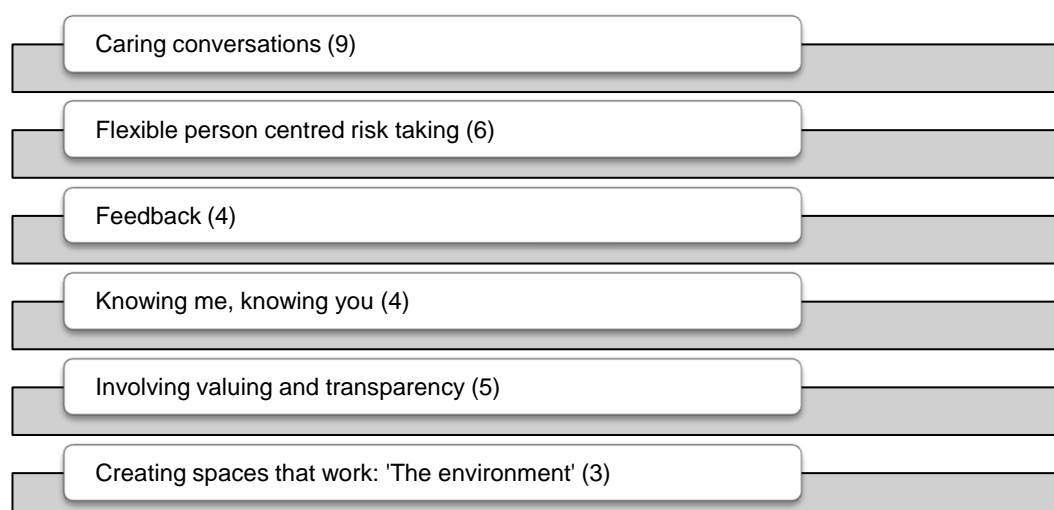
<sup>10</sup> Edinburgh Napier University & NHS Lothian (2012)

of the Programme alongside a combination of action research and practice development approaches), whilst the system (NHS Lothian) is inherently complex in terms of management systems, location, leadership styles, ongoing operational pressures and co-existent projects.

#### 1.5.4 Outcome of the Beacon Phase of the LCC Programme

The LCC Programme explored the delivery of compassionate care in inpatient care settings with a view to understanding its meaning and expression from the perspective of healthcare practitioners, patients and relatives, and to foster ways of embedding compassion in practice. The outcome of the action research undertaken by the LCC Team has been the generation of an analytic framework for a compassionate care model (Edinburgh Napier University & NHS Lothian 2012, p.159-161). This framework includes six themes for person-centred compassionate care that were investigated and observed within the four Beacon wards in LCC Phase 1, and subsequently tested in the four Development Sites in LCC Phase 2 and five Development Units in Phase 3 (Figure 2 below). Each theme contains a number of sub-themes that have been developed by the LCC Team into criteria to exemplify what constitutes compassion and a range of ways of ‘measuring’ these in practice<sup>11</sup>.

**Figure 2: Leadership in Compassionate Care Programme Themes (with indication of number of sub themes)**



<sup>11</sup> By the end of the formal period of the LCC Programme in 2011 these measurement tools were still under development and so it was not possible to validate or evaluate their use in practice.

The LCC Team developed the six key themes to mean:

**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 me, knowing you:** Developing mutual relationships and knowing the person's priorities, to enable negotiation in the way things are done around here.

**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.

**Creating spaces that work: the environment:** Need to consider the wider environment and where necessary be flexible and adapt the environment to provide compassionate care.

(Edinburgh Napier University & NHS Lothian, 2012 p.59)

## 1.6 This study

My research does not seek to analyse or evaluate the actual delivery of compassionate care within the clinical settings involved, as that was the purpose of the first three years of the LCC Programme. Rather this study sets out to develop an understanding of the concept and expression of compassionate care within the participating services and to critically examine the impact of the LCC Programme. It seeks to understand the factors influencing the success, or otherwise, of the achievement of the Programme aims 'to embed compassionate care as an integral aspect of all nursing practice and education in NHS Lothian and beyond' (Edinburgh Napier University & NHS Lothian 2012, p.14). Its focus is, on the processes of implementation, the context (macro, meso and micro) in which implementation proceeded and recognition of the changing landscape of compassionate care as a strategic and operational issue within the NHS both nationally and locally.

This study examines the processes and outcomes of the LCC Programme and locates them within the framework of Pawson and Tilley's (1997) realistic evaluation methodology. Pawson and Tilley (1997) use the term 'social

programme' as a descriptor of the type of interventions designed to deal with 'social problems' in a specific time and place. This study set out to determine the perception of key stakeholders as to the nature and origins of the 'social problem' (i.e. a diminution of compassionate care) that led to the inception of the Programme. This was at a time when the notion of 'compassion' in healthcare was not widely discussed, and yet there was a clear perception that something was 'wrong' with nursing in particular, not just in Lothian but throughout the UK and even beyond. The LCC Programme has been one response to this 'social problem', and this study will make reference to other approaches that have run in parallel.

The main focus of this study centres on eight case examples of the implementation of the LCC Programme, in the four Beacon Wards and four Development Sites.

### **1.7 Contribution to new knowledge**

The overall contribution to new knowledge that will emerge from this study is a systematic evaluation of a potentially complex conceptual entity, which is the delivery of a unique and innovative Programme to enhance 'compassionate care' in the 'real world' of healthcare delivery. What is important is the critical examination of the processes employed within the LCC Programme and whether context at all levels (macro, meso and micro) were influential in determining the Programme outcomes. This, in turn, will have important messages for ways to enhance organisational capacity to embed compassionate care in to routine practice. The findings have important implications for policy and practice and, as previously indicated, are timely given the current spotlight on compassionate care within the recommendations of the Francis Inquiry (2013) into care delivery in Mid Staffordshire NHS Trust.

### **1.8 Insider-outsider researcher**

As a researcher I have been in a privileged position to undertake this investigation by virtue of being embedded within the organisation in a formal role as the professional lead for nursing research. In addition at a crucial period for the LCC Programme between May 2008 and September 2009 I was on a part-time secondment to facilitate knowledge exchange between this

Programme and a range of other 'values based practice' initiatives detailed in section 2.5.5.

Corbin-Dwyer and Buckle (2009) analyse the concept of researcher as an insider-outsider in qualitative studies, which resonates with my own perspective of being an insider to the organisation; having a close working relationship to the LCC Team but with no specific role in Programme delivery. Being an insider to the organisation has permitted the opportunity to engage with a wide range of stakeholders and possess an in-depth knowledge of the organisational context that has had the potential to influence Programme direction and delivery. Corbin-Dwyer and Buckle (2009) argue that one of the realities of being in this insider-outsider position is that your perspective is strongly influenced by being a researcher who has read much literature on the research topic. Remaining an outsider to the Programme delivery has meant that through systematic inquiry based on a carefully planned research methodology, reflection and supervision I have been able to sustain an independent perspective on impact. My engagement with research participants, including the Programme Team, has been conducted in isolation from the delivery of the Programme and confidentiality has been strictly maintained.

Taylor (2011) presents a comprehensive analysis of the advantages and disadvantages of 'insider knowledge'. Advantages include: deeper levels of understanding afforded by prior knowledge; knowing the lingo or native speak of field participants (described as being 'empirically literate'); closer and more regular contact with the field; more detailed consideration of the social actors at the centre of the phenomena under investigation making access to, and selection of research participants easier and better informed; and more open and readily accessible lines of communication between researchers and informants due to the researcher's continuing contact with the field. All these advantages have applied to my own position and experience. I have had direct contact with senior nurses in the organisation (at Executive, Associate Director and Chief Nurse level), participated in a number of learning events that have included a focus on the LCC Programme and towards the end of the initial three year period I was a key player in discussions about future

directions for the overall Nursing and Midwifery Quality Plan which became known as 'Delivering Better Care'

Nevertheless, critical assessments of the insider-outsider position are also important. Taylor (2011, p.11) cites Bennett (2003) who raises questions regarding whether 'cultural proximity' results in the collection of authoritative data. He argues that one should not presume that being an insider necessarily offers an absolute or correct way of seeing and/or reading the culture under investigation, given that insider views will always be multiple and contestable. Furthermore they can generate their own epistemological problems due to subject/object relationality. Taylor (2011) adds to this dimension by raising the question of 'insider friendships' and the potential impact that they may have upon the processes of perception and interpretation within and of the field under examination.

### **1.9 Reflexivity**

Gilgun (2010) suggests that the core concept of reflexivity is awareness. She argues that this should be directed in three areas: first, the topic under investigation (both personal and professional responses); second, the perspectives of the people who will be involved in the research (mainly the participants); and third the audience to whom the findings will be directed. With regard to the first area, I was aware that I came into the study with my own personal beliefs about compassion and the value I had placed on delivering compassionate care when I was in a clinical role. I needed, therefore, to be attuned as to how this might influence my thoughts and judgements when I went into clinical settings. With regard to the perspectives of the people who would be involved and whether or not I might be unduly influenced by them through our respective relationships, this was a subject that I returned to frequently in my reflective diary<sup>12</sup>. The prospective audience for my research was also an important consideration, since to a large degree my

---

<sup>12</sup> *Looking back at my reflective diary between 2008 and 2012 this position is something I have been very attuned to and I can see that there have been definite variations in my position as insider-outsider researcher (researcher, colleague and employee). Whilst my engagement with the LCC Team in terms of this research study went through a series of natural phases related to data collection (interviews Jan – April followed by transcribing and analysis), my involvement with them as colleagues which had been consistently in place between May and September 2009 diminished considerably after 2010, when my secondment to the values-based practice initiative came to an end.*

research subjects were my both my informants and my eventual audience and yet I needed to remain both distant from a desire to reach potential research findings that I knew they desired before I had completed the full research process including analysis and synthesis of my ideas.

### **1.10 Chapter overview**

There are two ways to approach the literature review surrounding the LCC Programme. The first is the more traditional approach to analyse the literature on the concepts of 'compassion' and 'compassionate care' and the second to examine the literature and evidence that perhaps substantiates the need for this type of Programme. I have chosen to present the latter first in Chapter Two in order to foreground the more conceptual analysis relating to the choice of the term 'compassion' associated with this work.

Chapter Two presents a critical analysis of the context of concern around the caring dimension to healthcare that has become prevalent over the last 10 years and explores evidence surrounding patients' experience of care in the wider NHS in the UK. It does so in three phases: the first in the period up to 2009 when the LCC Programme was just underway; the second from late 2009 to 2011; and the third late 2011 to present time in June 2013. It will examine the articulation of disquiet around the issue of compassion itself and contrast a range of national and local projects and campaigns that have been instigated in recent years to address such issues. This will include analysis of the local context in NHS Lothian, including the LCC Programme.

Chapter Three presents the literature review on the concept of compassion up to and including 2009, which is when the research questions for this study were developed. The breadth includes perspectives from philosophy, ethics, social psychology as well as healthcare. Whilst it offers important insight into collective thinking on the concept of compassionate at that time and a range of perspectives that examine its forms of expression it also points to gaps in knowledge. These centred on the lack of empirical studies examining actual initiatives to investigate compassionate care in practice and measures to enhance its delivery. This analysis will in turn lead to the rationale for the research questions themselves.

Chapter Four addresses the research methodology. It firstly presents early considerations for a quasi-experimental design with reasoning for its subsequent rejection. This is followed by an analysis of evaluation methodology and the specific selection of realistic evaluation (Pawson & Tilley, 1997) as the underpinning theoretical framework and basis for the research design. The research design including sampling strategy, recruitment, data collection methods and analysis will be described, along with ethical considerations.

Given the breadth of findings in this study two chapters have been created to provide greater clarity in addressing the research aims and response to the specific research questions. Chapter Five: Findings Part 1 addresses the stakeholders' perspectives on the prevailing context for the nursing profession at the outset of the Programme and how this linked to the perceived need for it. It goes on to examine how compassionate care was recognised by the stakeholders, leading to an emerging definition and model of compassionate care.

The main focus of the Chapter Six: Findings Part 2 is the presentation of the views, experiences and perceptions of stakeholders that are presented within eight case examples (the four Beacon Wards and four Development Sites), illustrating the context, mechanisms and outcomes in each. This chapter introduces the concept of 'level of adoption' to delineate the degree to which the participating wards engaged with and sustained the work of the LCC Programme. Through analysing each ward in turn and constructing the outcomes within a realistic evaluation framework (Pawson & Tilley, 1997) a picture emerges regarding the enabling and limiting factors that influenced the level of adoption. These findings are further corroborated against stakeholder views on implementing the Programme, formulated as 'lessons learned'. The final section synthesises the key findings across the eight case examples in such a way that points towards Chapter Seven and the presentation of the type of 'middle-range' theory that Pawson and Tilley (1997) describe as an output of the realistic evaluation framework.

Chapter Seven puts forwards and critically examines the key messages of my study and in doing so gradually builds a model of organisational capacity to



embed and sustain compassionate care in routine clinical practice. As will be discussed this model is grounded from my data and is founded on four key elements: strategy, relationships, practice development and leadership. Within each element there are a number of important attributes that were identified within the 'high adopting' wards within the LCC Programme. Having examined the strengths and limitations of my study and areas for future research, this chapter will lead to the overarching conclusions of my work in terms of the importance of compassionate care to the current and future NHS and the potential impact that this model holds.

Chapter Eight draws on this model of organisational capacity for delivering compassionate care and makes recommendations that have implications for policy and practice. Policy recommendations are directed at both national (Government) and local (NHS Board or Trust) level, whilst practice recommendations are offered for local consideration at macro (Board), meso (middle management) and micro (individual ward/department) level. I conclude this chapter with what I view as being the priority recommendations that have emerged from the data.

## Chapter Two: Context

### 2.1 Why worry about compassion?

*'If we can't get compassion into our healthcare, the system is failing. It's as fundamental as that'.*

Niall Dickson, Chief Executive, The King's Fund (Dreaper, 2008 n.p.)

Over the past number of years there has been an increasing perception that the caring dimension to healthcare delivery 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; Patients Association, 2009, 2010, 2011; Francis 2010 & 2013). This concern has come both from within the profession and outside. Back in 2008, the Nursing Standard was moved to run a series on *The State of Nursing* centred on the question of whether 'the profession has lost its way?' (Whyte, 2008). On the basis of her own recent experience of nursing care, Corbin (2008 p.163), a leading US nursing academic, posed the question 'Is caring a lost art in nursing?', and called for an international 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' (p.165).

This chapter will analyse the evidence, primarily surrounding the concern about care of older people in hospital settings, and how this debate has been linked to the concept of compassion in a number of inquiries, reports, professional journals and the media. The inclusion of media headlines in this analysis has been deliberate, since they convey messages (whether fully reflective of the detail of the situation) that bring these issues into the public domain and influence the perception and opinion of the public.

Much of the published evidence comes from England rather than Scotland, and whilst acknowledging that there are important cultural and structural differences in healthcare provision, there has been convergence in all four UK countries for several years around the perception that 'something needs to be done'. Given that the concept of compassion only emerged as a distinct issue

in 2007-8 and had not in itself been defined as a health construct, the evidence examined takes a much broader focus on patient experience, including dignity. It also includes the concepts of both patient-centred and person-centred care that have, to some degree, been at the core of the nursing profession's internal debates into the caring dimension of nursing.

The analysis will include an examination of responses, both political and professional and will make reference to factors that are known to influence the delivery of care, particularly in inpatient settings. This scrutiny places the LCC Programme in the wider national and international healthcare context and serves as a foreground to the literature review on the concept of compassion in Chapter Three. Furthermore it points towards many of the contextual influences that are at the core of the realistic evaluation methodology (Pawson & Tilley, 1997) presented in Chapter Four.

## **2.2 Historical perspective**

Whilst the focus of this study relates to concerns around care practices in the NHS over the last 15 years it is important to recognise that concerns about care in a number of UK hospitals were highlighted from the 1960s onwards. Following her own experience of hospital care as well as survey data Gerda Cohen (1964) wrote a book *What is wrong with British Hospitals?*, in which she argued that 'patients don't count' (Catholic Herald, 1964). She claimed this was largely as a result of the planning of the patient day, hospital rules and poor care (Cohen, 1964 cited in MacFarlane, 1974 p. 28). In 1967 Barbara Robb, a campaigner on behalf of the Association for the Elderly in Government Institutions published a book *Sans Everything* which detailed allegations concerning the care of elderly patients in seven hospitals in England. A subsequent investigation for the Minister of Health (NHS, 1968) considered that the majority of the allegations were unfounded or based on unreliable evidence. However, following another scandal at Ely Hospital, Cardiff in 1969 the then Health Secretary Richard Crossman established the Hospital Advisory Service to act as his 'eyes and ears' (McLellan, 2008). Ultimately the Health Ombudsman System was set up in England in 1972, which McLellan (2008) argued was largely as a response to the ongoing parliamentary debates that continued to exist following the publication of *Sans Everything* (Robb, 1967).

### 2.3 Evidence on patient experience

Although concerns about care delivery continue to be raised they should be contextualised in an overall picture of high levels of positive patient experience with the NHS. Some of the evidence supporting this comes from large scale patient experience surveys undertaken throughout the UK by organisations such as the Healthcare Commission<sup>13</sup>, who have published annual patient surveys since 2002, which consistently demonstrate that hospital services are rated highly (Coulter, 2005; Healthcare Commission, 2007a). In 2007 92% of English inpatients that participated in the survey rated their overall care in hospital as 'excellent', 'very good' or 'good', with this figure remaining the same in both the 2010 and 2011 surveys (Care Quality Commission, 2010 & 2012). In Scotland the inpatient survey conducted in 2010 as part of the *Better Together Programme* (Scottish Government, 2010b) indicated that 87% of the 30,880 respondents were positive about staff (rating them as good or excellent) and 82% rated their care and treatment as good or excellent<sup>14</sup>. These figures were sustained in the repeat survey in 2011 involving 31,048 patients, with 87% again rating staff as good or excellent and 85% rating their care and treatment similarly (Scottish Government 2011a), and again in the 2012 inpatient survey (Scottish Government 2012).

National patient experience surveys remain important to politicians; however they do have their critics. For example in their review paper for the 'Point of Care' Project<sup>15</sup>, Goodrich and Cornwell (2008) acknowledged that whilst national survey data do have strengths, this method forces patients to generalise in order to rate their own experience. They go on to argue that having to respond to questions on the basis of reflection on their experience as a whole and categorise their responses into categories such as 'always' or 'sometimes' presents a certain view without actually being able to determine what happened along the way. Help the Aged (2008) expressed similar concern and therefore, as part of their *Dignity in Care Campaign* commissioned some qualitative research that, they argued, would attempt to go beyond the large scale surveys, which they suggested were 'insufficiently

---

<sup>13</sup> Now known as the Care Quality Commission <http://www.cqc.org.uk/>

<sup>14</sup> Whilst there are broad similarities between the English and Scottish surveys they are not fully comparable, including having different likert scale options for responses.

<sup>15</sup> The King's Fund *Point of Care Project* is discussed in more detail in Section 2.5.4.

sensitive to pick up nuances of a complex concept such as dignity' (p.5). One of their reasons for expressing caution about the survey method for examining patient experience was the fact that when they undertook secondary analysis of the 2007 English National Inpatient Survey it revealed that older people (70+) tended to give more positive responses about whether they were treated with respect and dignity than younger people. They also responded more positively to questions about their general care, privacy, food, and pain control (Magee, Parsons & Askham, 2008). In describing this as a 'benign impression', the researchers went on to argue that the findings of their own qualitative research involving focus groups with older people raised important questions about the validity of the methods used for measuring experience.

In the Help the Aged research (Magee, Parsons & Askham, 2008) a series of focus groups were held with 35 older people and their carers from London and Oxfordshire. This was followed up with individual interviews with 11 key informants from organisations representing older people. The focus of the research was to support the identification of effective measures of dignity; however, the broad findings suggested that dignified care remained problematic. Research participants suggested a number of reasons for this:

- An over-emphasis on targets and budgets
- The 'sacrifice of compassionate nursing care' in the development of more technical skills base
- Ageism in society and among healthcare staff

(Magee, Parsons & Askham 2008 p.11)

The researchers also highlighted that expectations about being treated with dignity altered depending on the care setting, with a suggestion that in hospitals, where more urgent care was provided, patients were willing to compromise on aspects of dignity.

In recent years there has been a move to eliciting patient experience through methods described under the broad term of 'Experienced Based Design' (Bate and Roberts, 2007) that particularly involves collection of patient stories. Goodrich and Cornwell (2008) argue that whilst such methods bring experience to life in ways that survey data cannot, they are difficult to generalise from. They conclude that to understand and describe patients' experience there is a need to obtain more detailed information that gets closer

to clinical service, care processes and pathways of care, and to the actual setting and circumstances in which care is delivered.

Despite the positive picture painted by national surveys, there has nonetheless been a perception in the public domain that something has changed and 'something needs to be done' about nursing, especially with regard to the care of older people in hospital. These concerns have been hugely magnified following the publication of damning reports into care at Maidstone and Tunbridge Wells NHS Trust and Mid Staffordshire NHS Trust in England (Healthcare Commission, 2007b and 2009) and the publicity surrounding the circumstances of deaths and illness at the Vale of Leven Hospital in Scotland between January 2007 and June 2008 attributed to *C.difficile* infection<sup>16</sup>.

The patient's experience of care has, therefore, become an important focus of NHS care delivery in a way that was not the case two decades ago. Goodrich and Cornwell (2008) highlight three main factors behind this in their review paper for the *Point of Care Programme*:

- 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.

#### **2.4 More recent cause for concern**

In more recent times Help the Aged were the first organisation to initiate a concerted campaign to address the manner in which patients were cared for in hospitals. The 'Dignity on the Ward Campaign' was launched in 1999 with the support of the RCN and the British Geriatric Society. It was positioned as a two year initiative to improve what they described as 'shocking levels of ill treatment' for elderly people in hospital with a specific focus on feeding, cleaning, communication and dementia (BBC News, 1999). Calls for 'patient-

---

<sup>16</sup> The public inquiry in to the Vale of Leven outbreak continues under the chairmanship of Lord MacLean and is ongoing <http://www.valeoflevenhospitalinquiry.org/> with the final report due for publication in Autumn 2013.

centred' or 'person-centred' care focusing on older people were outlined in strategic documents published by each of the UK Government or Assembly Health Departments (Department of Health, 2001; Scottish Executive, 2002; Welsh Assembly, 2006). These gave the first strong indication that issues relating to care provision and core values within the NHS were being acknowledged politically as a cause for concern. The professional literature was similarly reflecting these matters with an emerging critique and the development of conceptual frameworks for person-centred care in gerontological nursing (McCormack, 2003; McCormack, 2004; Dewing, 2004; Kelly et al., 2005). There were also studies examining factors influencing the delivery of patient-centred care, including one by West, Barron and Reeves (2005) involving nearly 3,000 nurses in 20 acute London Hospitals, which identified that many were aware that there were deficits in standards of care. The majority felt overworked (64%) and reported that they did not have enough time to perform essential nursing tasks, such as addressing patient's anxieties, fears and concerns and giving patients and relatives' information. The authors concluded that in many cases nurses lacked the time, tools and training to deliver high quality care.

Given the longitudinal nature of this study it has been possible to investigate and reflect on whether or not the situation has changed, and indeed whether evidence suggests that the nursing profession has effectively responded to what has become an increasingly negative image. The following analysis will be dealt with in three phases: firstly 2007 to early 2009, the period leading up to the LCC Programme and during its early days; second late 2009 to 2011 and finally 2012 to present (July 2013) which follow a period of professional focus and a range of initiatives. It is not possible to state fully the degree to which the LCC Programme has influenced the debate; however it has become recognised nationally and internationally as contributing to the focus on compassion and the need to foreground its place within the healthcare arena (Edinburgh Napier University & NHS Lothian, 2012).

## **2.5 The period 2007 – early 2009**

It was during this period that questions about the standard of nursing care were beginning to increase and there were claims that some hospitals and care homes were failing to protect the human rights of older people (BBC,

2007; House of Lords and House of Commons Joint Committee on Human Rights, 2007). In 2007 Professor Dame Christine Beasley, Chief Nursing Officer (CNO) for England hosted a conference for nurse leaders that included a workshop entitled 'A social movement for compassion' and challenged nurse directors to reintroduce into their executive roles the qualities of compassion and caring. Her choice of language in using the term 'social movement' gave an indication to the sense of urgency and concern on the part of one of the most senior nurses in the UK, who concluded that 'this is a timely opportunity to initiate a 'quality renaissance' and put caring and compassion back at the centre of nursing: for all our patients and their carers, not only the lucky few' (Proctor, 2007 p.11).

The word 'compassion' became explicitly linked to this overall agenda during 2008 when the call for 'compassionate care' became elevated to the status of a 'campaign' alongside that of dignity, which was already featuring strongly. Help the Aged (2008, p.5) went as far as to describe 'the sacrifice of compassionate nursing care in the development of a more technical skills base' as being a key factor influencing their ongoing concern about the dignity of older people in hospitals. In December 2008 Niall Dickson, Chief Executive of The King's Fund warned of 'a deterioration in the level of compassion that is shown by staff to patients', which he linked to escalating pressure in the service related to increased patient acuity and reduction in length of stay, rather than 'staff turning into nasty people' (Dickson, 2008).

The question of whether nurses had lost their way was also raised in reports including the National Nursing Research Unit's position paper *Nurses in Society* (2008) that was commissioned by the English CNO to inform work contributing to the Department of Health's *Next Stage Review* (Darzi, 2008). In the *Nurses and Society* report Maben and Griffith (2008, p.5) again positioned this loss as being related to the challenge of 'navigating the complexity of the increasingly technical environment that is contemporary healthcare'. In the forward to the report, Rafferty (2008, p.4) drew on nurses' professionalism and suggested that it 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 regarding compassion became mirrored by political attention on the issues when in June 2008 Alan Johnston, Secretary of State for Health in the then Labour Government, announced that nurses were to be measured on their compassion. His proposal was to create a ‘compassion index’, which would be compiled by health regulators using surveys of patients’ views while in hospital, including feedback about the attitude of staff (Carvel, 2008). The notion of compassion becoming yet another indicator in the growing series of health service metrics did not go unchallenged (Smith, 2008, Sturgeon, 2008), including the label of the ‘MacDonalised nurse’ (Bradshaw, 2009). It also prompted further public debate on the BBC News and Radio 4 (Dreaper, 2008a & 2008b; Hollins, Hope & Sturton, 2008), placing the term compassion firmly within the political and media arenas. This type of media debate has been repeated at regular intervals as each subsequent report of poor care has emerged.

It would be wrong, however, to assume that this agenda was only of concern or related to nursing, or indeed to the United Kingdom. Compassion emerged within a wider debate on the challenges to the UK health and social care systems when the NHS Confederation (2008, p.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 content of the briefing was based on another campaign, this time led by Robin Youngson a UK-trained anaesthetist working in New Zealand who, as a result of personal experience as a parent, had gone on to found a national ‘Centre for Compassion in Healthcare’ as a charitable trust<sup>17</sup>. Once again the level of concern expressed in this publication was high and emotively expressed with the description of health services ‘leaching compassion from the system’ (NHS Confederation, 2008 p.7).

---

<sup>17</sup> This organisation was re-launched in 2011 as ‘Hearts in Healthcare’ <http://heartsinhealthcare.com/>.

'It's our belief that all health practitioners enter their profession with a genuine desire to provide caring and compassionate service to patients and families. Unfortunately, the evolution of our health professions and institutions has seriously limited the expression of that humanity and compassion. Clinical detachment and objectivity are emphasised over and above compassionate caring. Our hospitals are overcrowded and under stress. Resources are limited. There doesn't seem to be time to care'.

(NHS Confederation, 2008 p.7)

Back in 1994 in the United States a health attorney Kenneth B. Schwartz died of lung cancer at the age of 40. During his illness he realised that what matters most during an illness is the human connection with professional caregivers. He reminded caregivers to stay 'in the moment' with patients and how 'the smallest acts of kindness made the unbearable bearable' (Schwartz, 1995). This led him and his family to found the Kenneth B. Schwartz Centre for Compassionate Healthcare<sup>18</sup>, which is an organisation that aims 'to promote compassionate healthcare so that patients and their professional caregivers relate to one another in a way that provides hope to the patient, support to caregivers and sustenance to the healing process'. The Schwartz Centre has been influential in developing leadership programmes and communication approaches that will be detailed in Section 2.5.4.

### **2.5.1 What is compassionate care?**

What emerged during the debate in 2008 was the lack of precise definition or specific understanding of the meaning of compassion and how it could be measured. The focus on the development of a 'compassion index' generated some work within the Department of Health in an attempt to define and create effective indices, which the media focused on the degree to which nurses smile (Clout, 2008). Early indications were that the metrics for compassion would focus on patient reported experience of care and communication (Mooney, 2009). This accorded with conclusions drawn by Sanghavi (2006) from the Schwartz Centre that although compassionate care itself cannot be quantified meaningfully (it is difficult, he suggested to measure 'small acts of kindness'), the consequences of such care can be measured in the form of

---

<sup>18</sup> <http://www.theschwartzcenter.org/>

prospectively tracking patient satisfaction, health knowledge, and health outcomes in terms understandable to patients<sup>19</sup>.

### **2.5.2 Impact of the Mid Staffordshire Inquiry**

The findings of the inquiry into care provided at the Mid Staffordshire NHS Foundation Trust between 2005-2009 have contributed enormously to the deteriorating public perception of nursing and the health service (Healthcare Commission, 2009; Francis, 2010 & 2013). In the Independent Inquiry into the care provided by the Trust the Chairman Lord Francis, QC made specific reference to the fact that ‘it was startling how many accounts [from patients and relative witnesses] related to basic nursing care as opposed to clinical errors’ (Francis, 2010 p.9). He went on to single out failures in continence, bladder and bowel care leading to injury and loss of dignity, and surmised that ‘the impact of this on them and their families is unimaginable’ (p.11). In terms of overall privacy and dignity, Francis described degrading conditions, patients being inadequately dressed, rudeness or hostility from some members of staff and a failure to refer to patients by their name or preferred name. His commentary on these particular findings was strong:

‘However difficult the circumstances, there is no excuse for staff to treat patients in the manner described by some witnesses to the inquiry. Respect for dignity must be priority of care and must be at the forefront of clinician’s minds’. (Francis 2010, p.13)

In his opening statement to the report he emphasised the fact that it was apparent that during the period under investigation that many staff did express concerns about the standards of care being provided. He stated however, ‘the tragedy is that they were ignored’ (p.3), stating later that the culture was not conducive to providing good care for patients or providing a supportive working environment for staff. Although some members of staff were singled out for praise by patients, concerns were expressed about ‘the lack of compassion and uncaring attitude exhibited by others towards vulnerable patients and the marked indifference they showed to visitors’ (p.15). The second Francis Report was published on February 6<sup>th</sup> 2013 and includes 290

---

<sup>19</sup> There is no evidence that this ‘Compassion Index’ ever came to fruition in the professional or public domain (Ford 2009).

recommendations that cover issues seen to be essential to support the delivery of high-quality of care. These include clear and robust accountability, openness and transparency, effective regulation and fostering a culture of caring. The latter is outlined in Recommendation 185 and includes strong references to compassionate nursing care in terms of recruitment, training, leadership and care delivery (Francis 2013, p.105).

A notable outcome of these concerns and high profile inquiries 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, 2008a; The King's Fund, 2009; Nursing and Midwifery Council, 2010).

### **2.5.3 The policy response**

As already stated concerns about the care of older people had been raised in the 1990s by organisations such as Help the Aged (1999) and had stimulated the Government to develop focused strategies. The first was the publication of the Department of Health's *National Service Framework for Older People* (Department of Health, 2001) followed by the Scottish Executive's strategy *Adding Life to Years: Report of the Expert Group on Healthcare of Older People* in 2002. The Welsh Assembly's *National Service Framework for Older People* was not published until 2006, by which time the initiatives in England and Scotland were taking shape and the 'Older Person Agenda' itself had moved forward. The RCN responded to the concerns about the care of older people with a strategy *Caring in Partnership: Older People and Nursing Staff Working Towards the Future* (Ford & Waddington, 2004) and later with their high profile *Dignity Campaign* (RCN, 2008a & b). The Nursing and Midwifery Council (NMC) produced a guidance document *Guidance for the Care of Older People* (NMC, 2010) designed to be used by employers to measure performance.

Compassion became identified as a 'Core NHS Value' (along with respect and dignity, commitment to quality of care, improving lives, working together for patients, everyone counts) within the Department of Health's *NHS Constitution* (2009). The emergent explanation of compassion within the Constitution

focused on 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, 2009 p.12)

This was one of the first detailed definitions of compassion to appear within a high level document.

The Scottish Government (2007) demonstrated a commitment to improving the patient experience in its health strategy *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’ (p.42). The *Better Together - Patient Experience Programme* was established to encourage and empower patients, carers and healthcare 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 has become a central driver to NHS Scotland policy and was articulated in its *Healthcare Quality Strategy* (Scottish Government, 2010b). A central tenant of this strategy was the recognition that patients want ‘caring and compassionate staff and services’ and a commitment that the NHS would increase the value placed on the quality of the experiences of the people who use healthcare services.

#### **2.5.4 The practice response**

A number of projects and research studies emerged across the UK with the aim of developing practice-based responses to enhance care delivery. The Leadership in Compassionate Care Programme has sat alongside many of these initiatives, and as will be discussed in Section 4.12 there was intra-professional dialogue between many of the programme leaders and researchers during this period in order to attempt to bring the agenda forward together. The initiatives include:

- the body of work originally built around research into the care of older people in nursing homes that led to the development of the *Senses*

*Framework* (Nolan et al., 2004 & 2006) and the promotion of relationship-centred care<sup>20</sup>. The application of the Senses Framework has now extended to dementia care (Ryan et al., 2008), inpatient services (Patterson et al., 2010a) and support for students (Andrew et al., 2011).

- Research leading to the development of a *Person-Centred Nursing Framework* (McCormack & McCance, 2006 & 2010) in Northern Ireland resulting in 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; McCance, McCormack & Dewing, 2011; McCance et al., 2012).
- *Confidence in Caring*, which was a national project conducted in four acute hospital settings in England (Department of Health, 2008) 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 findings placed emphasis on nurses being seen as the 'owners' of the caring system by patients and relatives, and that nurses must 'care for' and 'care about' in equal measure. Recommendations from this report were articulated at organisational level (the MEANS), team (the WAYS) and individual (the SKILLS and WILLS).
- the UK-wide 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 & Wainright, 2008; RCN, 2010a).
- the Department of Health's *Dignity in Care Campaign* launched in 2008 including the appointment of Sir Michael Parkinson as *National Dignity Ambassador* (Parkinson, 2010). It led to over 23,000 people in England and Wales joining the campaign as Dignity Champions with access to a wide range of resources to support local initiatives (Dignity in Care Network, 2010).

---

<sup>20</sup> The *Senses Framework* (Nolan et al 2006) argues that an *enriched* environment of care is one in which all stakeholders experience six Senses: belonging, continuity, purpose, achievement and significance.

- the *Dignity in Care Project*, which was a 2 year joint venture between City University, Royal Free Hampstead NHS Trust and Barnet and Chase Farm Hospitals NHS Trust London that involved a programme of research to promote and sustain dignity of care in acute settings (Nicholson et al., 2010a, 2010b, 2010c). It 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*<sup>21</sup> led by The King's Fund (Goodrich & Cornwell, 2008; Firth-Cozens & Cornwell, 2009) that 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', experienced-based co-design and Schwartz Center Rounds<sup>®</sup>, which are monthly, one-hour session for staff from all disciplines to discuss difficult emotional and social issues arising from patient care.
- *From Metrics to Meaning: Culture Change and Quality of Acute Hospital Care for Older People* (Patterson et al., 2010a) which was a longitudinal study of four acute Trusts in England undertaken for the National Institute for Health Research Service Delivery and Organisation programme. The aim was to examine different cultural contexts of care and develop measures of nursing team environments important for the delivery of good quality care and associated patient, carer and staff ratings of care quality.

### **2.5.5 Local responses – values-based practice initiatives in NHS Lothian**

Prominence on the issues relating to the quality of nursing care in NHS Lothian followed the publication of a report by the External Reference Group for Older People's Service (NHS Lothian, 2006), which was commissioned in response to specific episodes where care in two hospitals was seen to have been deficient. Similar to other investigations, at the heart of reported dissatisfaction was a lack of respect offered by services and the impact that this had on the personal dignity of older people. The recommendations were, in part, the stimulus for a corporate initiative known as 'The Lothian Way' (Emslie & Chen, 2007), and the instigation of a range of values-based initiatives seeking to

---

<sup>21</sup> [http://www.kingsfund.org.uk/current\\_projects/the\\_point\\_of\\_care/index.html](http://www.kingsfund.org.uk/current_projects/the_point_of_care/index.html)

refocus attention on the delivery of care and the patient's experience of that care (Wilkinson & MacArthur, 2009). In addition to the LCC Programme these included:

- *Leading into the Future* - a person-centred leadership programme for staff working in older people's services based around the Senses Framework (Nolan et al., 2006).
- *Connect in Care* – direct involvement in a Scotland-wide network supporting learning and practice development in the care of older people in hospital and care home settings (Connect in Care, 2009).
- Implementation of the *10 Essential Shared Capabilities for Mental Health Practice* capabilities developed to support cultural change and the delivery of values-based care (NHS Education for Scotland, 2007).
- *Leading Better Care* – a national initiative focusing on the role of the Senior Charge Nurse with an explicit commitment to an improvement in the delivery of direct, person-centred care (Scottish Government, 2008a).
- *Releasing Time to Care*<sup>TM</sup> – local implementation of the 'Productive Ward' methodology that focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care (NHS Institute of Innovation and Improvement (n.d.)<sup>22</sup>).

## **2.6 The period late 2009 – 2011**

Given this focus on nursing care, whether it is articulated as the promotion/protection of dignity or compassionate care, there has been a hope and expectation both from within and outside the profession that the situation should have changed and improved. However, the following section analyses another set of high profile reports (mainly from the Patients Association) and responses that suggest that, in some quarters, this has not been the case, and if anything the picture of acute care of older people and the public reputation of nursing may have deteriorated further.

Evaluations linked to the specific practice initiatives outlined in Section 2.5.5 have demonstrated some real improvements in patient experience. For

---

<sup>22</sup> [http://www.institute.nhs.uk/quality\\_and\\_value/productivity\\_series/productive\\_ward.html](http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html)



example the Patient-centred Care Project (The King's Fund, 2011) undertaken with patients receiving treatment for breast and lung cancer at Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust led to the establishment of a new patient group, greater and more open team working and better communication and improvements in patients' experience through attention to the simplest things. However, although improvements did occur, these were not universal within the organisation and it was noted in the report that it was difficult to engage with senior managers and so broader strategic issues were not addressed. Baillie and Gallagher (2011) undertook a mixed methods evaluation of the RCN campaign *Dignity: at the heart of everything we do* in seven healthcare organisations across the UK<sup>23</sup>. They found that the campaign was largely supported and that the key enablers were staffs' receptivity and creativity, organisational support and leadership and the quality of the campaign materials themselves. The challenges that were identified included other demands on time and the prevalence of poor staff attitudes and behaviours in some settings.

In August 2009 the Patients Association published a damning report '*Patients ... not numbers, People ... not statistics*' detailing poor nursing care of sixteen elderly patients in hospital. They did so in response to high volumes of calls to their Helpline, from people they reported wanting to talk about the 'dreadful, neglectful, demeaning, painful and sometimes downright cruel treatment their elderly relatives had experienced at the hands of NHS nurses' (Patients Association, 2009 p.3). There were suggestions that a small proportion of nurse were simply 'bad and cruel' (Patients Association, 2009 p.4). The media response was similar to those that had occurred previously; for example *The Telegraph's* headline "'Cruel and neglectful" care of one million NHS patients exposed' (Smith, 2009). However, this time organisations such as the RCN attempted to 'stand up' for nursing. Dr Peter Carter, General Secretary acknowledged that the level of care described by these families was completely unacceptable, and that the RCN would not condone individuals who behave in ways that were contrary to the principles and ethics of the profession (Evans, 2009). He stressed, however, that the RCN 'believe[s] that

---

<sup>23</sup> The DVD from this campaign was one of the resource materials that the LCC Programme used to facilitate discussion.

the vast majority of nurses are decent, highly skilled individuals'. Furthermore, he suggested that this was reflected in the fact that the last survey of patients by the Care Quality Commission found that over 90 per cent rated the care they received as good, very good or excellent. Dr Carter said the Patients Association report was based on the two per cent of patients who felt their care was unacceptable (Evans, 2009).

Nonetheless other members of the profession argued against this position, including Professor Philip Darbyshire, a research and practice development leader from Australia. His response to Dr Carter's position was emphatic:

'The Patients Association Report may well be the most important report for Nursing in a generation - IF we choose to engage with it and tackle the fundamental and elemental issues that it raises, for nobody really believes that this is about 'only' 16 people. This is about the heart and soul of nursing. This RCN and NMC responses are masterpiece examples of 'circling the wagons'. The problem with circling the wagons of course is that all you ever do is go around in circles'.

Darbyshire (2009)

In 2010 the Patients Association published another report highlighting more examples of poor care reported to their helpline. '*Listen to patients, Speak up for change*' was a collection of 17 firsthand accounts of hospital care of older patients from across the NHS (Patients Association, 2010). This time they called for:

'independent clinical 'patient safeguarding champions' that would be able to identify those wards where a long term cultural change is required, and continue to scrutinise those wards until they deliver the levels of care and dignity that the elderly people being treated there deserve. We continue to call for their introduction, and believe that they would be a crucial step forward in tackling poor care'. (p.4)

As a response to this report, the Secretary of State for Health asked the Care Quality Commission (CQC) in England to look at standards of dignity and nutrition in NHS hospitals.

What was emerging during this period, however, was some recognition that organisational culture and work environment within hospitals had some role to play in the prevailing situation. During 2010 the NHS Confederation in

England published a report aimed at Board Leaders '*Feeling Better? Improving patient experience in hospital*' (NHS Confederation, 2010), which aimed to pull together evidence on what is known about methods to improve patient experience and to share approaches from the UK and USA. The Confederation, working under the direction of the Coalition Government, emphasised their commitment to make 'all experiences excellent' (p.3) and acknowledged that in the past there were 'unspoken but widely held beliefs [at Board level] that providing good patient experience was "nice but not necessary" or "nice but too expensive"' (p.3). Furthermore, they cited a study by the Commonwealth Fund that had appraised the health services in seven countries and rated the UK as 7<sup>th</sup> for patient-centred care (Davis, Schoen & Stremikis, 2010)<sup>24</sup>. The NHS Confederation report made strong recommendations for establishing a culture focussed on a high quality patient experience, citing evidence from the USA linking this to better health outcomes, lower overhead costs and shorter lengths of stay. The body of evidence linking hospital environments and quality of care were further supported by Aiken et al. (2012) who undertook an extensive cross-sectional survey study to identify deficits in hospital care quality in 12 European countries and the USA, looking at both nursing and patient outcome measures. Their overall findings were that nurses and patients both agreed on which hospitals provided good care, and that improving hospital work environments led to an increase in care quality and patient satisfaction.

In a study into organisational culture in four NHS acute Trusts in England, Patterson et al. (2010) recognised the pressures within acute hospitals and discussed the tension between 'pace' and 'complexity' (Williams et al., 2009), which they suggested made 'often conflicting and paradoxical demands' on those delivering care (Patterson et al., 2010 p.48). Firth-Cozen and Cornwell (2009) similarly argued that the emphasis on targets (i.e. pace) as opposed to the totality of patient experience (i.e. complexity) has the potential to exert a profoundly negative effect on the culture of care and staff morale.

---

<sup>24</sup> The other countries were Australia, Canada, Germany, The Netherlands, New Zealand and USA. The report examines a range of parameters including quality, access, efficiency, equity, health outcomes and health expenditure. Overall the UK ranked 2<sup>nd</sup>. Full report and summary available <http://www.commonwealthfund.org/Publications/Fund-Reports/2010/Jun/Mirror-Mirror-Update.aspx?page=all>

The examples of poor care in the UK did, however, continue. In Scotland, the Mental Welfare Commission's report into the care of Mrs V, an 80-year-old woman with dementia who died in hospital in December 2008 caused widespread concern and publicity (Mental Welfare Commission, 2011). Mrs V suffered from dysphagia and, following transfer from a mental health hospital to allow her to have intravenous fluid treatment, was for a considerable period of time nil by mouth and given a large amount of sedative medicine in response to her distress and agitation whilst being cared for in a medical ward. The investigation by the Mental Welfare Commission concluded that there were deficits in staff knowledge, behaviour and attitudes, poor decision-making and a lack of responsibility for the administration of medication. In particular, the investigation pointed to a lack of shared understanding, across medical and mental health services for older people, about the best way to manage people with dementia who became physically unwell while in mental healthcare (Mental Welfare Commission, 2011 p.7)

The Parliamentary and Health Service Ombudsman published '*Care and Compassion?*' in February 2011, which was a report on ten investigations into NHS care of older people. In her introduction Ann Abraham, Health Service Ombudsman went as far as stating:

The investigations reveal an attitude – both personal and institutional – which fails to recognise the humanity and individuality of the people concerned and to respond to them with sensitivity, compassion and professionalism.

Parliamentary Health Service Ombudsman (2011 p.7)

*The Guardian* described these findings as representing the 'harrowing plight' of the elderly in the NHS (Campbell, 2011). The report itself highlighted practice including doctors having to prescribe water for patients to ensure that they were provided with fluids, a situation which gained notoriety in the press (Laurance, 2011). Christina Patterson, a commentator in *The Independent* followed up the Ombudsman's report with a picture of two contrasting experiences of her own recent hospital care under the headline 'Nasty Nurses? Tell me something new' (Patterson, 2011). This (like many other of the online news stories) prompted a great deal of on-line debate between former and current nurses, as to whether the move to degree education was

part of the cause of these examples of poor nursing care. Such views echo the so-called 'too posh to wash' labels against the move to degree level education that had been prevalent during the early 2000s (Salvage 2007), which remain largely anecdotal rather than formally substantiated. As will be discussed in Section 2.6 the recent report on nurse education by the Willis Commission (RCN 2012) has similarly refuted this notion.

Jocelyn Cornwell, Director of the *Point of Care* Programme responded to the Health Ombudsman (2011) report by emphasising that blaming staff was not the answer. Rather, she stated:

'they [nurses] need active, sustained supervision and support. In the high-volume, high-pressure, complex environment of modern healthcare it is very difficult to remain sensitive and caring towards every single patient all of the time. We ask ourselves how it is possible that anyone, let alone a nurse, could ignore a dying man's request for water? What we should also ask is whether it is humanly possible for anyone to look after very sick, very frail, possibly incontinent, possibly confused patients without excellent induction, training, supervision and support?'

Cornwell (2011, n.d.)

In response to the Secretary of State's request, the CQC planned and delivered a series of 100 unannounced inspections of acute NHS hospitals in England between March and June 2011, looking at standards of dignity and nutrition on wards caring for elderly people. The findings were made public in October 2011 and indicated that, of the 100 hospitals inspected 45 fully met the standards with 20 not meeting one or both. Some of the issues identified included patient's privacy not being respected, call bells being placed out of reach, staff tone and attitude when speaking to patients and poor attention to nutrition. These findings stimulated further media outcry, with for example the *Daily Mail* suggesting that, 'while most are still 'angels' asked why was Britain 'now producing nurses without a scintilla of compassion?' (Wilson, 2011). *The Guardian* placed emphasis on the fact that the report highlighted how some patients were denied pain relief by nurses and were sometimes left without food and water (Mitchell, 2011). Members of the profession also responded with pieces such as 'Shame on us Nurses' (Peate, 2011) and Sir Stephen Moss, former Chairman (and previously Nurse Director) at Stafford Hospital stating that there is something 'fundamentally wrong' with the nursing

profession (Express & Star, 2011). An editorial in the *British Medical Journal* appeared immediately stating 'We need to talk about nursing' (Delamonthé, 2011) and an opinion piece in *The Independent* (2011 p.16) went as far as stating:

'Evidence of the routinely appalling treatment of older people in Britain's hospitals should stand as a warning to us all. The latest Care Quality Commission research paints a picture of shameful inhumanity: elderly patients not helped to eat and drink, being left lying in soiled clothing, reduced to rattling their bed bars to attract attention as their calls for help go unheeded'.

What was not widely reported, however, were Dame Jo Crawford, Chair of the CQC's observations in the report's overview:

I was heartened by the amount of good and excellent care we saw. Many of the hospitals we visited showed a genuine commitment to delivering person-centred care, with registered nurses, doctors, other care professionals and health care staff pulling together to treat the people they cared for with compassion and respect.

Care Quality Commission (2011 p.3)

### **2.6.1 Responses**

The responses across the UK have continued from both professional, government and public organisations. Following the publication of the NHS Scotland *Healthcare Quality Strategy* (Scottish Government, 2010a) the Chief Nursing Officer (CNO) and Chief Health Professions Officer articulated a 'Joint Declaration' emphasising Nursing, Midwifery and Allied Health Professionals (NMAHPs) professional leadership objectives and actions focussing on the Quality Ambitions of the Strategy and workforce issues (NHS Scotland, 2010). Their intention was that its implementation 'will be achieved through revitalised professionalism alongside the NMAHP ethos of value based, person centred, and relationship based approaches to care delivery'. Four NMAHP Quality Councils were established to take forward this work. These were: Effective, Person-centred, Safety and Support, which would work closely with a Quality Alliance Board<sup>25</sup>. Work in the Person-Centred Council centred on scoping the literature for a 'Care Governance Measurement Framework' (Strachan, 2011), which examined the evidence on the impact of person-centred care and the

---

<sup>25</sup> For further information see <http://www.knowledge.scot.nhs.uk/qualitycouncils.aspx>

drivers and influences associated with its delivery. In addition, four action groups were established to focus on:

- Enabling person-centred care
- Clear communication, effective collaboration
- Improving experience and outcomes
- Supporting staff to have the best possible experience

(Urquhart 2011)

In June 2011, Nicola Sturgeon, the then Cabinet Secretary for Health in Scotland announced that the CNO, reporting to her, would oversee the implementation of a new set of dementia standards in hospital settings and lead a programme of work to give assurance that care for older people in these settings, whether or not they have dementia, meets the highest standards of care and compassion (Scottish Government, 2011b). In addition Health Improvement Scotland would carry out a programme of inspections to ensure that hospitals are living up to the Care for Older People in Acute Settings standards first published in 2002 (Clinical Standards Board for Scotland, 2002)<sup>26</sup>.

In England, the Patients Association and Nursing Standard magazine joined forces to hold an 'emergency meeting on the causes of poor nursing care and its solution' on October 21<sup>st</sup> 2011 in London (Nursing Standard, 2011). It was attended by many of the UK's top nurses, policy experts, patient champions as well as doctors and managers. Once again there was an immediate focus on compassion, with Dr Phillip Hammond, GP and media personality arguing:

We need to get our politicians talking about compassion in care and not be embarrassed about talking about humanity. Medicine and nursing and all healthcare, and social care, is founded on humanity, it's almost like a helegal thread that weaves through everything, and we need to remind people of that, it's really important.

(Nursing Standard, 2011 p.1)

Sir Stephen Moss emphasised the point that the debate should not be distracted by discussions surround the move to an all-graduate profession, as 'that was missing the point; it is not about that at all' (Nursing Standard, 2011

---

<sup>26</sup> The unannounced inspections commenced in Scotland in December 2011 and have continued on a regular basis, including in the study site.

p.2). The meeting identified ten priorities for action that took a broader perspective than simply 'blaming' nurses and recognised the pressures that they were under<sup>27</sup>. The priorities included:

- Ensuring that all healthcare organisations make patient care the core focus. This was linked to introduction of measures such as intentional rounding (Fitzsimons, Bartley & Cornwell, 2011) and the routine collection of patient stories and patient shadowing.
- Recognising inadequate staffing levels as an indicator for poor care.
- Enhance support for ward managers and community leaders, particularly in relation to challenging poor performance.
- Reducing bureaucracy and the burden of paperwork in order that nurse leaders can be undertake greater support and supervision.
- Foster an understanding that good nursing care makes economic sense.
- Build resilience in nurses to prevent them burning out, partly through acknowledging the challenge of the work but also bringing in mechanisms to alleviate that challenge.
- Change the term 'whistle blowing' to 'speaking up' or 'raising concerns'.
- Improving training and encourage better correlation of theory and practice.
- Setting explicit standards and expectations for nurse's behaviour and care provision.
- Promote and enhance support for nurse leadership centrally and locally to create good role models.

## **2.7 The period 2012 - present**

Whilst there continues to be recognition and concern about the quality of patient care in some hospitals in the UK, there has also been a clear shift to examination of factors that may impact on this situation. The argument relating to the perceived shortcomings in nursing education and its potential responsibility for poor practice or the perceived decline in standards of care were that received strong media attention in 2011 were investigated by Lord

---

<sup>27</sup> Lord Francis echoed many of these priorities in his 290 recommendations following the Mid Staffordshire Inquiry (Francis 2013).



Willis of Knaresborough in the 2012 *Quality with Compassion* Report (RCN, 2012). Lord Willis stated that the Commission had not found any shortcomings in nursing education 'Nor did it find any evidence that degree-level registration was damaging to patient care' (p.6). Part of the Willis Commission's conclusions and recommendations were that they did not understate or deny unacceptable care, but an understanding of the *context* [my emphasis] of care was vital if it is to be more effectively tackled. The report particularly emphasised the evidence on well-qualified nurses with improved patient, nurse and financial outcomes; a direct correlation between poorer care and a lower proportion of registered nurses in the skill mix; and the economic value of well qualified and effectively deployed nurses (RCN, 2012 p.43). The report called for more research into the outcomes of nursing education and its contribution to the quality of patient care.

There is now a distinct policy directive in all four UK countries to address the issues of care quality and the word compassion is now the term of choice in this sphere. The Commissioning Board for the Chief Nursing Officer in England *Compassion in Practice: Nursing, Midwifery and Care Staff: Our Vision and Strategy* (Department of Health, 2012) set out a vision that centres around the '6Cs': 'care, compassion, competence, communication, courage and commitment' (Department of Health, 2012 p.11). Within the 6Cs the definition of compassion is:

Compassion is how care is given through relationships based on empathy, respect, dignity – it can be described as intelligent kindness, and is central to how people perceive their care.

(Department of Health, 2012 p.13).

In response to the Patient Association and other reports the RCN launched a publicity campaign called 'This is Nursing'<sup>28</sup> in September 2012 in an attempt to create a positive image of nurses, focussing on the reality of the role.

A further response to the call for focus on compassionate care is the new NHS Leadership Academy in England, which has launched an initiative that will see

---

<sup>28</sup> <http://thisisnursing.rcn.org.uk/>

5,000 nurses participate in 'it largest ever development programme: leading with compassion' by 2015 (NHS Leadership Academy, 2013).

In Scotland the National Nursing, Midwifery and Allied Health (NMAHP) Research Unit has recently initiated a large-scale study known as the 'Scottish Person Centred Interventions Collaboration' (ScoPIC). This study will bring together two initiatives – Releasing Time to Care™ and the Caring Behaviours Assurance System™ (CBAS) focusing on improving broad culture on wards including caring behaviours. The study will involve 30 wards, 6,000 patients and 1,000 nurses (NMAHP Research Unit, 2013).

## **2.8 Conclusion**

This chapter commenced with the question 'why worry about compassion?'. The answer would appear to be that in some quarters at least there has been sufficient evidence to support the public and professional perception that compassion in nursing could no longer be assumed to be assured. Much of the evidence has related to the care of older people in acute hospital settings, but it is not limited to this location or age group. What has been evident over the last five years is that the term compassion has been increasingly linked to the overall agenda relating to the quality of patient care. Although there have been a number of initiatives and research studies that focus on these questions few have explicitly addressed the question of the meaning and expression of compassionate care in the current NHS context, nor organisational capacity to embed it in routine practice.

The scale of concern, evidenced by organisations such as the Patient Association and unequivocally presented in the two Francis Inquiry Reports (2010 & 2013) make sober reading for healthcare professionals, managers and policy makers in the UK and beyond. The issues are firmly in the public domain. What is less clear are the solutions that will embed and sustain a culture of compassionate care within the prevailing complexity of healthcare delivery.

Before moving ahead to my own study proposal Chapter Three will foreground the discussion with a critical examination of the concept of compassion and compassionate care as it stood up to the point of formalising the research questions in 2008-2009.

## Chapter Three: Literature Review

'Clearly we should expect nurses to have empathy for their patients, but can we expect compassion?'

Dietze and Orb (2000 p.169)

### 3.1 Analysing Compassion

This literature review involves a detailed analysis of the concept of 'compassion' from a wide range of perspectives. It synthesises a series of ideas from the literature that have informed a critical analysis of the rationale for, implementation and outcomes of the LCC Programme. At the same time as the LCC Programme was being conceived Schantz (2007) published a concept analysis of compassion and argued that the meaning of 'compassionate care' was neither clearly defined in nursing scholarship nor widely promoted in contemporaneous everyday nursing practice. This indicated that the LCC Programme was, therefore, particularly timely and had the potential to make an important contribution to both nursing theory and practice.

Systematic exploration of the literature in the early stages of my study up to 2009 identified a focus on compassion not only in the UK but also in the USA, Canada, Australia, New Zealand and Scandinavia<sup>29</sup>. This supported the currency of concern about the 'state' of care delivery across a range of professions and health systems outlined in the previous chapter. Over and above consideration within the health domain, review of the literature revealed compassion to be an important construct within religion, ethics, philosophy, social justice, social psychology, disaster management, aid programmes, social welfare and organisational development. The aims of the literature review at this stage were to understand how 'compassion' and 'compassionate care' were articulated in the literature and whether there was any existing systematic research that had examined the delivery of compassionate care within healthcare settings.

---

<sup>29</sup> My search strategy is outlined in Appendix 1.

Two landmark papers within the nursing literature had emerged that presented a conceptual analysis of the term 'compassionate care' (Dietze & Orb, 2000; Schantz 2007). Their discussions centred on the question of 'how important is compassion to nursing?', with Schantz (2007, p.48) describing compassion as being nursing's 'most effective strength' and its 'most precious asset'. Both Dietze and Orb (2000) and Schantz (2007) positioned 'compassion' against the related concepts of 'empathy' and 'sympathy', and elevated its status as embodying the 'moral dimension' of nursing. Scrutiny of these three concepts allowed me to critically reflect on the choice of 'compassion' for this particular Programme, and whether indeed the concept of compassion as articulated by these and other authors continued to hold currency in contemporary healthcare contexts. Even in 2000 Dietze & Orb (2000 p.173) cautioned that such contexts increasingly viewed nursing care as a *product*, which they suggested may impact on the ability to be truly compassionate.

Within the nursing literature compassion is frequently aligned to the concept of care itself (Dietze & Orb, 2000; Schantz, 2007). In contrast to the somewhat limited literature on compassion at that time, there is an extensive body of philosophical debate, empirical studies and theoretical analysis on the concept of care, which offers a body of empirical work contributing to development of caring frameworks, assessment tools and inventories (for example Watson, 1995 & 2005; McCance, 2003; Cossette et al., 2008). Finfgeld-Connett (2008) undertook a meta-synthesis of the concept of caring involving 49 qualitative reports and 6 concept analyses on caring and placed strong emphasis on context and there being outcomes for both patient and nurse when she concluded:

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. Consequences include enhanced mental well-being among nurses and patients, and improvements in patients' physical well-being.

Finfgeld-Connett (2008 p.202)

### **3.2 Scope of the literature review**

Examination of the literature pointed to the fact that before focusing specifically on compassion in nursing and healthcare, there were fundamental principles and questions to consider. Foremost was (and remains) the debate as to whether compassion is an innate characteristic or something to be learned (Johnson, 2008). The notion of compassion being an inherent trait links to questions of motivation for compassion that can be linked to altruism and/or reciprocity. Conversely the question of needing to learn to be compassionate resonated strongly with some of the debate outlined in Chapter Two<sup>30</sup>.

Compassion is widely positioned as a moral entity and is recognised as one of the key virtues within the domains of ethics and philosophy. This has led to it being interpreted as a 'global character trait' (Miller, 2009). In the context of some of the high profile enquiries identified in Chapter Two (such as the House of Lords and House of Commons Joint Committee on Human Rights, 2007) that identified failure to deliver compassionate care in some settings, the notion of entitlement to compassion has been identified as being a human right. Other important elements that emerged in the literature are the concepts of compassion fatigue and compassion satisfaction both of which were found to be relevant within healthcare but also beyond in the world of disaster management.

It became quickly apparent that much of the literature was in the form of philosophical enquiry and debate rather than on empirical studies since few were found to exist. There was rarely a focus on the context of care under discussion and how this may influence expression and receipt of compassionate care. This points, therefore, to gaps in the evidence based on how to influence compassionate care within the context of contemporary healthcare and points to the significance of my own study as well as the findings of the LCC Programme's own action research study.

Having critically reviewed a range of theoretical and empirical perspectives, I was able to develop a preliminary conceptual framework situating compassion within the context of care delivery in the NHS. The literature review also

---

<sup>30</sup> Training and experience in the delivery of compassionate care were part of Recommendation 185 in the Francis Inquiry (Francis 2013, p.105).

shaped my research questions alongside parallel considerations of research methods.

### **3.3 Compassion: emotion and/or virtue?**

Compassion is generally characterised as a feeling or emotion, however, as Crisp (2008) indicates compassion is also positioned within philosophical, religious and ethical thinking as one of the great virtues (that is an expression of moral excellence) alongside others such as courage, generosity and truthfulness. Williams (2008, p.17) quoting Aristotle (republished 1976) points out that virtues are dispositions and those dispositions require cultivation. Furthermore he suggests that the disposition towards compassion is a capacity or potentiality that each of us has 'by virtue of being human'.

McHolm (2006) proposes that compassion contributes to establishing trust and therapeutic relationships with patients, on the basis that it is an emotion 'whereby we enter into the world of the client, become aware of his suffering, and upon feeling his pain, take action to ease it' (p.13). In understanding compassion as an emotion, Oakley (1992, cited in Sabo, 2006 p.137) refers to its affective dimension reflected within feeling, including a psychic dimension. She suggests that this can be understood in terms of 'the mental tone which affects us and which characteristically permeates our perceptions, our desires and actions in ways that we are not always aware of'. This issue of whether or not compassion is a subliminal emotion perhaps stands in some contrast to the other definitions that focus on deliberate intention.

### **3.4 Definitions of compassion**

Definitions of compassion generally have cognitive, emotional, affective and motivational components. The Oxford English Dictionary offers three dimensions:

- i. Suffering together with another, participation in suffering; fellow feeling, sympathy.
- ii. The feeling or emotion when a person is moved by the suffering or distress of another, and by the desire to relieve it; pity that inclines one to spare or to succour.
- iii. Sorrowful emotion, sorrow, grief.

Oxford English Dictionary (2008)

Aristotle defined compassion – *eleos* - as:

Let compassion be a sort of distress at an apparent evil, destructive or distressing, which happens to someone who doesn't deserve it, and which one might expect to happen to oneself or someone close to one, and this when it appears near.

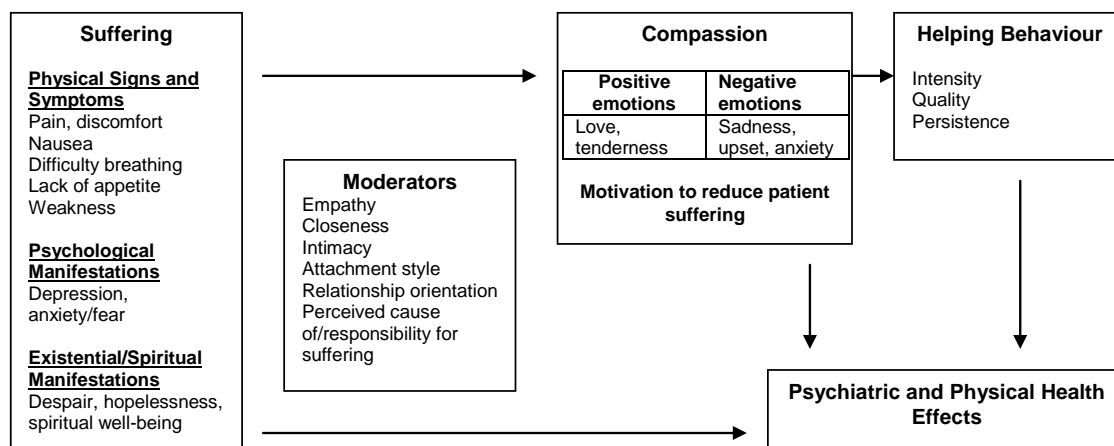
(Aristotle, 1959, 2.8, 1385b 13-16. Cited in Crisp, 2008 p.234)

The New Zealand Centre for Compassion in Healthcare (2008) defined compassion simply as 'the humane quality of understanding suffering in others and wanting to do something about it'. One of the defining characteristics of compassion is, therefore, that it is an *active* emotion or indeed, an intentional state. It demands a *response* [my italics], rather than simply an awareness of the plight of another or as Cash (2007, p.71) asserts 'the truly compassionate have a desire to change the situation'. Williams (2008, p.7), speaking from a social justice perspective, characterises compassion as a 'vital conative force' in that it directs and impels action which may be directed either to preventing further suffering or remedying existing suffering wherever possible.

### **3.5 Models of compassion**

What compassion looks like in practice is open to interpretation and to a large degree remains a subjective understanding. Schulz et al. (2007) developed the only model sourced within the literature review prior to the implementation of the LCC Programme (presented in Figure 3 overleaf) in which the significance of the caregiver response (the helping behaviours) is seen to be a function of intensity, quality and persistence. The model also demonstrates the links between perception of suffering and compassionate response being mediated by a series of moderators that will be explored in more detail within this literature review. What is also of significance in the model is the recognition that all of these elements have the potential to impact on the health of the caregiver.

**Figure 3: Schulz et al.'s Model of Compassionate Care (2007, p.9)**



There is a strong focus in the literature on relationships being at the core of compassion. Schulz et al. (2007, p.7) proposed that the experience of compassion occurs under the following circumstances:

- a) there are affectionate ties between two individuals,
- b) there is an awareness of suffering,
- c) this awareness generates distress and negative effect in the observer, and
- d) the observer is motivated to reduce or eliminate the observed suffering.

The centrality of relationships to the delivery of compassionate care will be examined in detail in subsequent sections, however, at this stage the recognition within the model of the impact of moderating and motivating factors within such relationships should be considered to be important.

The notion of measurement of the degree of helping behaviour on the basis of intensity, quality and persistence could perhaps be extended to consider a continuum of compassion. Whilst it was possible to source numerous case study examples in the literature of compassionate responses that represented high intensity and quality (particularly in relation to end of life care), there were others that suggest a more limited response. For example, in its weakest form, in the context of a randomised trial of 'compassionate care' for the homeless in an emergency department in Canada, compassion was presented as an intervention variable that was defined simply as giving 'some attention' and 'attentive listening' (Redelmeier, Molin & Tibshirani, 1995).



A more detailed exemplar of what compassion looks like in practice was provided by The Kenneth B. Schwartz Centre, which pronounced to patients 'You have a right to compassionate healthcare' (Kenneth B. Schwartz Centre, 2007 n.p.). On its website it claimed that 'compassionate caregivers are sensitive and empathic, demonstrating the following qualities:

- Respect for you and your family
- Ability to understand your needs
- Strong communication, listening and interpersonal skills
- Ability to impart strength and hope
- Availability to you, especially in time of crisis
- Ability to think and act creatively'.

It could be argued that such qualities could form the basis of a range of competencies or indicators.

### **3.6 Compassion and suffering**

Most definitions of compassion use the term 'suffering' to represent the physical or emotional state of the beneficiary of the act. Nussbaum (2003) suggested that in order for compassion to be present, a person must consider the suffering of another as an important part of his or her own scheme of goals and ends. She argued that it is important that the individual recognises the other person's ills as affecting their own 'flourishing'. In effect, Nussbaum argued that recognition of one's own vulnerability is an 'indispensable epistemological requirement for compassion' (2003, p319). The alternative responses to suffering where this is not present might be distance or indifference. Torjul, Elstadd and Sørli (2007) examined suffering in the context of ethically difficult situations and proposed that combating and alleviating suffering 'is the ultimate purpose for healthcare personnel' and that 'it awakens an immediate response in the nurse to alleviate it, ameliorate it and prevent it when possible' (p.529). Furthermore they argued that perception of a situation in a compassionate way was predicated on the fact of being close to and 'morally moved' by the suffering of patients, something that they argued is beyond a strictly medical perspective.

In their discussion about patient suffering and (family) caregiver compassion, Schulz et al. (2007) presented a detailed analysis of the concept of suffering in the context of illness and disability. Their proposition carries important resonance, particularly as their specific interest was the impact of the

manifestation of suffering *on others* (rather the impact on the individual themselves) and the way it impacts on the perceiver (which in this analysis would be a healthcare professional rather than a family carer). They argued that suffering is distinct from illness and disability, given that not all illnesses necessarily entail suffering and because there is considerable variability in how people respond to illness and disability, and hence degree of suffering will vary. In addition they argued, even if two patients have identical symptoms their suffering is likely to be different; what causes suffering to one person may not do so in another. It follows, therefore, that if assessment of suffering is such a fundamental component to the compassionate response then caregivers need to be equipped with capabilities and tools to effectively consider each individual patient.

Schantz (2007 p.52) emphasised that for compassion to be realised suffering must be identified and acknowledged, something that she labels as the 'antecedent' to compassion. She went on to reflect on Dietze and Orb's (2000, p.172) suggestion that the ability to remain alive to this antecedent is a particular challenge for the profession. This they argued is because nurses need 'to resist indifference or insensitive familiarity with suffering', which they suggest 'is a task full of personal, professional and systemic obstacles'.

Compassion is strongly represented in religious thinking and again the notion of suffering is given prominence, particularly in Christian spheres. Nouwen, McNeil and Morrison (1982 p.4) captured this engagement with suffering to a high level:

'Compassion asks us to go where it hurts, to enter into places of pain, to share in brokenness, fear, confusion and anguish. Compassion challenges us to cry out with those in misery, to mourn with those who are lonely, to weep with those in tears.'

The first dimension of the earlier Oxford English Dictionary definition of compassion which emphasises 'suffering with' is borne out within a range of theoretical paradigms. Williams (2008) suggested that it is the act of experiencing the suffering of others in this way that prompts a compulsion to act towards alleviation. He argued that because it involves 'relatedness' to that suffering and those of others that it has a consequence of suffering within oneself.

Dietze and Orb (2000, pp.168-169) similarly emphasised deliberate participation in another person's suffering, not merely identification of that suffering, 'but identification *with* it' [their italics]. They suggested that to fulfil this expectation of compassion may evoke resistance and even protest on the part of caregivers and comment bluntly 'compassion is not easy'. A clear question for contemporary nursing practice is whether it is possible or even desirable for nurses to engage with their patient's suffering to the degree called for by Nouwen, McNeil and Morrison (1982). The potential consequences of such engagement are an important consideration and, indeed, can be examined in relation to its potential to cause suffering to the caregiver. As will be raised in the subsequent comparison of the concepts of sympathy and empathy with compassion in Section 3.11, if this dimension of compassion is taken to its literal meaning, then the demands and expectations on nurses are considerable.

### **3.7 Compassion and pain for the compassionate**

In his philosophical analysis of the idea of 'compassionate strangers' within the conflict zone of Lebanon, Cash (2007) draws on the words of Aristotle who drew a strong association between pain and compassion:

'Let compassion then be a kind of pain excited by the sight of evil, deadly or painful, which befalls one who does not deserve it'

(Aristotle 1926, line 1358b cited in Cash, 2007 p.71)

The idea that experiencing or expressing compassion for patients can exert a physical or emotional toll on nurses is recognised in the literature on 'emotional labour' (Smith 1992) and 'compassion fatigue' (McHolm, 2006; Sabo, 2006). In a phenomenological study examining ethically difficult situations in surgical units in Norway, Torjul, Elstadd and Sørli (2007, p.526) interviewed ten registered nurses. Their analysis led to the identification of a theme of 'moral perception' that encompassed the concepts of 'closeness to suffering' and 'compassion'. In articulating their experience of being moved by caring for suffering patients, these nurses expressed a wide range of challenging emotions that exemplify the potential impact of this type of engagement. These included 'heavy', 'demanding', 'tough', 'physically and emotionally draining', 'exhausting', 'energy consuming'.

The question of whether there is this physiological dimension that links pain and compassion has undergone investigation within the field of neurology where there have been many studies examining the neural basis of empathy/compassion<sup>31</sup>. De Vignemont and Singer (2006, cited in Loggia et al., 2007) determined that the subjective experience of ‘feeling another’s pain’ is mediated by some of the brain structures involved in reception to painful stimuli. Loggia et al. (2007) investigated these mechanisms in the context of whether a sense of compassion for another individual actually impacts on the sensory and affective components of pain perception. They conducted a comparative study in which they created a sense of either ‘high empathy’ or ‘low empathy’ in their subjects towards an actor (through presenting two alternative narratives about his personality and behaviour). Whilst the subjects were watching a video involving the actor in a situation of distress they applied painful stimuli to them in order to test ‘empathy-evoked activation’ in the pain network. Those subjects that were prepared to feel ‘high empathy’ for the actor experienced statistically significant higher levels of pain perception, which the authors proposed indicates that it is the feeling of empathy itself that alters pain perception and not necessarily just the observation of pain behaviours. Loggia et al. (2007) drew the inference that ‘empathy hurts’, and whilst this is clearly an experimental study, the association of the experience of feeling compassion in itself affecting the experience of pain does carry resonance with the notion of ‘compassion fatigue’ or ‘secondary post traumatic stress disorder’ which are considered later in Section 3.20.

### **3.8 Compassion and pity**

Several commentators draw a fine line between compassion and pity. Crisp (2008, p.234) made an important observation relating to Aristotle’s use of the term *eleos* in his influential account of compassion in the *Rhetoric* since its translation is taken to mean either compassion or pity. Cash (2007, p.71) discussed pity as representing ‘degenerate compassion’ or something in which the ‘evil’ afflicting others is seen as something distinct from the everyday world of the person feeling compassion. He suggested that pity is a self-regarding feeling, where the object of pity is viewed from the secure vantage point of the

---

<sup>31</sup> There is no attempt to differentiate the terms in these studies.

pitier. A true state of compassion, he argued, is one in which there is a desire to change the situation, given that compassion is an intentional state. The salience of challenging the boundary between pity and compassion is also articulated by Diggins (2007) in a reflection on her motivation to pursue a career in nursing. She argued strongly that compassion has its roots in respect for another human being, implying seeing that person as an equal. In contrast she suggests that with pity there is a lack of respect for the person and a danger in losing sight of each patient's individuality. Blum (1980, cited in Sabo, 2006 p.137) accords with this position and argued that compassion promotes equality as experiencing compassion suggests an inherent regard and respect for the other as a fellow human being. Crisp (2008, p.233) went as far as to suggest that 'because of its contemporary connotations of condescension or contempt pity is also often now thought of as shallow and motivationally idle'.

Dietze and Orb (2000) also highlighted the issue of pity, and linked it to the engenderment of paternalistic attitudes, to a degree that they argue it presents an assault on the individual concerned. Clearly, therefore, there is a distinction to be drawn between the positive attributes of compassion in terms of respect, identification with the individual's situation and an intention to act, and that of pity that may evoke paternalism and control.

In an expert seminar on the 'asymmetry in care-giving relationships' involving Dutch and Flemish ethicists and nursing scientists, Grypdonck (2008) addressed the place of pity within compassionate responses, which perhaps stand in some contrast to the more negative connotations outlined above. She did, however, acknowledge that pity has not been and is not a popular concept in nursing. The focus of debate at the seminar was the fact that many care situations are characterised by asymmetry within the relationships, on the ground that patients are essentially dependent on care and the willingness of others to give it to them. Whilst Grypdonck suggested that pity is an emotion that underlines or creates asymmetry, she contended that it is rooted in the belief that all human beings are worthy of compassion and care. Within ethical philosophies pity is described as a virtue, which Grypdonck argues means that it can 'help nurses not to turn their backs on patients they cannot help' (2007

p.75) and can also help them to give considerate and sincere care to a person who behaves differently to what professionals may expect.

Stockwell's (1972) seminal research on the notion of the 'unpopular patient' raises the question of whether nurses can experience and express compassion for someone they do not 'like' (or do not like the impact that their behaviour has on their health)? If not there is a question whether in this situation pity becomes the underpinning emotion that permits the care-giving response that goes beyond simply professional engagement. Olsen (2007) examined this issue in relation to 'ethical caution' on the grounds that nurses, like all people, are prone to having special feelings for others who are like them or who are endearing, or for patients who are 'easy'. He suggested that the real ethical problem is how to connect with patients whom they see as different or 'difficult'. Furthermore, he warned that the 'ethical struggle' is not in having compassion for patients who give back willingly and knowingly; 'it is in learning to feel that one has received something in return from the patient who rebuffs or is different from the nurse' (Olsen 2007, p.75).

### **3.9 Compassion as a global trait?**

Within the field of social psychology, Miller (2009) presented a critical analysis of the virtue of compassion and whether it represents a 'global characteristic trait' that underpins people's motivation and response to helping others in need. The existence of 'global characteristics', which would demand consistency of response across circumstances and time periods is effectively challenged within the analysis, drawing on the work of Doris (2002) on the grounds that behavioural variation across a population owes more to situational differences than disposition differences between people. Within this context Miller focused more specifically on empathy, which he presents as a 'helping trait' rather than a virtue like compassion. Global helping traits are described as dispositions to help others who are thought to be in need, which Miller (2009) argued are highly sensitive to different psychological inputs that act as a 'trigger' and lead to the individual to try to help as long as the trigger is of sufficient strength to pass a minimum activation threshold. Miller (2009 p.252) indicates that research in social psychology has shown that helping behaviour is remarkably sensitive to the following psychological factors (among others):

- Guilt
- Embarrassment
- Moderate Good Moods
- Moderate Bad Moods
- Empathy

Research drawn on by Miller (2009) demonstrates that helping behaviours are strongly influenced by mood. Elevated levels of positive affect are strongly linked to helping behaviours, whereas experimental research indicates that when experiencing negative affect subjects will help but only as a means of improving their own mood or where the benefits for him/herself of helping outweigh the perceived costs and believes that there are no other effective means of relieving the negative effect. Whilst there is reason to consider the relationship between nurse's mood and their ability to be compassionate, it is important to note that much of the social psychology research relates to bystander helping behaviour rather than professional helping behaviour.

### **3.10 Compassion, empathy and sympathy**

Schantz's (2007, p.49) call for the identification of compassion as being 'nursing's most precious asset' comes with a backdrop of what she described as widespread misconception or 'erroneous assumptions' that the terms caring, empathy, sympathy and compassion are synonymous. She argued that such a position compromises the validity of research findings in this domain and, in terms of the LCC Programme and this research points to the need for clear differentiation of these terms.

Whilst differentiation does have merit in the context of this literature review it is important to recognise that in the broader literature at this time the terms 'compassion' and 'empathy' tended to be used interchangeably, with empathy often being regarded as a key component of the expression of compassion. In a comprehensive analysis of both concepts, Sabo (2006) drew on the works of many leading nurse theorists to examine the dimensions of each, however, focused more strongly on empathy as the key emotion influencing the nurse-patient relationship. Several commentators emphasise empathy's cognitive-behavioural components (Morse et al., 1992) and perceptual and interactional dimensions (Rogers, 1975) that suggest that it is 'more than a way of being'. In a conceptual analysis of empathy Kunyk and Olson (2000)

provide a classification system that offers a potential framework for considering motivation for compassion/empathy which is presented below in Table 3.

**Table 3: Classification system for examining compassion/empathy (Kunyk & Olson, 2000)**

<b>Feature</b>	<b>Explanation</b>
Human Trait	Innate natural ability
Professional State	Learned communicative skill comprised of cognitive-behavioural components
Communication Process	Exchange where the professional perceives, expresses understanding and the client perceives this understanding
Caring	Compulsion to act because of understanding the experience of the client

Dietze and Orb (2000), on the other hand, paid particular attention to demarcating empathy and compassion, to the degree that they appeared to denigrate the notion of empathy, even suggesting that it can put a distance between the nurse and patient. Furthermore they contended that ‘an empathic relationship is one of a nurse professionally detached from a patient’ (p.168) on the grounds that whilst empathy implies being touched by and understanding the reality of another person, it does not specifically require action.

In his philosophical analysis of compassion/empathy Miller (2009) did not fully distinguish the two concepts, which does pose a conceptual limitation to his paper. His description of some of the central features of empathy is, however, helpful and allows some postulation of the relationships between sympathy, empathy and compassion. Miller’s (2009) analysis is conducted in the context of a debate on the existence or otherwise of ‘global helping behaviours’, and draws on psychological experiments outside the health domain which have attempted to test the constructs of empathy and sympathy and how they impact on helping responses



To illustrate these features he presents a paradigm case involving two friends: Jennifer suddenly loses her parents and experiences great distress. John tries to imagine how she must be feeling, and as a result, comes to form similar feelings in his own mind. In this way, John has come to empathise with what Jennifer is going through. Miller (2009) distinguishes two possibilities in terms of this response:

- a) John tries to imagine what *Jennifer* perceives in the situation and what she feels as a result.
- b) John tries to imagine what *he* would perceive in the situation if he were in Jennifer's position and how he would feel as a result.

Miller (2009) suggested that these are clearly two different acts of imagining, and can give rise to different feelings, with perhaps the second act of imagining leading to greater personal distress for John. He also suggests that it is perhaps the first act that is conceptually tied to empathy. It is not necessary for John to feel exactly the same thing as Jennifer to empathise, only a similar type of emotion (for example, sadness in comparison to deep depression). Sympathy on the other hand he describes as an emotion which involves some form of care or concern for another person. The person is the subject of this state, and so the attitude is third-personal (concern *about* the person) rather than first-personal (concern *with* the person). By empathising, John becomes focussed with Jennifer on the death of her parents. By sympathising, John is focussed on Jennifer herself.

Miller does not extend the analysis to include compassion. However, it could be hypothesized that in being compassionate, John recognises the suffering that Jennifer is experiencing and on the basis of making an attempt to understand that suffering (through perhaps empathy) he undertakes some form of action to help alleviate that suffering. Sympathy and empathy in themselves do not demand or include action to alleviate, although this may well be an outcome. Miller's interest was to test whether elevated feelings of empathy induce 'helping behaviours'.

Wispé (1986) argued, however, that sympathy refers to the heightened awareness of another's plight as something to be alleviated (which does imply action), whereas empathy refers to the attempt of one self-aware self to

understand the subjective experiences of another self. She suggests that sympathy is a way of relating, whereas empathy is a way of knowing.

On the basis of this analysis Table 4 overleaf presents my own critique of the commonality and distinction between sympathy, empathy and compassion.

**Table 4: Comparisons between sympathy, empathy and compassion.**

	<b>Sympathy</b>	<b>Empathy</b>	<b>Compassion</b>
Definition (Oxford English Dictionary)	The 'capacity for being simultaneously affected with the same feeling as another'	The 'power of projecting one's personality (and so fully comprehending) the object of contemplation'.	'Suffering together with another, participation in suffering'
Personal response of healthcare professional	Affected with some feelings for another.	Enables interpretation of the feelings, thoughts or perceptions of the person so as to provide professional care.	Suffering together, being moved by the person's suffering.
Objective or subjective?	Subjective assessment of the perspective of the other.	Attempt to objectify the experience through cognitive understanding of another person's experience.	Can be both objective and subjective through identification and acknowledgement.
Response	Does not demand any response.	Does not demand action or commitment to join in other person's suffering.	Deliberate participation in other person's suffering with commitment to act to reduce or minimise that suffering.
Impact on professional relationships	Maintenance of professional relationships.	Detached professional relationship – distance between patient and professional.	Deeper level of participation in the suffering of others – blurring of professional boundaries.
Level of engagement with the patient	Can be superficial.	Possible to feel for others, but not necessarily in solidarity with them.	Shared experiences and actions.
Type of activity	Passive activity.	Intellectual activity.	Moved to action on account of the suffering.
Type of engagement with patient	May not involve actual engagement	Doing for the patient	Doing with the patient

Sources: Dietze and Orb (2000), Schantz et al., (2007), Oxford English Dictionary Online (2008)

The applied relevance of these philosophical debates lie in a number of studies that attempt to measure levels of empathy and compassion using validated tools including the Jefferson Scale of Physician Empathy (Hojat et al., 2001) and the Santa Clara Brief Compassion Scale (Hwan, Plante & Lackey, 2008). The Jefferson Scale (or validated alternatives of it for other healthcare professionals and students) has been used widely and is validated in a number of countries across the world. In 2009, Ward et al. undertook a study examining the psychometrics of the modified version of the Jefferson Scale with 333 undergraduate nurse students. From their factor analysis 3 underlying constructs emerged which they felt were consistent with the conceptual framework of empathy: 'Perspective Taking'; 'Compassionate Care' and 'Standing in the Patient's Shoes'. Yu and Kirk (2008 & 2009) undertook a systematic review and evaluation of empathy evaluation tools in nursing and found twenty different tools developed over the preceding twenty years, although found inconsistencies between them.

### **3.10.1 Response to suffering - is there a continuum?**

Having reviewed a range of literature and determined that there are a range of responses to the recognition of suffering; it may be possible to position the four concepts of pity, sympathy, empathy and compassion on a continuum. Such a scale would position pity and compassion at polar ends, on the basis that pity demands the least degree of response while compassion the most. It could be argued that a compassionate response represents full engagement with the individual whilst pity accords distance. What is more challenging to determine is the relative move through distance, to possible indifference (in relation to sympathy and empathy) and so forth. A range of criteria would need to be developed in order to permit examination of an individual or situation. The relative merit of such a continuum in the context of healthcare practice may rest with self-reflection and recognition of the interplay between patient and context-related factors that influence individual responses to suffering.



### 3.11 Motivation for compassion

Motivation is a human characteristic that has many dimensions including fulfilment of a vocation, response to a religious calling, altruism and personal esteem, each of which infer a 'higher' motivation for compassion which may be an innate characteristic.

There may be an assumption that compassion is an innate characteristic for someone who becomes a healthcare professional particularly when it is linked with vocation. Vocation has been defined as 'a job you do because you have a strong feeling that doing this job is a purpose of your life, especially because you want to help other people' (Longman's Dictionary of Contemporary English, 2008). In an economic analysis of vocation, Heyes (2004) proposed a model that views vocation as a dichotomous variable - either you have it or you do not (although he did acknowledge that in reality it is more of a continuum). He went on to suggest that within such a model a nurse who does not possess vocation is indifferent to whether they spend time on administration or direct patient care. The vocational nurse on the other hand derives 'non-pecuniary' benefit from their direct patient care, which in turn impacts on their sense of job satisfaction. It is this concept of 'non-pecuniary' benefit that merits analysis in relation to compassion, and it has been argued that it is the nurse-patient relationship that is at its core. Olsen (2006, p.75) used the term 'therapeutic reciprocity' to characterise a dimension of this relationship which can serve as an important motivating factor, to the degree that he suggest that it is 'the gratification nurses get from patients is what makes nursing a great vocation'.

Dietze and Orb (2000, p.168) argued that compassion has at its core 'deliberate altruism', a position that perhaps needs to be questioned in terms of whether altruism should be a recognised basis for professional practice. These types of questions surrounding motivation for compassion are particularly relevant to the issue of recruitment to the 'helping professions'<sup>32</sup>.

---

<sup>32</sup> As was discussed in Chapter Two such issues of recruitment to the nursing profession have been fore-grounded in recent years and Recommendation 188 from the Francis Report (Francis 2013 p.105) calls for the introduction of an aptitude test for compassion and caring for those aspiring to enter the nursing profession. This has been followed by the Department of Health's controversial proposal that all prospective nursing students should work for one year as a care assistant both to learn essential care but also to demonstrate their caring attitudes (Campbell, 2013)

Sussman (1995) argued those that gravitate towards this career option usually see themselves as helpers, or perhaps as Sadler (2004) described they have an 'internalised motivation for doing good'. The concept of 'compassion satisfaction' is recognised within the literature on disaster management, with Jacobson (2006) acknowledging the fact that alongside the feelings of distress that can be brought on by helping trauma victims there are also positive reactions. These positive feelings relate to being satisfied with one's ability to offer care and connect with another person.

Reflecting on her own humanist philosophy, Noravian (2008) recognised that she was motivated by compassion and sympathy to help others, however, also acknowledged that her actions were beneficial to herself in satisfying her own sense of responsibility and duty. She extended her discussion through recognising that there is a potential tension inherent in this position, and stated that it is important to differentiate between our own need to help and the needs of those that we are helping.

Motivation to become a nurse does have a strong underpinning faith dimension for some individuals, even to the degree that Prater (2006) described as 'being called' to nursing. In a descriptive, cross-sectional survey conducted with 212 nursing students in their final two years of study at a private, faith-based university in the United States, Prater (2006) reported almost two thirds of the students indicated they were 'called' by God to become nurses. The students also described compassion as being the most significant personal characteristic that would be helpful to them in their career. They did not, however, define what compassion meant to them, and given the UK health and higher education systems do not have faith-based infrastructure it is not possible to estimate the significance of faith as motivational factor for entry to the profession in this country or the generalisability of Prater's findings in the US itself.

Miller's (2009) interest in global helping traits led him to examine motivation for helping behaviours, particularly in relation to feelings of empathy. He initially examined these issues from a virtue ethics perspective, which he proposed holds compassion as being a virtue based solely on altruistic intentions. He located this perspective to Aristotelian traditions that purport that virtuous

agents will not only perform right actions but also do them for the right motivating reasons. Thus Miller argued someone who helps another might be doing what he ought to do, but if he does it either solely or even in large part because of considerations such as social recognition or monetary reward, 'he would not be exhibiting the virtue of compassion' ( 2009, p.275). Clearly if this perspective were taken literally it could challenge the fundamental tenant of remuneration for being a healthcare professional.

### **3.12 Demonstrating compassion in professional practice**

Graber and Mitcham (2004, p.88) undertook a qualitative, phenomenological study in the USA involving what they described as 24 'compassionate healthcare clinicians'. The research subjects were employed in two hospitals and came from a range of disciplines including nursing, medicine and the allied health professionals. Each had been nominated by managers as meeting the inclusion criteria which were 'exemplary individuals who are really caring and compassionate in their interactions with patients.' Through semi-structured interviews the researchers sought to identify and understand the specific actions, interventions and interpersonal relationships that they demonstrated with their patients. The analysis led Graber and Mitcham (2004, p.87) to propose that the ability to provide compassionate care has its source in 'individual motivation and wisdom'. They contended that, given, the demanding work environment where most health professionals work, that to be consistently compassionate they must possess 'considerable tact, self control and other inner resources'. Their investigation led to the development of a four-level model of 'affective clinician/patient interactions' with the levels being distinguished by a shift in the nature of the motivation and reward factor for the clinician, a gradual diminution of concern for or focus on self, and an increasing concern for the patient or 'other-centred' caring and compassion. This model is presented in Table 5 overleaf.

**Table 5: Graber & Mitcham (2004) Preliminary model of affective clinician/patient interactions**

<b>Level of clinician-patient interaction</b>	<b>Primary expression</b>	<b>Primary motivational source</b>	<b>Focus of concern</b>
IV. Transcendent	Love Compassion	Feeling and intuition	Primary concern for patient
III. Personal/feeling	Intimacy and friendly patient relations	Secular or religious values Sense of duty (higher) Altruism Social needs	Concern for patient and self
II. Personal/social	Friendly patient relationships Emotional involvement	Social need Altruism	Concern for self and patient
I. Impersonal/practical	Fulfilling job responsibilities Superficial patient relations Detached concern	Material reward Sense of duty (lower)	Concern for self

Whilst this study is perhaps limited by its sample size, it does nevertheless raise some important dimensions that may serve to draw distinction between individual behaviours within specific organisational contexts and cultures. The 'Transcendent' level of interaction is described by Graber and Mitcham (2004) as one in which clinicians experience a deep sense of compassion for their patients, and experience an exchange of sharing and support that appeared qualitatively distinct from ordinary emotional or social interactions.

### **3.13 Compassion – innate characteristic or taught skill?**

Much of the debate on compassion leading up to 2009 centred on nursing care, however, there was also a body of comment and opinion within medical journal editorials that raise the same issue. Within this context the question of whether compassion is innate or can be taught was described as 'a continuous and inconclusive debate' (Lancet 2007, p.630). There was, however, acknowledgement that compassion is essential if care is to be 'more than a manufactured product'. A model for the medical curriculum was proposed within this Lancet editorial and given the acronym CARE – Compassion, Attention, Respect and Empathy – with the observation that, if the ability to feel compassion is missing, or if it is a trait that cannot be learned, then 'paying



attention to patients, respecting them, and being empathic towards them certainly can be’.

Youngson (2008), in his action plan for making healthcare systems more compassionate, argued that empathy is as much a skill as an inborn character trait. Reflecting on his own practice as an anaesthetist he recognised that he had to learn how to get to the heart of a patient’s concerns in the course of one visit. He acknowledged that for most of his career he did not have those skills and was completely unconscious of the way he used power to control the agenda of a patient consultation.

### **3.14 Fostering a culture of compassion**

In his analysis of what makes for a compassionate patient-care giver relationship Sanghavi (2006) reported that most interventions to improve compassion primarily target students and involved short courses, or approaches involving the maintenance of ‘personal illness narratives’. Whilst acknowledging the benefit of at least including a focus on compassion within the medical curriculum, he argued that there were limitations, which he described as being inherent in the medical model in that there was a lack of continual reinforcement. He proposes that advocates for compassionate care should adopt a different strategy which views lack of compassion not as an acute trauma, but a chronic condition requiring ‘a lifetime of continuous support, regular guidance, repeated reinforcement, specific targeted outcomes and more innovative care programmes’ (2006, p.290). He proposed a five-dimensional approach to achieving this strategy:

- a) sponsoring regular meetings of small networks of interested people that are part of a larger movement (a ‘cellular model’ for establishing group identity and purpose);
- b) ‘therapeutic leaders’ modelling behaviour for younger health professionals, essentially through the ‘hidden curriculum’ of learning involving mentorship and a clear organisational values base;
- c) regular teaching and reinforcement of compassionate behaviour;
- d) a targeted outcome for measuring performance (whilst acknowledging the complexity of this requirement);

- e) recognition that existing structures for delivering healthcare may not be adequate and introduction of more innovative ways of delivering care (such as group visits, day long retreats for those with chronic conditions and self management training).

These proposals carry resonance with several of the practice-based initiatives that were outlined in Section 2.4.4.

### **3.15 Compassion and relationships**

The Kenneth B. Schwartz Centre was established in Boston, Massachusetts in 1995 to 'support and advance compassionate healthcare in which caregivers, patients and their families relate to one another' (Sanghavi, 2006 p.283). Within the Centre a key method for focussing on these dimensions was the development of the Schwartz Center Rounds<sup>®</sup> that have now been piloted in the UK in The King's Fund *Point of Care* Programme (Cornwell & Goodrich, 2010) as described in Section 2.5.4. To celebrate the centenary of the Schwartz Centre, a study described as a 'national conversation' was undertaken involving 54 hospitals in 21 US states using Rounds as a means to collect qualitative data in response to the question 'what makes for a compassionate patient-caregiver relationship?'. Each 'conversation' involved a recorded facilitated discussion during a Round with a panel made up of patients, families and caregivers, along with questionnaires issued to participants. Analysis of the transcripts and questionnaires led to the identification of three categories: communication, common ground and respect for individuality (Sanghavi, 2006).

Table 6 on the next two pages presents an overview of the key components of each of these categories alongside consideration of how these might be applied in clinical practice, based particularly on the responses of patients and families. Sanghavi's (2006) study represents one of the most detailed analyses of the features of compassionate care in practice and, therefore, affords some opportunity for comparison with the potential outputs of the action research dimensions and outcomes of the LCC Programme.

**Table 6: Kenneth B Schwartz Centre's three categories that contribute to a Compassionate Patient-Caregiver Relationship** (adapted from Sanghavi, 2006)

Category	Component	Dimension	Application
Communication	Style	Non-verbal	<ul style="list-style-type: none"> <li>• Sitting rather than standing</li> <li>• Eye contact</li> <li>• Uncrossed arms</li> </ul>
		Tone and cadence of speech	<ul style="list-style-type: none"> <li>• Frequent head nodding</li> <li>• Posture of leaning forward</li> <li>• Remembering names</li> </ul>
		Showing emotion	<ul style="list-style-type: none"> <li>• Use of humour</li> <li>• Making responsive comments</li> <li>• Orienting patients by telling them what to expect</li> </ul>
		Imparting facts in clear and useful manner	<ul style="list-style-type: none"> <li>• Respecting occasional silence</li> <li>• Avoiding interrupting patients</li> <li>• Avoiding rapid-fire question and answer session</li> </ul>
	Content	Conveying competency	<ul style="list-style-type: none"> <li>• Responding to empathic clues e.g. 'I'm scared'</li> </ul>
			Prompt feedback on test results

Table continued overleaf.

**Table 6: Kenneth B Schwartz Centre’s three categories that contribute to a Compassionate Patient-Caregiver Relationship** (adapted from Sanghavi, 2006)

Category	Component	Dimension	Application
Common Ground	Caregiver-patient partnership	Unchangeable ('fixed') factors	<ul style="list-style-type: none"> <li>• Connection between caregiver and patient (based on ethnic or geographic area)</li> <li>• Personal experience of health problem by caregiver</li> </ul>
		Voluntary ('controllable') factors	<ul style="list-style-type: none"> <li>• Conscious choice to 'care deeply'</li> <li>• Sharing personal information with patients (but not intimate or otherwise inappropriate)</li> <li>• Comfort through physical touch</li> <li>• Validation of the patient's emotions</li> <li>• Building trust which can help retention of hope</li> <li>• Giving recommendations based on what caregiver knows about the patient's values, medical situation, goals and fears</li> <li>• Recommendations being based on:               <ul style="list-style-type: none"> <li>– always allowing for possibility of cure (while being realistic about prognosis)</li> <li>– Having hope for the future (by focusing on attainable goals)</li> <li>– assuring patients they will not be abandoned or forgotten.</li> </ul> </li> <li>• Admitting mistakes</li> <li>• When appropriate, making prompt and honest apology</li> </ul>
Treating the patient as an individual	Small Acts of Kindness	Generosity of spirit	<ul style="list-style-type: none"> <li>• Remembering a birthday</li> <li>• Asking 'how was your night?'</li> <li>• Spending sufficient time in an unhurried manner</li> </ul>
		Brief moments of connection	<ul style="list-style-type: none"> <li>• Small courtesies during ward rounds</li> </ul>
	Telling Patients' Stories	Preserving individuality	<ul style="list-style-type: none"> <li>• Use of memory boxes for people with dementia – reminders of patient's life before the illness</li> </ul>
		Accurate assessment of patient's needs	<ul style="list-style-type: none"> <li>• Communicating the social history of patients – profession, hobby, religious background</li> </ul>
	Shared decision-making	Individualised balance of providing guidance and allowing autonomy.	<ul style="list-style-type: none"> <li>• Supporting complex decision-making when patient has access to complex, often contradictory information via Internet and other sources</li> </ul>

Sanghavi (2006) argued that the idea of making a conscious choice to care deeply for patients is at the heart of the meaning of compassion ('to suffer with') and suggested that it demands caregivers to be willing to take emotional risks.

### **3.16 Compassion and therapeutic benefits**

Sanghavi (2006) presented a brief review of some of the identified clinical therapeutic benefits reported to be derived when physicians deliver compassionate care. Physicians with a good bedside manner are reported to be more effective, particularly in terms of obtaining better information about patient's symptoms and concerns and creating treatment plans that are more effective in enhancing patient recovery. Youngson (2008, p.4) quoted what he described as 'compelling research' from the Alliance of Healthcare Research in the USA (Mead, Bursell & Ketelsen, 2006) to show that empathic concern and investing time up front to check a patient's needs increases efficiency, safety and patient satisfaction. Whilst not framed within an analysis of compassion, the study, which was conducted in 27 wards in 14 hospitals, involved the introduction of a protocol based on the introduction of an hourly round of patients that would involve formal assessment of pain; ensuring essential items are within reach; offering toileting assistance; assessing position and comfort; asking patients if they have any additional needs and telling the patient that a member of nursing staff will be back in the room in 1-2 hours.

Baseline data was collected for two weeks prior to the introduction of the protocol, followed by four weeks introduction of the rounds. As well as demonstrating immediate benefits, follow up one year later found that:

- Of the units that participated 12 (85.7%) continued the practice;
- Of the hospitals that participated 13 (92.8%) decided to expand the rounding to other units or all units in the hospital;
- Patient satisfaction scores increased an average of 8.9 points on a 100-point scale, (from 79.9 to 88.8%);

- Comparing the four weeks prior to rounding with four weeks one year after the study, falls had been reduced by an overall 60%.<sup>33</sup>

### **3.17 Compassion and end of life care**

There has long been a strong association between the term compassion and palliative and/or end of life care although there is generally little associated analysis of the actual meaning of the term when it is examined in the literature. In a review of the emergence of hospital-based palliative care in the United States, Meyer (2007) traced the establishment of one programme in Wisconsin to the statement of its chief executive that ‘in a nutshell, hospitals are losing a key element of providing quality care and that’s compassion’ (Petasnick, 2007 cited by Meyer, 2007 p.20). Meyer’s suggestion was that, as the patient population ages, some hospitals are finding that they are not prepared to handle the social, physical, emotional and quality-of-life issues presented by a growing influx of chronically ill patients with complex diseases. The link between compassion and care oriented to maximising quality of life is a consistent theme within the palliative care domain, with one commentator suggesting that ‘it helps fulfil the humane part of healthcare’ (Wiener, 2007 cited in Meyer, 2007 p.20).

In this context compassion is generally portrayed as a positive attitude and philosophy towards the dying (Phillips et al., 2007), coupled with a focus on the management of pain, meeting the patient’s emotional needs and communication with the family. Johnston and Smith (2006) undertook a phenomenological study involving 22 patients and 22 nurses from both hospice and hospital settings to investigate patients’ and nurses’ perceptions of the concept of the expert palliative nurse. Compassion was identified along with interpersonal skills as being the two most important characteristics of such experts. In the study compassion was described as a ‘quality’ in the nurse, along with kindness, warmth and genuineness. Two key themes that emerged from the patients’ perspectives when attempting to explain these qualities were

---

<sup>33</sup> This concept of ‘Intentional Rounding’ or ‘Care Rounding’ has now gained profile in the UK (National Nursing Research Unit 2012) and commenced implementation in NHS Lothian in 2012. The remaining members of the LCC Team have contributed to the development of the care rounding documentation to ensure that the learning from the Programme in terms of ‘what matters to the patient’ were made an overt element of each round, thereby contributing to wider dissemination and sustainability of the LCC Programme.

the concept of 'connecting' and 'meeting my needs'. Both of these resonate with the definition of compassion that emphasises both engagement with the individual and taking action in response to identification of suffering. The patients' explanation of 'connecting' stressed the importance of the nurse-patient relationship and specifically the role of the expert nurse as being 'someone to talk to', 'willing to listen' and 'getting to know me'. In terms of meeting needs, they describe this as about 'knowing about my illness', 'providing comfort', 'being there for me' and 'supporting me'. Those patients from hospices also identified the theme of 'hospice as family', with the focus on the environment and atmosphere making them feel relaxed as well as safe and secure (which was reported as being in contrast to their hospital experiences). 'Connecting' also emerged as a theme with the nurses, although the categories that surfaced within this extended beyond those of the patients to include 'willing to listen', 'facilitating communication', 'providing information', 'building rapport', 'spending time with patients' and 'supporting the patient and family'. Another key theme emphasising the action response was 'providing comfort', which was made up of 'keeping patients comfortable' and 'controlling pain and symptoms'. The nurses emphasised the 'working together' as a key aspect to the delivery of expert care, both in terms of teamwork and 'acting as a go-between for the patient.

### **3.18 Compassion and 'presence'**

There are many individual testimonies from patients and nurses reported in the literature that convey acts of compassion which emphasise the perhaps 'unseen' nature of nursing, or the notion of 'presence' being an essential element of a therapeutic relationship. Wright (2007, p.24) described this quality as 'being fully present for patients' and suggested that it is a nursing skill of immense value invoking a sense of trust, healing and wellbeing. Within the definition of compassion that emphasises an active response to suffering, it is important to recognise that such a response may in fact involve qualities that Wright describes as attentiveness, stillness, focus and presence. Suwanski (2004, p.32) described an encounter with a patient experiencing acute psychosis, who despite receiving medication was uncontrollable and did not respond to interventions to calm her. Her response was to simply 'be' with the patient throughout an entire night shift, holding her hand, reassuring her with

calm words and placing a cool cloth on her forehead. Two days later when the acute episode was over the patient approached Suwanski to thank her, 'throughout my crazy behaviour, I heard your soft voice and it kept pulling me back to earth. That night I didn't care if I lived or died. But hearing you through the night and feeling your hand in mine and the cool cloth on my forehead made me want to live'. In her reflection, Suwanski (2004, p.32) observed that even through a traumatic event like this a patient knows whether he/she is being treated with compassion or not, and that as a consequence 'compassionate care is never wasted, even when the patient seems unaware of it'.

### **3.19 Compassion and ethical decision-making**

Dietze and Orb (2000, p.166) drew a strong link between compassion and ethical practice to the extent of describing it as a moral virtue, which 'gives context and direction to nurses' decisions and actions'. Within the biomedical ethics tradition (Beauchamp and Childress, 2009) it is usual to analyse specific situations according to the four core ethical principles:

- Respect for choice (autonomy)
- Positive help (beneficence)
- Do no harm (non maleficence)
- Treat fairly and equality (justice)

Whilst compassion is not overtly framed within the 'big four' (Beauchamp & Childress, 2009), it is possible to recognise its affective dimension within each. This includes recognising and responding to 'suffering' in such a way as to respect an individual's right to clear, timely information to support their own decision-making; taking action in such a way that will deliver positive benefit to that individual's health and well-being, whilst at the same time minimising risk of harm through opting for the most minimally invasive, yet effective treatment.

Whilst ethical theories and principles are often used to guide decision-making and are the foundations for analysing ethical dilemmas, Hentz (2007, p.14) argued that in clinical practice they are limited by being abstract in nature. Her concern is that they do not address the relational aspects, contextual details or the personal nature of the situation. She suggested that it is precisely these relational aspects of ethical situations and the human pain and suffering



involved 'that leads to much of the moral anguish that nurses experience'. Her position is that ethical decision-making needs to be more inclusive in nature addressing the subjective and objective aspects of the ethical situation, requiring a conceptual shift in focus from 'ethical dilemma' to 'human dilemma'. It is within this conceptual shift that she proposes a role for 'the voice of compassion', along with the 'voice of reason' (linked to ethical theories and principles). Hentz (2007, p.14) argued that compassion stems from the ability to imagine the experience of another, and that this subjective and emotional understanding should inform the rational, and 'prevent it from becoming cold and calculating'. Within this context, she contended that a key requirement for a nurse is moral sensitivity and moral reflection that is grounded in the belief that one can not and should not separate one's self and one's history. This means that experience, beliefs and values all shape how an individual views an ethical situation. Understanding that ethical situation requires attention to the social/interactional, ethical and situational/contextual aspects of that situation, which is what Hentz sees as the 'voice of compassion'.

In pursuing a similar argument, Dietze and Orb (2000, p.170) proposed compassion to be the congruence between 'reasoned justification and morally driven action' and even that it 'blurs the distinctions of professional boundaries – it blurs the distinction between emotion and reason'. They did, however, acknowledge that compassion does demands reason and in some cases difficult choices, stressing that the attention to emotion should not in itself be misinterpreted as being laid open to sentiment, rather than involving rational thought and evaluation based on understanding and deliberate decision.

### **3.20 Compassion fatigue**

In the last two decades there has been increasing recognition of the consequences and costs of caring work (Sabo, 2006; Coetzee & Klopper, 2010). Many of these are seen to have both negative personal health and organisational outcomes (Lilius et al., 2003), something that McHolm (2006, p.14) has described as 'emotional toil'. Having explored definitions and dimensions to the delivery of compassionate care, there is strong merit to examining the potential impact of this type of engagement with patients, both in terms of recognising its existence, but also to develop a basis for analysing contexts where compassionate care may be less evident.

Terms associated with this phenomenon include ‘burn out’, ‘compassion fatigue’, ‘vicarious traumatisation’ and ‘secondary post traumatic stress disorder’. McHolm (2006, p.14) defines compassion fatigue as ‘the emotional, physical, social and spiritual exhaustion that overtakes a person and causes a pervasive decline in his or her desire, ability, and energy to feel and care for others’. Many commentators characterise compassion fatigue as a ‘natural consequence’ of caring for people who are suffering, with Sabo (2006 p.136) stressing that nurses’ health can be ‘profoundly affected’ by caring for patients experiencing trauma, pain and suffering.

McHolm (2006) presents three responses to work stress: Burnout, Compassion Fatigue Level 1 (CF1) and Compassion Fatigue Level 2 (CF2). These are summarised from her analysis in Table 7 below.

**Table 7: Nurses potential responses to work stress.**

Burnout	Associated with routine hassles of nursing work (dealing with time pressures, managing complex caseloads, co-ordinating care) that can lead to feelings of powerlessness and frustration. Involves a gradual wearing down. Nurses who are burned out usually become less empathetic to their patients and display negative behaviours to colleagues. Recovery from burnout can be resolved by changing jobs or taking a holiday.
Compassion Fatigue Level 1	Occurs when nurse closely identifies with the patient and personally absorbs the patient’s trauma or pain. It is a response to the <i>people</i> who are suffering rather than the <i>work</i> situation. Results not from being busy, but from giving high levels of energy and compassion over prolonged period to those who are suffering, often without experiencing the positive outcomes of seeing patients get better. Nurses continue to give themselves fully but find it difficult to maintain balance empathy and objectivity. Onset can be acute. Nurses become emotionally drained, experience stress related illnesses and eventually leave the profession if the condition is not addressed.
Compassion Fatigue Level 2	Same responses to compassion fatigue level 1, but in addition may re-experience traumatic events through descriptions of the patients, in experiences similar to ‘flashbacks’. Individual attempts to shield him or herself through avoidance or addictive behaviours. This has been described as secondary post traumatic stress disorder. This can lead to withdrawal from colleagues and even families, although the nurse may continue to give to patients emotionally despite feeling they are losing sense of self.

(McHolm, 2006)

Compassion fatigue is also acknowledged as a job hazard for rescue workers providing aid after natural or man-made disasters, and there is a large body of literature to address ways of recognising the phenomena and providing intervention for those working in disaster response (Jacobson, 2006). McHolm (2006) highlights the fact that when compassion fatigue occurs it can also cause decline in job performance and efficiency and a rise in mistakes. In addition the impact on the organisation can be influential in terms of sickness absence and turnover<sup>34</sup>.

### **3.21 Compassion and emotional labour**

The concept of 'emotional labour' was introduced by Hochschild (1983) in her study of air cabin crew and has subsequently been researched and debated in the field of healthcare and specifically nursing (for example Larson & Yao, 2005; Smith & Lorentzon, 2005; Gray 2008). Hochschild described emotional labour as involving the induction or suppression of feeling to sustain an outward appearance that produces in others a sense of being cared for in a convivial safe place. She suggested that this kind of labour calls for 'a co-ordination of mind and feeling and it sometimes draws on a source of self that we honour as deep and integral to our individuality' (2003, p7). Emotional labour is composed of two strategies: deep and surface acting. Erickson and Grove (2007) provide the following delineation: deep acting (the attempt to actually feel the emotions one is expected to display) and surface acting (managing the outward expression of feelings in the hope that the authentic feeling will follow). Within the field of nursing it was Smith's (1992) study on student nurses and ward sisters that demonstrated that emotional labour requires an individualised but trained response that helps to manage patient's emotions. Gray's (2008) qualitative study with 16 pre- and post-registration nurses highlighted that emotional labour is largely implicit in the minutiae of nursing practice, but is missing more broadly in health and social care policy. This latter view was previously echoed by Mann (2005) in her evaluation of the literature on emotional labour in healthcare and the benefits and costs to patients and carers. She concluded that emotional labour should be formally

---

<sup>34</sup> A notable feature of my ongoing literature review, particularly through the use of Zetoc Alerts, was the regularity of the publication of research and other literature on compassion fatigue amongst nurses, especially those working in mental health, oncology, critical care and emergency department (for example Hooper et al., 2010; Jenkins & Warren, 2012; Ray et al., 2013; Potter et al., 2013.)

recognised as a key skill in facilitating the patient journey, with emotional skills being taught in innovative ways outside the formal classroom. Furthermore, healthcare professional should be offered training to cope with the effects of emotional labour performance.

Whilst the concept of compassion has not been explicitly linked to that of emotional labour<sup>35</sup> (in contrast perhaps to empathy), in their concept of analysis of emotional labour underlying caring, Huynh, Alderson and Thompson (2008) do identify it as a 'related term' but without much further clarification. They do, however, make the link between emotional labour and professional burnout and depersonalisation and echo Mann's (2005) call that nurses need to have time and a supportive environment to reflect, understand and discuss their emotional labour. In addition they advocate the introduction of the concept in preregistration curriculum and in interactive sessions during orientation programmes in order to enhance nurses' awareness of their emotions and their performance of emotional labour.

### **3.22 Synthesis of literature review on compassion**

My review of the literature in this chapter (predominantly from 2000-2009) has identified a number of domains which position compassion as:

- i) a deliberate act (in response to suffering);
- ii) something that is linked to an underpinning motivation (whether that is altruism, vocation, personal satisfaction);
- iii) a concept that is increasingly being defined as an essential healthcare competence or attribute (in relation to communication, expression of caring and treating the patient as an individual)
- iv) an aspect to caring that for the care giver can lead to both satisfaction and negative consequences in the form of compassion fatigue.

Furthermore it is evident that the debate surrounding the delivery of compassionate care needs to take account of the importance of culture and

---

<sup>35</sup> More recently however, the ongoing work of the LCC Programme is being linked with Professor Pam Smith's current research on emotional labour in nursing including a joint seminar on 6<sup>th</sup> March 2013 at the University of Edinburgh.

the fostering of effective relationships in order that the potential therapeutic benefits can be realised for patients and their families.

Viewing compassion as a deliberate act points to the fundamental requirement for healthcare professionals to effectively and promptly recognise suffering in whatever form that presents. This demands well-developed assessment skills that provide the antecedent to compassionate care-giving. Whilst the focus on the individual healthcare professional's response is important, such personal resources are also dependent on wider organisational resources that can either facilitate or inhibit the delivering of compassionate care. Although this context was hinted at in some of the literature, it was rarely made explicit or examined in any detail. This points to an important gap in current research.

Motivation for compassion featured strongly in the literature, both in relation to healthcare professionals and the general public (in the form of global helping traits). There may be a question of whether indeed it is safe to assume (or expect) that nurses and other healthcare professionals exhibit higher motivation to be compassionate. The current focus on how to recognise appropriate compassionate attributes at the time of recruitment to the profession also demands research that supports exploration of how nurses can express and demonstrate such attributes cognitively, emotionally and in their practice. Given that the literature pointed to the possibility of a continuum of responses that involves pity, sympathy, empathy and compassion, there may be some merit in examining this idea within an overall critique of compassionate care in practice.

What is clear is that compassion has become firmly situated within healthcare debates and is openly acknowledged as an essential attribute. Its manifestation is personal and varied and whilst little of the literature found within this particular review came from the patient's perspective it is evident that core features of compassionate care centre on communication, establishing a common ground and treating the patient as individual.

*My own reflective notes recorded in April 2009 indicated that I was trying to formulate my own definition(s) of compassion. These were essentially responsive to all the theoretical and organisational stimuli surrounding me at that time rather than based on systematic analysis of the data that I had collected at this stage (which is presented in Section 5.2). The following are two extracts from my notes:*

*'Compassion is both an emotion and an action that is situated in the context of a relationship. The relationship may be brief, even with a stranger, or can be intense, familial or professional. The action is deliberate and is based on the recognition of some kind of suffering'.*

*'Compassion is about connecting with someone and recognising their needs and being able to get the heart of what would make them feel 'better' through the development of a connection'.*

### **3.23 Gaps in the literature**

To date few studies have examined the constituents of successful initiatives designed to embed compassionate care in contemporary healthcare practice or systematically evaluate their impact in the medium to long term. There is little guidance as to what such initiatives actually do and how they operate most effectively. Much of the literature is theoretical, and whilst helpful in constructing a conceptual analysis of compassion and compassionate care, has not contributed significantly to a much needed evidence base on ways to enhance organisational capacity to embed compassionate care.

The LCC Programme came, therefore, at a timely moment in the changing landscape of compassion. Chapter Two has positioned the need for focus on ways to address the concerns about hospital care of older people that were repeatedly being highlighted. The broad aims of my study at this stage were to develop an understanding of the concept and expression of compassionate care within the participating services and to critically analyse the impact of the LCC Programme. The intention was to generate theoretical explanations about how the specific interventions and underpinning approach were used and to highlight what factors would enable the successful ones to be transferred to other locations both internally and externally.

Sanghavi's (2006) work on fostering a culture of compassion that was discussed in Section 3.14 was perhaps the closest articulation of practice-based approaches that carry resonance with my inquiry. Whilst Sanghavi's work included proposals for establishing meetings, role modelling, teaching,

measuring performance and reviewing structures, it had not been formally evaluated.

### **3.24 Research questions**

Having completed the literature review and developed my understanding of the operational delivery of the LCC Programme my research questions centred on both the rationale for the LCC Programme and whether these mirrored the issues analysed in Chapter Two and also to examine the impact of the LCC Programme over its lifetime.

1. What were the underlying organisational, professional and practice contexts for the Leadership in Compassionate Care Programme?
2. How is compassionate care recognised and expressed by different participating stakeholders?
3. What are the views, experiences and perceptions of participating stakeholders of the impact of the Leadership in Compassionate Care Programme?
4. How are the mechanisms used in the LCC Programme seen to influence the outcomes in different clinical settings?
5. What are the early signs of sustainability of the work of the LCC Programme?

Chapter Four will focus on how I answered the research aims and questions, firstly through an examination of my underpinning methodology followed by detailed explanation of the methods adopted.

## Chapter 4: Methods

### 4.1 Introduction

This chapter will critically review the rationale for the adoption of Pawson and Tilley's (1997) realistic evaluation framework, before going on to describe the research design and data collection methods.

I will briefly discuss an alternative methodological approach that I considered as a way of evaluating the impact of the LCC Programme. This was a quasi-experimental design, formulated before the LCC Team had been appointed and the implementation plan designed. I was not, therefore, truly in a position to grasp the nature of the Programme itself (i.e. the three underpinning principles of appreciative inquiry, action research and relationship-centred care) nor the full complexity of controlling potential variables that might influence the findings.

This will then lead to an analysis of realistic evaluation within the broader realist tradition of theory-led research, followed by a more detailed exploration of Pawson and Tilley's (1997) rationale and design for evaluation of what they describe as 'social programmes' and how this accords with the perceived need for the LCC Programme. Finally I will build on this critical review to describe my research design and data collection methods.

Wainwright (1997) emphasises the importance of distinguishing methodology from method. Methodology involves a philosophical analysis of research strategies, whereas method refers to the techniques used to gather and analyse data. Furthermore, in terms of an overall philosophy of research, Wainwright (1997) stresses ontology (what exists or the study of being) and epistemology (how we can come to know about it) as being fundamental to the construction of knowledge. It is important, therefore, to understand the epistemological basis of this enquiry through a critical reflection of my journey to arriving at the final research design. Wainwright (1997, p.1268) uses a helpful analogy when he states that 'methodology provides the power and epistemology the rudder that guide both the research and theory which should underpin research-based nursing care'. Furthermore he says 'without methodology we will lie becalmed, without epistemology we may circle aimlessly without direction'.



## **4.2 Evaluation research**

Evaluation research is strongly identified with the scientific study of social problems, which Rossi, Lipsey & Freeman (2004, p.2) suggested involves collating, analysing interpreting and communicating information about the working and effectiveness of social programmes that are designed to a 'benefit the human condition'. They argued that the link between evaluative research and the concept of social problems is vital in the sense that the evaluation should examine where that problem is located, whom it affects and how it affects them. Evaluation research has, therefore, an important role to play in informing the development of policy and practice. Weiss (1998 p.4) promoted evaluative research as a research design that involves the 'systematic assessment of the operation and/or the outcomes of a program or policy, compared to a set of explicit or implicit standards, as a means of contributing to the improvement of the program or policy'. However, this latter definition with its focus on comparison against standards did not accord fully with the LCC Programme, given that at the outset there were no predetermined standards for the delivering of compassionate care within the organisation nor (at that time) in the wider literature.

### **4.2.1 The need to demonstrate impact**

At these early stages I was focussing on being able to 'demonstrate' the impact of the LCC Programme on the organisation. My reflective notes from that period indicate that I was strongly influenced by the discussions within the Compassionate Care Operational Group<sup>36</sup> to which I had been invited.

Purdon et al. (2001) defined impact evaluation as a research method that seeks to measure the impact a policy or programme has on defined outcome measures. They indicated that it is possible to employ both qualitative and quantitative research methodologies in such studies; however, given the emphasis on outcome measures experimental designs predominate. Experimental research generally involves two subject groups – experimental and control – with the experimental group receiving the 'treatment' and the results compared with the control group that does not receive the treatment.

---

<sup>36</sup> This group was made up of key stakeholders from both the NHS and Higher Education Institution, but not the Executive Leads. During 2007 the Group was still shaping how the LCC Programme would be implemented in terms of the appointments of the team and the identification of Beacon Wards. The Programme itself did not commence until 2008.

This type of methodology is very familiar within healthcare, mainly for clinical treatments/interventions. However, Gray (2009) put forward the contrast of organisational research within healthcare as 'real world' research, and argued that in the real world it is often not possible to conduct truly experimental research because it is difficult to find experimental and control groups that are closely matched in terms of key variables (in the case of the LCC Programme variables might include clinical specialty, skill mix, model of care). Accordingly quasi-experimental designs are used where the researcher has to take existing groups rather than drawing on random samples and an attempt is made to compare the behaviour of this group with that of a similar group that has not experienced the event or phenomenon (Siriwardena, 2007).

#### **4.3 Initial Quasi-experimental Design**

In the early stages of my discussions with the LCC Operational Group we explored the potential of undertaking a quasi-experimental, time series study with a view to comparing proxy measures of compassion in a series of clinical settings with varying degrees of involvement with the LCC Programme. The overall model I developed at the time was partly influenced by an all-Ireland study examining the contextual indicators that enabled or hindered evidence-based continence care and management (Wright et al., 2006). Whilst the research focus of their study was not directly linked to the concept of compassion, the employment of practice development methods, the aim of achieving person-centred care and the fact that contextual factors and facilitation were recognised as being central to the success of any intervention carried resonance with the overall nature of the LCC Programme. As previously stated there is considerable evidence to support the significance of context (culture, leadership and evaluation) and facilitation (characteristics, role and style) in the success or otherwise of practice development initiatives (Harvey et al., 2002; McCormack et al., 2002; Rycroft-Malone et al., 2002a; McCormack et al., 2006). These factors have been articulated in the PARIHS framework described in section 1.3 (Kitson et al., 1998) and which had been influential in the continence study. Wright et al. (2006) adopted a multi-faceted data collection strategy including structured questionnaires, observation of practice, audit and focus groups.

My outline plan for the proposed quasi-experimental design for evaluation of the LCC Programme was to involve a stratified sample of clinical settings that would be measured against each other at different time points using a range of tools generating both qualitative and quantitative data (Table 8 below). The independent variable would be the interventions of the LCC Team.

**Table 8: Tentative Quasi-experimental design for impact evaluation**

	4 Beacon Wards <sup>37</sup>	4 Development Sites <sup>38</sup>	4 Other Wards <sup>39</sup>
Baseline (prior to involvement of LCC Team)	Measurement involving: Staff Patients/Families Observation of Practice	Measurement involving: Staff Patients/Families Observation of Practice	Measurement involving: Staff Patients/Families Observation of Practice
Phase 1 of LCC action research in Beacon Wards (7 months)			
12 Months	Repeat Measures		
Phase 2 of LCC practice development in Development Wards (7 months)			
	—————→		
24 Months		—————→	

Given the fact that no measures for compassionate care existed at the time, proxies were considered in order to examine some of the key concepts identified from the literature and to source potential measurement tools where these had been developed. These included the following:

1. *Caring* – Caring Assessment Tools (Duffy, 1992)
2. *Dignity* - Essence of Care Benchmarks for Privacy and Dignity (DoH 2003)
3. *Empathy* - Jefferson Scale of Physician Empathy (Hojat et al., 2001) and Empathy Construct Rating Scale (La Monica, 1981)
4. *Experience of Care* – User Defined Service Evaluation Tool (UDSET) (Joint Improvement Team, 2008)
5. *Person-centred Care* – Valuing People as Individuals – person-centredness in secondary care (Coyle & Williams, 2001)

<sup>37</sup> Wards identified as centres of excellence and involved in action research to develop understanding of compassionate care.

<sup>38</sup> Wards selected for practice development input from the LCC Team to test principles of compassionate care identified from Beacon Wards.

<sup>39</sup> Wards with no direct involvement with LCC Team but part of the organisation.

6. *Work Environment* - Revised Nursing Work Index (Aiken & Patrician, 2000).

#### **4.3.1 Rejection of Quasi-Experimental Design**

As I embarked on further reading and the LCC Programme implementation plan began to take shape this methodology was rejected for the following reasons:

1. At the outset of the study there was no precise understanding of the meaning and expression of compassionate care. Whilst there were potential proxy measures relating to empathy, person-centredness and caring available, it was impossible to ascertain whether or not they could be utilised as outcome measures in a meaningful way to examine the interventions of the LCC Team and understand whether they demonstrate change in the 'level' of compassion.
2. Further examination of several of the measurement tools demonstrated methodological weaknesses that suggested their application could be flawed in terms of reliability and validity. For example, in a systematic review of the measurement of empathy in nursing research, Yu and Kirk (2008) highlighted a lack of consistency both in terms of what contributes to empathy and how the tools were administered. Cumming, Hayduk and Estabrooks (2006) undertook a detailed analysis of the Nursing Work Index (NWI) in order to examine the validity and causal relationships between its constituent factors (autonomy, control over the work environment, relationship with physicians and organisational support) within the index. They reported a lack of fit between the factors within the NWI and three associated published instruments, which they suggested raised questions about the validity of these instruments as measures of the nursing practice environment.
3. Quasi-experimental research does to a large degree depend upon the control of variables in order that the independent variable (the input of the LCC Team) can be attributed as influencing the outcomes. Given the complexity of the healthcare environment including the different specialties, models of care, management structures and leadership styles it would not be possible to control variables and therefore ascertain that any change in the outcome could be attributed to any specific factor. Other important variables that emerged during the consideration of the research design

were the emergence of the range of values-based initiatives described in Section 2.5.5 that could potentially impact on the overall organisational awareness and response to care practices. These included a leadership programme 'Leading into the Future' founded on the Senses Framework (Nolan et al., 2006); a practice development initiative 'Connect in Care' examining work-place culture and positive care practices in older people settings (Connect in Care, 2008); and the Scotland-wide development programme for Senior Charge Nurse 'Leading Better Care' (Scottish Government, 2008a). All potential sample sites would be influenced by these initiatives to varying degrees, which would make it impossible to isolate specific impact of the LCC Programme, particularly in those settings more remote from the actual direct Programme interventions.

4. The proposed roll-out of the LCC Programme would mean that the Development Sites would not be identified until 12 months into implementation, which meant that it would not be possible to undertake baseline data collection simultaneously in all sites as had been planned in the research design. The benefit of this approach had been seen to be the attempt to control or account for what Purdon et al. (2001) describe as the *counterfactual*, that is the positive outcomes that could be observed amongst the eligible population irrespective of the programme or if indeed it was not in place. Given the range of initiatives underway, plus the ongoing nature of change in the NHS, it was possible that the 'level of compassion' (or whatever proxy measures were going to be put in place) may have changed in these wards during that 12 month period with no possibility of correlating this to the LCC Programme interventions.

#### **4.4 Seeking an Alternative Research Design**

It was evident, therefore, that a fundamental reconsideration of methodology was necessary, that would take account of the demands of the 'real world' conditions described by Gray (2009) and would support analysis of the interplay and interdependence of the key factors known to be essential in terms of implementation of evidence and change into practice. As previously mentioned these emphasised the interplay between evidence, context and facilitation (Kitson et al., 1998; Harvey et al., 2002; Rycroft-Malone et al., 2002b; McCormack & Garbett, 2003; McCormack et al., 2007; Kitson et al.,

2008). Rather than being concerned with the degree to which compassion (however that may be defined) 'improved' within the organisation, my interest lay in *what* impact the LCC Programme had within the organisation in both the intermediate and long term, *how* this might be sustained and what lessons might be learned to influence future policy and practice in this area. In order to address the emergent research questions I was aware that there was a need to analyse organisational context, process and outcomes. At this point in time I had not been introduced to the realist tradition.

#### 4.5 Realistic Evaluation

Having explored Pawson and Tilley's (1997) realistic evaluation text I was immediately drawn to its underpinning philosophy and how this accorded with my developing thinking and understanding of both the aims of the LCC Programme (which was now in progress) and my own study. Rather than seeking an answer to the question of whether a programme has 'worked' (or not), realistic evaluation is designed to provide detailed answers to the questions of *why* a programme works, for *whom* and in *what* circumstances? The core assertion of realistic evaluation is that programmes 'work' (i.e. have successful outcomes) only in so far that they introduce appropriate ideas and opportunities (mechanisms) to groups in appropriate social and cultural conditions (context), thereby linking to what Pawson and Tilley (1997) describe as 'Context-Mechanism-Outcome' (CMO) configurations.

Outcome = Mechanism + Context

O = M + C

*My reflective diary indicate that as I read this underpinning basis of realistic evaluation was akin to a 'eureka moment'. I could recognise the existence of a 'social problem' within nursing in the broadest sense as well as within the local context. Identifying the LCC Programme as a 'social programme', therefore, followed naturally. With my 22 years experience of working within this particular health organisation, 15 of them in a practice/research development capacity I was fully appreciative of its social complexity and how culture and practice become embedded both at macro, meso and micro levels. Similarly I knew both as an individual and observer of individual practitioners and teams that preferred choices are frequently mediated by capacity, which impacts on how care is delivered, and in turn is experienced by patients. The realistic evaluation framework and the potential of examining conjectured and subsequent refined CMO configurations appeared apposite.*

My research aims subsequently became to:

1. Develop an understanding of the concept and expression of compassionate care within the participating services
2. Critically analyse the impact of the LCC Programme within this NHS organisation
3. Examine the interplay of context and process that are seen to influence the programme outcomes in order to understand *why* the Leadership in Compassionate Care Programme works, for *whom* and in *what* circumstances.

#### **4.5.1 Background to realistic evaluation**

Pawson and Tilley's (1997) formulation of their realistic evaluation framework stemmed from a primary criticism of experimental evaluation of social programmes that was, in part, related to the struggle to control variables. In addition, they argued that coming to a judgement as to whether a programme 'works' is partly dependent on the criterion for 'success', which were all issues that I had encountered during the phase of considering a quasi-experimental study. Furthermore Pawson and Tilley (1997) contended that programmes should not be treated as an independent 'variable' or 'treatment', rather 'complex processes of human understanding and interaction' (p.17). They claimed that whatever the programme, it will 'work' through a process of reasoning, change, influence or negotiation. Consequentially the focus of the evaluation shifts from outputs to processes with the centre of attention being on wider stakeholders rather than simply experimental and control groups.

Criticism of traditional scientific approaches to evaluative research had also been made by a number of the early nursing proponents of realistic evaluation, particularly those that were exploring practice development initiatives in the late 1990s and early 2000s. In an early critique of Pawson and Tilley's (1997) work, Tolson (1999, p.383) suggested that realistic evaluation was borne out of desire to move away from an 'over indulgence on epistemological correctness' and in the search for a design that combined methodological rigour with context specific application. Redfern, Christian and Norman (2003) undertook a critical reflection of three evaluation studies they had undertaken in the

1990s and in doing so synthesized a range of views of social researchers who promoted a social constructivist approach. They also argued that traditional evaluation studies raise problems, due to concerns about outcome measures, the control of influencing variables, process monitoring and the inadequacy of causal epistemology within experimental designs. Tolson (1999) went as far as suggesting that realistic evaluation offered 'unparalleled opportunities' (p.381) for nurse researchers to engage in defining best practice, implementing and evaluating change. She went on to acknowledge that at that stage the methodological rules for conducting realistic evaluation were still emerging, but suggested that its complexity would ease as its application matured and its practice was documented.

Rycroft-Malone et al. (2011) more recently emphasised the importance of the underpinning philosophy of realism on the grounds that it recognises reality as a construction of social processes. Realists, therefore, attempt to understand complex social interactions/interventions. Referring back to Pawson and Tilley's (1997) text, Rycroft-Malone et al. (2011) emphasised that complex social interventions are comprised of theories; involve the actions of people; consist of a chain of steps or processes that interact and are rarely linear; are embedded in social systems; are prone to modification; and exist in open, dynamic, systems that change through learning. All conditions that I believe resonate strongly with the LCC Programme. The focus of their own study is not wholly dissimilar to the LCC Programme in that it involves an academic and clinical partnership, the Collaborations for Leadership in Applied Health Research and Care (CLAHRC), which is focussed on implementation of health research. Rycroft-Malone et al. (2011) suggested that realistic evaluation is particularly useful for capturing contextual influences and changes at multiple levels over time because of the cyclical approach to evaluation.

Amongst the growing number of study protocols being published using realistic evaluation, Pommier et al. (2010 p.2) summarised three guiding aims of the framework:

1. 'To understand the mechanisms through which a programme's interventions produce change;



2. To understand the contextual conditions necessary to trigger these mechanisms;
3. To develop outcome prediction patterns according to the context and mechanisms triggered’.

#### **4.5.2 Theory-led evaluation**

What distinguishes realistic evaluation from methods-led approaches (such as randomised controlled trials, qualitative methods and mixed-method approaches) is that the evaluation is *theory-led* and begins from a viewpoint that examines constituent theories influencing the programme under investigation in terms of context, mechanisms and outcomes. In a systematic review of theory-driven evaluation practice from 1990 to 2009, Coryn et al. (2011 p.4) defined theory-driven evaluation as:

Any evaluation strategy or approach that explicitly integrates and uses stakeholder, social science, some combination of, or other types of theories in conceptualizing, designing, conducting, interpreting, and applying an evaluation.

A number of healthcare policy units including the Manchester Business School, University of Manchester (Walshe, 2007), Health Services Management Centre, University of Birmingham (Dickinson, 2006) and NHS Health Scotland and University of Glasgow (Blamey & Mackenzie, 2010) advocate the use of theory-led evaluation in order to effectively evaluate complex policy and practice. Pawson and Tilley’s (1997) realistic evaluation is generally presented as one of the leading models of theory-led evaluation, along with the Aspen Institute’s ‘Theories of Change’ framework (Fullbright-Anderson, Kubisch & Connell, 1998).

In an opinion piece on the need for theory-driven research in healthcare, Walshe (2007) argues that the research methods need to consider the content of the intervention, the context of the intervention, the processes (mechanisms) applied and the nature of the results or outcomes. He argues that the findings from such an inquiry may indicate low variance (homogeneity) or high variance (heterogeneity). If the findings reveal homogeneity, he suggests it points to the potential for experimental methods being *subsequently* [my italics] applied that can ‘prove’ causality and a theoretical

basis for the intervention. However, if there is high variance in one or more of the above domains the value of an experiment is less clear because the variance reduces or eliminates the ability to generalise. Accepting this premise, he proposes that in this situation it is the theoretical basis (why and how something works) that becomes more important than its empirical performance (whether it works). Walshe (2007) goes on to suggest that the first stage of a realistic evaluation approach is to map out the programme theory lying behind the intervention and then design the evaluation. The purpose of the evaluation, therefore, becomes to establish when, how and why it works and to unpick the complex relationships between context, content, application and outcomes and to develop necessary contingent and situational understanding of effectiveness.

#### **4.5.3 'Folk theories'**

In their original text, Pawson and Tilley (1997) argued that whilst theory formation and development are part of the research process, the researcher is likely to come into the evaluation armed with rudimentary theory about the programme mechanisms. This might include what it is about the programme that might generate change and in what sort of settings and in what conditions might these initiatives be successful. They described the outcome of this initial exploration as the generation of 'folk theories' that should be explored at the outset with key stakeholders as part of the qualitative investigation and subsequently used to interrogate a range of data related to expected and actual outcomes.

Within the context of the LCC Programme, I came into this study with the knowledge of there being a range of international evidence that had investigated system, organisational, team and individual factors that influence the delivery of optimal nursing care within health settings. Accordingly, the concept of theory-led research and the generation of 'folk theories' within this paradigm resonated strongly with my renewed perspective on the research design. Table 9 overleaf and on the next page illustrates a summary of the range of 'folk theories' that influenced my thinking at the outset and during the data collection phase of the study.

**Table 9: ‘Folk theories’ informing the realistic evaluation research design**

‘Folk Theory’	Author(s)	Principal message(s)
Change management approaches	Marchionni & Ritchie, 2008; Powell et al., 2009.	<ul style="list-style-type: none"> <li>• Transactional – change based on sanctions and compliance.</li> <li>• Transformational – change based on values and involvement.</li> <li>• Sustained involvement of managers to ensure alignment with strategic objectives.</li> </ul>
Impact of workplace demands	Ramunujam, Abrahamson & Anderson, 2008; Patterson et al., 2010a.	<ul style="list-style-type: none"> <li>• Impact on nurses’ perceptions of patient safety.</li> <li>• Pressures within acute hospitals</li> <li>• Focus on targets and ‘patient flow’</li> </ul>
Implementation of evidence into practice	Kitson et al., 1998.	<ul style="list-style-type: none"> <li>• PARIHS Framework<sup>40</sup> – interplay of context, facilitation and evidence.</li> </ul>
Influence of the work environment	Aiken et al., 2008b; Van Bogaert et al., 2009; Burston & Stitchler, 2010.	<ul style="list-style-type: none"> <li>• Better hospital care environments associated with more positive job experiences, fewer concerns with care quality. In such environments patients have significantly lower risks of death and failure to rescue.</li> </ul>
Role of leadership	Alimo-Metcalf et al., 2007; Wong & Cummings, 2007; Marchionni & Ritchie, 2008; Caruana, 2008; Cummings et al., 2010.	<ul style="list-style-type: none"> <li>• Relationship between leadership and staff attitudes and well-being</li> <li>• Role of Senior Charge Nurse/Ward Manager</li> <li>• Influence of transformational leadership and embedded change.</li> </ul>

<sup>40</sup> The PARIHS Framework was discussed in Section 1.4.

**Table 9: ‘Folk theories’ informing the realistic evaluation research design (continued)**

‘Folk Theory’	Author(s)	Principal message(s)
Role of practice development in creating person-centred care and culture	Manley, McCormack & Wilson, 2008.	<ul style="list-style-type: none"> <li>• Practice development as a systematic process of transformative action.</li> <li>• Focuses on changing people and practice rather than just systems and processes.</li> </ul>
Teamwork	Rafferty et al., 2001; Meterko, Mohr & Young, 2004.	<ul style="list-style-type: none"> <li>• Quality of task-related and social interactions.</li> <li>• Impact on health outcomes, staff experience and performance.</li> <li>• Positive relationship between teamwork and patient satisfaction.</li> </ul>
Work/organisational culture	Kitson, 2008; Aiken et al. 2008a; Youngsen, 2008; Patterson et al., 2010a; Kirkley et al., 2011.	<ul style="list-style-type: none"> <li>• Organisational culture as key to health quality and performance in NHS</li> <li>• Different managerial and professional sub-cultures</li> <li>• Staff need to be respected and valued</li> <li>• Successful innovation is a function of the level of local autonomy experienced by individuals, teams and the unit involved;</li> <li>• Innovation is most effective when it involves key stakeholders</li> </ul>
Working in complex health systems	Kitson, 2008; McCormack et al., 2008; Patterson et al., 2010a.	<ul style="list-style-type: none"> <li>• Healthcare system best considered as a complex entity;</li> <li>• Policy does not always consider complex processes needed to turn vision into reality.</li> </ul>

I recognised that these factors are relevant at a macro, meso and micro level. I ensured, therefore, in constructing my topic guides for the semi structured interviews and focus group<sup>41</sup> that, whilst not explicitly directing my participants to the potential influence of these factors on the implementation of the programme that I asked sufficiently open questions about facilitators and barriers that, where relevant, could either refute or support the literature<sup>42</sup>.

In her critical review of the evaluation of health and social care partnerships, Dickinson (2006) cites Davies (2000), when she suggested that rather than inferring causation from the inputs and the outputs of a programme, theory-led evaluation aims to map out the entire process, and through this to say with confidence which parts of a programme worked and why. Furthermore, Davies (2000) argued that through taking a theory-led approach it is possible to say whether they would be applicable to different situations, and if there are any positive or negative effects which otherwise would not be anticipated. Wand, White and Patching (2011) endorsed this perspective and also argued that unless evaluation can illuminate how a particular programme works practitioners can be left with little guidance on how to adapt programmes for specific circumstances and settings.

#### **4.5.4 Importance of context**

Like Dickinson (2006), Blamey and Mackenzie (2007) compared 'Theories of Change' (Fullbright-Anderson, Kubisch & Connell, 1998) and 'Realistic Evaluation' (Pawson & Tilley, 1997) as the two current favoured ways of applying theory-based evaluation in the UK. They suggested that these two

---

<sup>41</sup> These are discussed more fully in Section 4.9.3 and the schedules are presented in Appendix 2.

<sup>42</sup> Subsequent to my data collection and analysis the University of Birmingham Health Management Centre produced a policy paper 'Time to Care? Responding to concerns about poor nursing care.' (Health Service Management Centre, University of Birmingham, 2011) that focused on three themes to provide a framework for an examination of the issues in more detail. This included a review of the literature and identification of actions to address concerns. The three themes were:

- Environment of care
- Education and development
- Emotional labour of care.

The key messages of this paper carried strong resonance with my synthesis of the literature on evidence on care deficits and responses outlined in Chapter Two as well as the influencing factors that I have summarised in Table 9. The most important elements that I feel relate to my 'folk theories' were the role of the charge nurse as leader and the need for systematic support for nurses in recognition of the emotional labour of nursing that was discussed in Section 3.21.

methodologies have emerged to fulfil a deficit in policy and programme evaluation, which have arisen as a result of the former concentration on quasi-experimental designs. They argued that although policy makers are ultimately concerned with efficacy, questions around the value of a programme or initiative are difficult to answer where context is identified as a unified entity through which recipients are 'processed' or a presumption that the evaluator can control confounding variables. By contrast, they contended that in theory-based evaluations programmes are not seen as 'monoliths' and people are not seen as 'passive recipients' (p.440). Context is seen as absolutely crucial in understanding the interplay between the programme and its effects. Given that context is multifaceted at a variety of levels (political, social, organisational and individual) they advocated that it is important to examine what these variations might be. Moreover, Blamey and Mackenzie (2007 p.441) argued that identifying and delineating such variations can become the 'key ingredients in the mix' for future recommendations for policy and practice.

#### **4.5.5 Generation of 'middle range theory'**

Blamey and Mackenzie (2007) pose the question of 'what is meant by theory?' (p.442) and suggested that it is used in a variety of ways within different theory-based approaches, with a resultant lack of consistency in how different type of theory are described. They considered that there are two discrete conceptualisations of theory: one relates to the hypothesised links between a programme's activities and its anticipated outcomes, or what is required to translate objectives into ongoing service delivery (implementation theory); and second the hypothesized links between mechanisms released by an intervention and their anticipated outcomes (programme theory). Blamey and Mackenzie went on to suggest that realistic evaluation attempts to uncover elements of both 'implementation' and 'programme' theory', but with a stronger emphasis on the latter. Such theory, rather than being concerned with the 'nuts and bolts' of the programme, is more concerned with psychological and motivational responses leading to behaviour change. They go on to argue that the explanatory theory sought by Pawson and Tilley (through the determination of CMO configurations), becomes a generalisable mechanism that explains why an individual or group of individuals (within a particular context) respond in a particular and relatively predictable way to an intervention (or aspect of an

intervention). Having determined CMO configurations in this way, these become testable theories, or 'middle range' theories, which are often put forward as the 'outputs' of such studies.

In their analysis of evaluation of mental health programmes, Wand, White and Patching (2011) argued that it is through this potential to generate 'middle range theories' that realistic evaluation seeks to explain successful programmes and provide transferrable lessons for elsewhere. Byng, Norman and Redfern (2005) discussed the importance of analysing CMO configurations across cases to create generalisations to form such middle range theory. This they suggested involves two-stage analysis; the first in terms of coding of individual cases to allow the development of CMO configurations and the second to generalise across cases. The resultant middle-range theories they argued can be reframed as hypotheses or 'conjectured middle range theories', which are potentially of use to practitioners and policy makers.

#### **4.5.6 Examining CMO configurations**

Pawson and Tilley (2007 p.55) laid claim to being the first proponents of evaluation that rests on realist principles. They explained these as focusing on understanding the principles of 'generative causation' which stress 'mechanics of explanation' in order to articulate how things within social systems change. They contended that careful enunciation of this theory is the 'pre-requisite to sound evaluation' and proposed this through the use of CMO configurations:

Outcome = Mechanism + Context

$$O = M + C$$

The task of realistic evaluation, they argued, is to find ways of identifying, articulating, testing and refining 'conjectured' CMO configurations. Once a study has been conducted Pawson and Tilley (1997) describe the actual findings as stemming from them as the 'refined' CMOs.

Central to this model is the concept of 'embeddedness', which Pawson and Tilley advised reflects the stratified nature of social reality. Actions within the social programme are seen as making sense because they contain inbuilt

assumptions about a wider set of 'social rules' and institutions, which in turn influence both mechanisms and context within the CMO configuration.

*My reflective notes recorded in December 2007 indicated that I saw the following issues as influencing such social rules: nurse-patient interactions; organisational pressures such as waiting times and patient turnover; local nursing philosophy, leadership of the Charge Nurse and the history of individual wards/departments themselves.*

#### **4.5.7 Mechanisms**

Pawson and Tilley (1997) differentiated two forms of mechanisms: the first explanatory/underlying mechanisms, which they suggested often explain how things work by going beneath their surface appearances and delving into their inner workings, which can be at a macro and micro level. This is perhaps where the 'folk theories' I linked to the LCC Programme previously highlighted come into play. The second are described as programme mechanisms, linked directly to the 'intervention' under investigation. Such mechanisms are those specifically aligned with the LCC Programme through the appreciative inquiry, action research and practice development techniques. Pawson and Tilley (1997) proposed that it is through the notion of programme mechanisms that researchers take a step from asking whether a programme works to understanding 'what it is about a programme which makes it work?' (p.66). Within this process they suggested that they would expect programme mechanisms to do the following:

1. reflect the embeddedness of the programme within the stratified nature of social reality.
2. take the form of propositions which provide account of how micro and macro processes constitute the programme.
3. demonstrate how programme outputs follow the stakeholder choices (reasoning) and their capacity (resources) to put these into practice.

Furthermore they stressed that a mechanism 'is not a variable but an account of the makeup of behaviours and interrelationships of those mechanisms, which are responsible for the outcome' (p.168). Pawson and Tilley (1997) identified the need to illuminate the mechanisms for change that were triggered by the programme and how they counteract the existing social



processes. This involves 'disentangling' the range of mechanisms that sustained the original problem as well as the mechanisms that were 'fired' within the programme (p.75). Furthermore they went on to emphasise that it is important to recognise that the context itself is unlikely to change, arguing that it is a social programme that is being evaluated, rather than a social movement (p.76).

#### **4.5.8 Regularity**

Whilst there is an emphasis on outcomes within the CMO configuration, Pawson and Tilley (1997) also used the term *regularity*, which led them to adapt the formula above to:

$$\text{Regularity} = \text{mechanism} + \text{context}$$

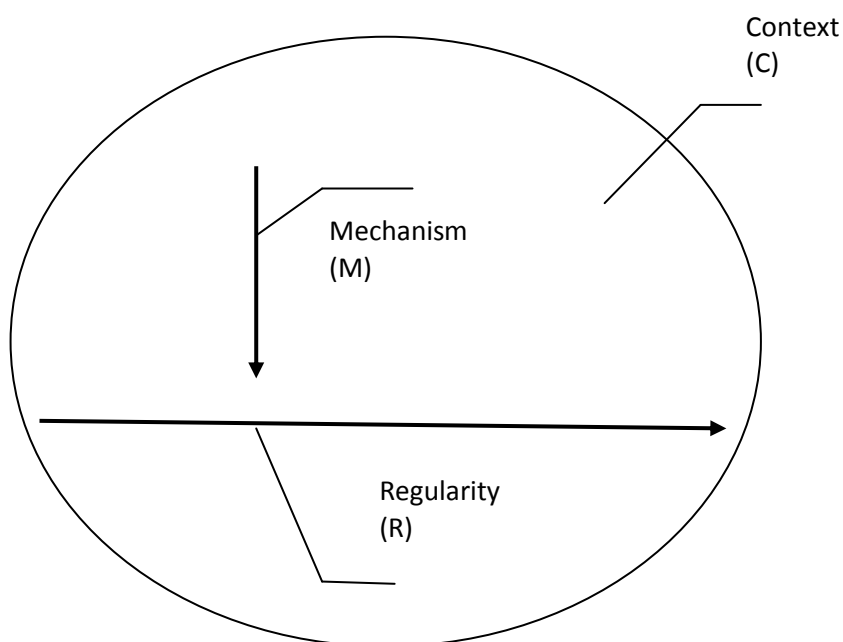
They went on to summarise that the basic logic of realist explanation is as follows:

The basic task of social inquiry is to explain interesting, puzzling, socially significant regularities (R). Explanation takes the form of positing some underlying mechanism (M) which generates the regularity and thus consists of propositions about how the interplay between structure and agency has constituted the regularity. Within realist investigation there is also investigation of how the workings of such mechanisms are contingent and conditional, and those only fired in particular local, historical or institutional contexts (C).

(Pawson and Tilley, 2007 p.71)

Pawson and Tilley (1997) represented this diagrammatically in Figure 4 (overleaf) where they illustrated the shift in regularity as a result of the mechanism(s) involved in the social programme. This diagram will be used in Chapter Six: Section 6.3 as a means of summarising a realist perspective of each of the eight case studies following the narrative description of the findings.

**Figure 4: Basic ingredients of realist social explanation (Pawson and Tilley, 1997 p.72)**



The process of data collection and analysis leads to the generation of refined CMOs, which Pawson and Tilley suggested should form the basis of hypothesis making. They went on to argue that such hypotheses should permit the programme to be broken down so that it is possible to identify:

- a) what it is about the programme that might produce change;
- b) which individuals/subgroups and locations might benefit most readily from the programme;
- c) which cultural and social resources are necessary to sustain the change.

(1997 p.85).

#### **4.6 Use of realistic evaluation in healthcare**

Pawson and Tilley's (1997) own application of realistic evaluation was primarily in the field of criminology, for example in community policing and use of CCTV in car parks. During the last decade realistic evaluation has become increasingly recognised within health services research. There is a strong tradition of methods-based research in clinical/medical research, with a focus on the evidence-based practice hierarchies that hold randomised controlled trials as the gold standard (Sackett et al., 1996). However, in a *British Medical Journal* editorial reviewing the Medical Research Council's (MRC, 2008)

guidance on evaluating complex interventions, there was criticism that the guidance lacked explicit recognition of the potential of theory-based evaluation approaches (Anderson, 2008). It was acknowledged that interest in such approaches had increased considerably following the publication of Pawson and Tilley's original realistic evaluation text in 1997.

There has been a demonstrable rise in the number of evaluative studies in healthcare that have adopted a realistic evaluation framework in the past 10 years. Early studies included those by Redfern, Christian and Norman (2003) who evaluated nine separate practice development projects in South Thames in England and a subsequent evaluation of primary healthcare interventions for patients with a long term mental illness by members of the same research team (Byng, Norman & Redfern 2005). In Scotland Tolson et al. (2007) used realistic evaluation (Pawson & Tilley 1997) to evaluate the establishment of a Scottish Palliative Care Managed Clinical Network, whilst MacDuff and West (2005) adopted it for the evaluation of a high profile policy initiative involving the introduction of Family Health Nurses in some of the remote and rural areas of the country. Internationally, realistic evaluation has been used as the underpinning methodology for a number of studies including one by Wilson, McCormack and Ives (2005) examining workplace culture within an Australian special care nursery and a study evaluating the impact of a Canadian computerised information system on nurses' clinical practice (Oroviogicochea & Watson 2009). The latter two illustrate the diversity of subject area that can be explored using this methodology. In the last three years the number of studies utilising realistic evaluation (Pawson & Tilley 1997) has grown considerably with a clear focus on health services research that focuses on care pathways, service redesign and implementation of evidence. Examples include the work of Wand, White and Patching (2010) who evaluated the introduction of nurse-led mental health clinics in an Australian emergency department; a study by Manzano-Santaella (2011) examining the introduction of fines in relation to delayed discharges in hospitals in England; and a UK-wide study currently underway that is evaluating the implementation of health research through the introduction of an initiative in England known as the Collaboration for Leadership in Applied

Health Research and Care (CLAHRC) designed to integrate research and practice between higher education and the NHS (Rycroft-Malone et al., 2011).

The methods adopted within the studies vary considerably, although they tend to be mixed methods. Whilst many studies purport to have adopted a realistic evaluation framework, it is noteworthy that only a few present a detailed overview of their theoretical framework other than attention to context, mechanisms and outcomes nor a detailed analysis of CMO configurations leading to middle range theories.

#### **4.7 How to conduct realistic evaluation**

In the original text Pawson and Tilley (1997) were not prescriptive in terms of how to conduct a realistic evaluation. They acknowledged that when it comes to choice of method, realistic evaluation can be based on methodological pluralism and thus the tendency to mixed methods as indicated above. They did, however, provide a set of 'New Rules for Realistic Evaluation' (p.215-219), that focused on a set of principles which are outlined below along with my reflective notes as I was considering my research design.

##### **Rule 1: Generative causation**

Pawson and Tilley (1997) argued that realists do not conceive that programmes 'work' rather it is the actions of stakeholders that make them work, based on the causal potential for participants to change. They suggest that capacity for change is only triggered in conducive circumstances; therefore there is a need to understand the conditions required for this causal potential to be released and then to examine whether it has been released in practice.

*Implications for my own study: Importance of identification of an appropriate stakeholder sample (Section 4.10.1) that are in a position to build on my existing knowledge of the reasons and resources likely to influence participants; consideration of appropriate research techniques – semi-structured interviews and observation/participation in events; questions to elicit insight into capacity for change.*

##### **Rule 2: Ontological depth**

Pawson and Tilley (1997) argued that interventions are embedded in a range of attitudinal, individual, institutional and societal processes and therefore

researchers need to examine these within their inquiry. Programme outcomes are, therefore, generated by a range of macro and micro social forces. Stakeholder's capacity for making choices is subject to the prevailing social constraints and are always limited by the power and resources associated with their position. Programme evaluators need, therefore, to understand how the changes introduced inform and alter the balance of constrained choices of the participants.

*Implications for my own study: Recognising the benefits of my insider-outsider position in contextualising the embeddedness of the Programme processes alongside the macro, meso and micro forces that may influence such 'constrained choices'.*

### **Rule 3: Mechanisms**

Researchers need to focus on how the causal mechanisms which generated the need for the programme are removed or countered through alternative causal mechanisms introduced in the social programme. There is a need, therefore, to understand why a programme works through an understanding of the actions of the mechanisms and the choices and capacities of the stakeholders that lead to new regular patterns of social behaviour. A key aspect of the evaluation design is to anticipate the diversity of the potential programme mechanisms involved and a key analytical task is to discover whether they have disabled or circumvented the mechanisms responsible for the need for the original 'social programme'.

*Implications for my own study: Based on the LCC Programme design, the opportunity to take on a case study analysis of the 4 Beacon Wards and 4 Development Sites to explore these issues across diversity of specialty, skill mix, leadership and acuity.*

### **Rule 4: Contexts**

Researchers need to understand the contexts within which the problem mechanisms are activated and in which the programme mechanisms are successfully fired. Subjects will only act on resources and choices offered by a programme if they are in conducive settings. Context should be seen both as spatial and institutional locations as well as the norms, values and inter-relationships found within.

*Implications for my own study: Recognition of diversity within the meaning of context in the complex hospital environments. The importance of understanding the underlying contexts to the overall LCC Programme as well as the individual contexts within each study site.*

**Rule 5: Outcomes**

There is a need to understand what the outcomes of an initiative are and how they are produced. In recognition that there will be multiple outcomes and that the outcomes are not inspected simply to see if the programme works but are analysed to discover if the conjectured mechanisms and context theories are confirmed.

*Implications for my own study: Within my study design there is a need to focus on outcomes within all elements of data collection within the thematic analysis. It will become important to ensure the outcomes are delineated for each of the case study wards.*

**Rule 6: CMO Configurations**

A CMO configuration is a proposition stating what it is about a programme which works for whom in what circumstances. Conjectured CMO is the starting point and the refined CMO is the finding of an evaluation.

*Implications for my own study: Prior to data collection there is a need to articulate my own conjectured CMO configuration.*

<b>Context</b>	<b>Mechanisms</b>	<b>Outcomes</b>
<p><i>Macro – leadership, financial position, targets</i></p> <p><i>Meso – management support</i></p> <p><i>Micro – leadership of Senior Charge Nurse, facilitation style of Senior Nurses, acceptance/engagement of staff</i></p>	<p><i>Culture</i></p> <p><i>Inter-professional relationships</i></p> <p><i>Make up of practice development processes</i></p> <p><i>Establishment of trust between the LCC Team and Programme participants.</i></p>	<p><i>Understanding of compassionate care</i></p> <p><i>Increase focus on compassion at macro and micro levels</i></p> <p><i>Specific outcomes at organisational and individual levels for staff, patients and relatives.</i></p> <p><i>Discrete practice development initiatives with potential to share best practice</i></p>

### **Rule 7: Teacher-learner process**

In order to construct and test CMO pattern explanations there is a need to engage in teacher-learning relationships with programme policy makers, practitioners and participants. There should not be an assumption that stakeholders act as 'respondents providing answers to predetermined questions, or that the researcher's task is the faithful 'reproduction' of the views of stakeholders.

The division of expertise between researcher and respondent becomes a teacher-learner relationship in which the medium of exchange is CMO theory and the function of the relationship is to refine the CMO theories.

*Implications for my own study: This was more difficult to grasp initially. My understanding came to rest through reflecting on my insider-outsider relationship previously articulated – as a researcher, but also with an insider relationship to the majority of the research subjects and also insight into the processes and work of the LCC Team. My teacher role linked specifically to my academic study and critical review of the literature presented in Chapters Two and Three, as well as subsequent integration of evidence from concurrent data collection and analysis and presented in the discussion.*

### **Rule 8: Open Systems**

Programmes are implemented in a changing and permeable social world, therefore the programme's effectiveness may be subverted or enhanced through unanticipated 'intrusions', new contexts or new causal powers.

*Implications for my own study: Recognition of the inevitability of this in real world research with the benefit of my own position in seeing potential 'intrusions' coming.*

In their critique of theory-based research, Blamey and Mackenzie (2007 p.444) acknowledged that there are no set steps for a realistic evaluation, but they offered a 'map' with four main components that the researcher should follow:

1. Hold dialogue with the programme implementers to understand the nature of the social programme. This should include the aims, the nature of the target population, the context and settings and the prevailing theories on the issues.

2. Map out a series of mini theories that relate to the various contexts of a programme to the multiple mechanisms by which it might operate to produce different outcomes.
3. Undertake an 'outcomes enquiry' in relation to these mini theories. This involves building up a quantitative and qualitative picture of the programme in action.
4. Through an exploration of how context, mechanism and outcome (CMO) configurations play out within the programme, refine and develop tentative theories of what works for who in what circumstances.

Given my position within the organisation I felt that was in an optimal position to follow Blamey and Mackenzie's recommendations.

#### **4.8 Realistic evaluation and the Leadership in Compassionate Care Programme**

The realistic tradition is very much centred on applied research undertaken to inform the thinking of policy makers, practitioners, participants and the public, with the concept of stakeholders being fundamental to both method and projected outputs. As previously stated one of the underpinning features is the recognition of the intervention as being a 'social programme'. Pawson and Tilley (1997) presented the concept of social programmes as those that are designed to deal with 'social problems' and are based on ideas that are located in a specific time and place. Chapter Two delineated a range of perspectives that firmly positioned the delivery of compassionate care (or a perception of a diminution of its routine presence in contemporary healthcare delivery) as being a 'problem'.

##### **4.8.1 Social Programmes**

Pawson and Tilley (1997 p.65) identified social programmes as a complex interplay of 'its personnel, its place, its past and its prospects'. They put forward that an essential feature of the realistic tradition is the recognition that social programmes:

- seek to change existing processes,
- involve interplay between individual and institution,
- are essentially built around social interactions that create interdependencies which develop into custom and practice.



Such custom and practice, they described as the 'emergent processes' that social programmes seek to change (Pawson and Tilley, 1997 p. xiii). Given the rationale for the LCC Programme being a perception that compassionate care was 'problematic' in some quarters at least, coupled with the broader concerns both locally and nationally regarding care delivery it was possible at the outset of this study in 2008 to match the LCC Programme to these criteria in Table 10 overleaf.

**Table 10: Mapping the essential features of social programmes to the rationale for the LCC Programme.**

Feature of realistic tradition	LCC Programme
Seeking to change existing processes:	An intention that the action research and practice development methods employed by the LCC Team would lead to changes in a range of processes at different levels: individual, team and organisational.
Interplay between individual and institution:	Practitioners (whether they are members of the clinical teams or the LCC Project Team) operate at all times as individuals but within the structures and processes of a complex organisation. Whilst all registered health professionals are individually accountable for their actions they are nevertheless influenced and bound by organisational regulations and culture.
Social interactions that create interdependencies which develop into custom and practice:	Clinical practice within a hospital environment is chiefly located within multi-professional teams. Ways of working within teams are strongly influenced by the quality and nature of the social interactions between all players. These social interactions also extend to relationships with patients and their relatives. Over time it is possible that ways of working based on these interdependencies become the established norms, whether or not they are in themselves efficacious to the care delivery processes.

#### **4.8.2 Rationale for the research questions**

Pawson and Tilley (1997) argued that to explain outcomes there is a need to first acknowledge the set of mechanisms that sustained the initial problem, including the capacities and choices open to the stakeholders to address the situation. They suggested that the key explanatory resource is to figure out the potential for change as a result of the programme mechanisms, on the basis that programmes are about breaking into existing chains of resources and reasoning which led to the ‘problem’. This was the rationale for the first research question that would be conducted within Phase One of my study.

1. What were the underlying organisational, professional and practice contexts for the Leadership in Compassionate Care Programme?

The remaining four research questions were specifically designed to follow on and were located within the realistic evaluation framework as illustrated below:

2. How is compassionate care recognised and expressed by different participating stakeholders? *Context, Outcomes*
3. What are the views, experiences and perceptions of participating stakeholders of the impact of the Leadership in Compassionate Care Programme? *Context, Mechanisms and Outcomes*
4. How are the mechanisms used in the LCC Programme seen to influence the outcomes in different clinical settings? *Mechanisms*
5. What are the early signs of sustainability of the work of the LCC Programme? *Mechanisms, Outcomes.*

These research questions were designed to provide recommendations for policy and practice in relation to implementing social programmes of this nature, scale and complexity within complex health organisations.

#### **4.9 Research Design**

A qualitative, longitudinal research (QLLR) design was adopted. QLLR was defined by Neale (2010) as qualitative enquiry conducted through time, with that time either being linear or cross sectional. There is no defined structure to QLLR and as Saldana (2003) argued it is important to recognise that each study is context-specific and driven by its particular goals, research questions, conceptual framework and methodology. Holland, Thomson and Henderson (2006) conducted a detailed review of QLLR within social sciences and concluded that it has a strong place as a key method for policy research. They suggested that what is important is the temporal nature of the design, the population under investigation and the waves or phases of the data collection. Given the nature of the LCC Programme, being conducted in three phases over a three-year period it was felt that a longitudinal design was appropriate, as it would permit examination of the CMO configurations prospectively as the Programme was implemented. The longitudinal data collected in each of the wards would allow for both unique and shared insights to emerge.

Whilst making a strong case for the value of QLLR, Neale (2010) recognised the challenges of data collection, analysis and a number of ethical considerations. In terms of data generation she suggested the challenges include maintaining the sample over time, which relies on sustaining relationships. In addition data collection trends tend to be eclectic at the outset because it is impossible to know what data might be important over time. Furthermore Neale (2010) highlighted that even with small samples, QLLR generates very large datasets, and that the data may always have a provisional feel as data collection may go on indefinitely. These were all challenges that I faced and discussed repeatedly with my supervisors, particularly the issue of volume of data.

#### **4.9.1 Key Role of Stakeholders**

The initial starting point for a realistic evaluation study is utilising stakeholder's knowledge, which is generally achieved through semi-structured interviews. The selection of appropriate stakeholders is seen as being fundamental to the success of this strategy and should be based on the recognition that within complex social organisations there is a division of expertise in relation to the specific programme. Pawson and Tilley (1997, p.160) identified four key agents – subjects, practitioners, evaluators and policy makers – who create a set of different but complementary views. Pawson and Tilley (1997, p.161) differentiated the perspectives of three of the stakeholder groups as follows:

- *Subjects* (those on receiving end of the mechanisms) – these are likely to be more sensitive to mechanisms than contexts or outcomes. They will have a very personal view of the programme. Their sensitivity to the influence of context may be very limited since the circumstances in which they encounter the programme will for them be routine and they tend to have the experience of a single journey.
- *Practitioners* (those that translate the programme theories into practice) - they will have specific ideas on what it is within the programme that works (the mechanisms). They are also likely to have experience of successes and failures (outcomes), and have awareness of people and places for whom the programme works (context). However, they cannot be expected to systematically chart what works for whom in what circumstances pathway.

- *Evaluators* (the researcher) tend to carry theories into encounters with the programme. The theories may be well developed or embryonic. They begin with the expectation that the programme will consist of a series of CMO configurations.

#### 4.9.2 Qualitative data collection

Patton (2002) classified three types of qualitative data: interviews, observation and documentation. Interviews were the main source within this study, although as Table 11 below indicates all types were used in order to examine both conjectured and refined CMOs and answer the research questions.

**Table 11: Types of data collection methods used within the study and their link to CMO configurations**

Type of data (Patton 2002)	Examples within study	Link to CMO configurations
Interviews – open-ended questions to yield in-depth responses about people’s experiences, perceptions, opinions, feelings and knowledge. Data consist of verbatim quotations with sufficient context to be interpretable.	Semi structured interviews and focus groups (outlined in Table 12, Section 4.10.2)	Identification of context and the nature of the social problem  Conjectured and refined CMOs
Observation – fieldwork descriptions of activities, behaviour, actions, conversations, interpersonal interactions, organisational or community processes or any other aspects of observable human experience. Data consists of field notes: rich detailed descriptions including the context in which observations were made.	Although not used extensively there were opportunities for observation within the participating clinical settings. All interviews and focus groups were conducted in the natural setting and in each case a ‘conducted tour’ of the ward/department was given by the subject.  Observation also took place during meetings, seminars and conferences detailed in Section 4.12.	Refined CMOs
Documents – written materials and other materials from organisational records, memoranda or correspondence and published reports. Data consists of excerpts captured in a way that records and preserves context.	Portfolios submitted by the Beacon Wards and Development Sites as part of their application process for inclusion in the LCC Programme.  Documents written by the LCC Team during their process of data analysis and development of their analytic framework for compassionate care detailed in Section 1.4.4.	Refined CMOs

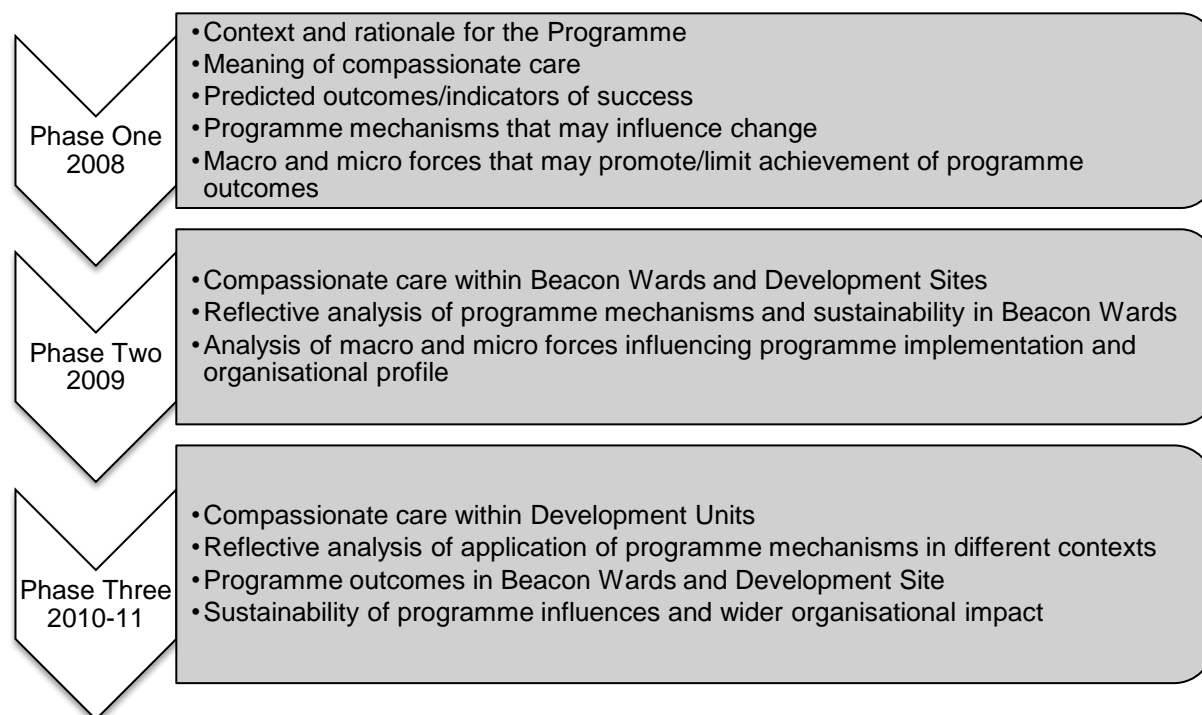
A pilot semi-structured interview was undertaken with a trusted colleague who had no direct involvement in the LCC Programme but was aware of its existence and the issues that had led up to its instigation<sup>43</sup>.

### 4.9.3 Phases of the research

Given the nature of the LCC Programme the longitudinal design involved data collection in three phases over the three years between April 2008 and April 2011. Each phase mirrored the progression of the LCC Programme through the Beacon Wards, Development Sites and Development Units with semi-structured interviews or focus groups conducted with the different stakeholders (detailed in Table 12, Section 4.10.2).

The five research questions outlined in Section 4.8.2 formed the basis of investigation during each phase. The focus of inquiry, however, shifted to reflect the progression of the Programme itself, moving from implementation of the Programme mechanisms to outcomes and finally issues of sustainability. The focus of inquiry in each of the three Phases is illustrated in Figure 5 below.

**Figure 5: Focus of inquiry in each of three phases of data collection**



<sup>43</sup> *My reflective notes at the time indicated that the interview felt comfortable and that I had kept well to the interview guide. I was pleased that the interviewee had responded well to the open questions and that I had been able to probe these. This interview lasted approximately one hour, which is what I had been expecting.*

The interview schedules for each Phase and stakeholder group are outlined in Appendix 2.

#### **4.9.4 Sampling**

Pawson and Tilley (1997) emphasised that sampling of stakeholders is crucial in recognition of the division and hierarchy of expertise across stakeholders in a programme, therefore, there was a need to have careful mapping of 'who knows best'. Green and Thorogood (2009) emphasise that the aim of a sampling strategy is to maximize the opportunity of producing enough data to answer the research questions. To this end sampling was purposive, based around the implementation of the LCC Programme itself and the categories of stakeholder groups delineated in the realistic evaluation framework (Pawson and Tilley 1997). Figure 6 overleaf outlines the three phases of data collection along with the sample profile within the following three stakeholder groups:

- **Subjects** (those on the receiving end of the mechanisms) - Charge Nurses and Clinical Nurse Managers in four groupings:
  - Beacon Wards
  - Development Sites
  - Development Units
  - 'Other Wards'.

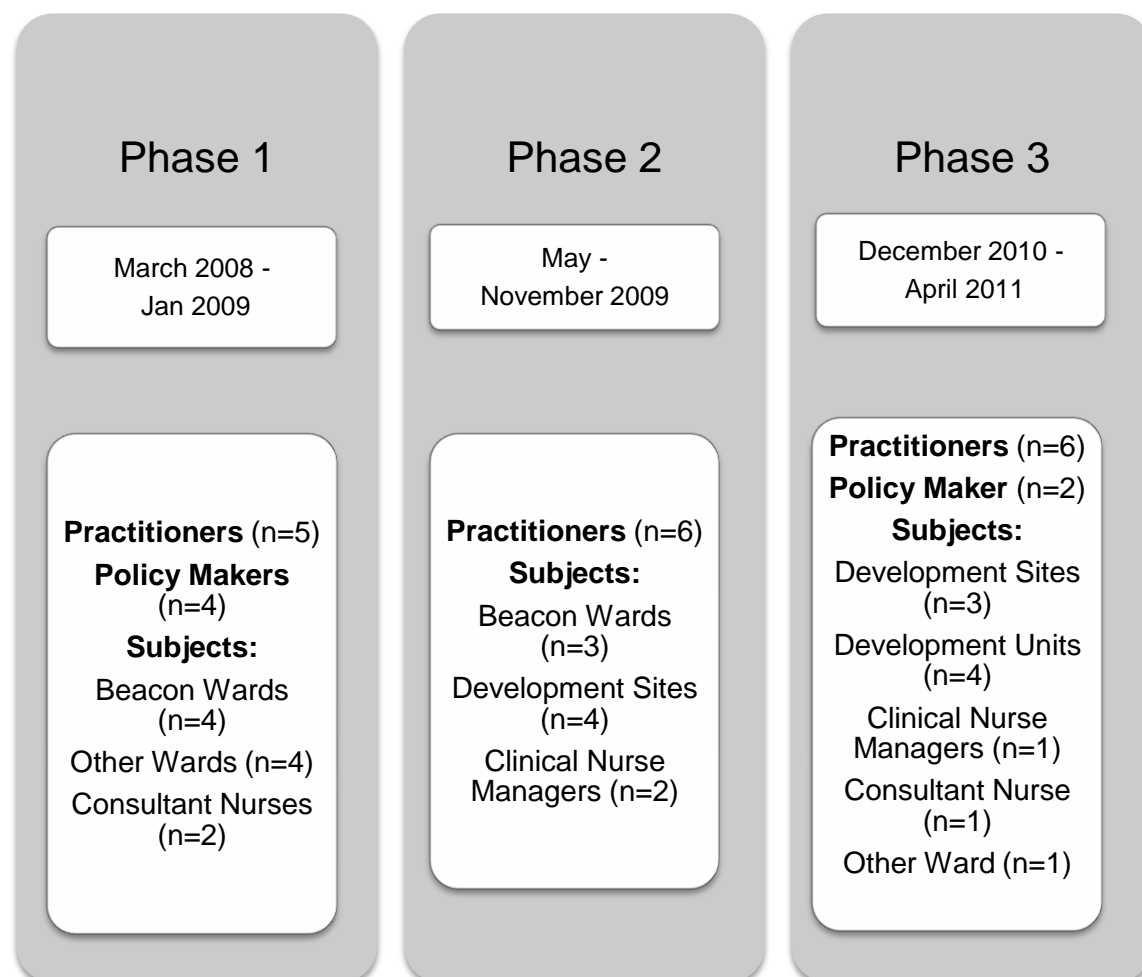
Two Consultant Nurses who had no direct involvement in the Programme .

- **Practitioners** (those responsible for translating the programme mechanisms into action) – Lead Nurse in Compassionate Care and Senior Nurses Compassionate Care.
- **Policy Makers** (those who agree or initiate a programme) – members of the Project Executive Board and Operational Steering Committee.

The rationale for the inclusion of 'Other' wards was to permit examination of the perceptions of the need for and subsequent impact of the LCC Programme on the wider organisation through seeking the perspectives of Charge Nurses who, at the outset at least, were not directly engaged with the Programme. In addition to gauge a broader organisational perspective of nurses working at both strategic and operational levels and yet unconnected to the Programme

directly two consultant nurses were recruited as part of the Subject Stakeholder group.

**Figure 6: Profile of stakeholder sample groups within each phase of data collection.**



#### 4.9.5 Recruitment

Research subjects from the Practitioner and Policymaker stakeholder groups were recruited by virtue of their position in the Programme. I approached them directly with the subject information sheet and gave them 24 hours to consider their participation before arranging an interview date. All agreed to participate. The Charge Nurses from the Beacon Wards and Development Sites were also approached directly. The two consultant nurses were selected from a possible group of ten on the basis that they represented very different specialities and settings that would give a contrasting perspective of the organisation.

Recruitment of the 'Other' wards was undertaken indirectly through an email via line management structures in the organisation. A poster was emailed to



Chief Nurses and Clinical Nurse Managers with a request that these be circulated to Charge Nurses. This was an open invitation to become involved in the study with an explanation that the focus was on the views of the Charge Nurses rather than a focus on the care delivery within their own wards. Four Charge Nurses came forward and volunteered to take part. They came from three different hospitals and contrasting settings including a general medical, general surgical, medicine of the elderly and a regional speciality unit.

Charge Nurses from the 5 Development Units (n=18) were contacted by email and invited to participate in a focus group for each setting. The response was poor, with a number declining participation and others not responding. Follow up yielded four respondents, and in addition the Clinical Nurse Manager for the surgical unit was invited to participate since none of the Charge Nurses from that setting had responded. She agreed to take part. In the end only two of the Charge Nurses from the Development Units were seen, one as part of an informal visit to the setting and the other a visit and semi-structured interview. The reason for the poor response to the invitation was discussed with both the LCC Team and the respective Clinical Nurse Managers. They all agreed that, to some degree, the Charge Nurses felt overwhelmed with initiatives, audits and evaluations as well as the day to day running of their wards/departments. In addition to participating in the LCC Programme all were simultaneously implementing Releasing Time to Care™ (NHS Institute of Innovation and Improvement 2006-2012), elements of the Scottish Patient Safety Programme (NHS Scotland 2012) and had recently participated in Leading Better Care (Scottish Government 2008a) and were now focussing on evidencing Clinical Quality Indicators and a range of efficiency measures.

Table 12 overleaf describes the overall sample for semi-structured interviews or focus groups, along with the number of interviews each individual participated in and the pseudonym adopted for the findings. This is followed by an explanation of the variation in number of interviews amongst the study sample.

**Table 12: Study sample including number of interviews and pseudonym**

Stakeholder Group		No. of Interviews	Phase of Data Collection	Pseudonym
1.	Policy Maker 1	1	1	Susan
2.	Policy Maker 2	1	1	Molly
3.	Policy Maker 3	2	1, 3	Jack
4.	Policy Maker 4	1	1	Sophie
5.	Policy Maker 5	1	3	Martha
6.	Practitioner 1	3	1, 2, 3	Lucy
7.	Practitioner 2	3	1, 2, 3	Ruth
8.	Practitioner 3	2	1, 2	Elisabeth
9.	Practitioner 4	3	1, 2, 3	Diana
10.	Practitioner 5	3	1, 2, 3	Michael
11.	Practitioner 6 <sup>44</sup>	1	2	Sam
12.	Practitioner 7	1	3	Joanne
13.	Subject - Consultant Nurse 1	2	1, 3	Doug
14.	Subject - Consultant Nurse 2	1	1	Melanie
15.	Subject - Manager 1	1	2	Abigail
16.	Subject - Manager 2	1	2	Liam
17.	Subject - Other CN 1	1	1	Jane
18.	Subject - Other CN 2	1	1	Claire
19.	Subject - Other CN 3	1	1	Caroline
20.	Subject - Other CN 4	1	1	Helen
21.	Subject – Beacon Ward A	2	1, 2	Catherine
22.	Subject – Beacon Ward B	2	1, 2	Emma
23.	Subject – Beacon Ward C	2	1, 2	Gordon
24.	Subject – Beacon Ward D	1	1	Sarah
25.	Subject – Development Site E	2	2, 3	Tom
26.	Subject – Development Site F	2	2, 3	Laura
27.	Subject – Development Site G	1	2	Christine
28.	Subject - Development Site H	1	2	Sean
29.	Subject – Development Site H	2	2, 3	Hannah

<sup>44</sup> The LCC Programme was funded for four senior nurse posts in addition to the lead nurse post. Over the course of the 3 years there were changes in personnel, resulting in there being seven post holders included in the study.

<b>Stakeholder Group</b>	<b>No. of Interviews</b>	<b>Phase of Data Collection</b>	<b>Pseudonym</b>
30. Subject – Development Site H	1	2	Rachel
31. Subject – Development Unit J	1	3	Catriona
32. Subject – Development Unit K	1	3	Monica

The participants who were interviewed on three occasions were members of the LCC Team who had remained in post from the outset (Lucy, Ruth, Diana and Michael). Amongst the Practitioner Group (Senior Nurses) Sam and Joanne joined the Programme in its second and third year respectively and so it was only possible to interview them on one occasion. Sam left the Programme after one year. It was possible to interview most of the Beacon Ward and Development Site Charge Nurses on two occasions, other than Sarah who had gone on maternity leave and Christine who had left the organisation. Amongst the Policy Maker Group only Jack was in the same post throughout the Programme, which is why he was the only stakeholder from that group to be interviewed twice. Martha joined the organisation during the second year of the Programme and so had been involved for a full year before I interviewed her in Phase Three of my study.

#### **4.10 Ethical considerations**

The Research Governance Framework for Health and Community Care (Scottish Executive, 2006) states that ‘the dignity, rights, safety and well-being of participants must be the primary consideration in any research study’ (p5). Key elements of the ethical components of the Framework that needed to be addressed were informed consent of all participants, use and protection of data, ensuring confidentiality of personal information and preserving anonymity of subjects.

##### **4.10.1 Ethical Principles**

When articulating the ethical considerations in making the formal ethical applications and during the actual conduct of the study I took account, where relevant, of the four ethical principles put forward by Beauchamp and Childress (2009):

- **Autonomy** (respect for choice): A comprehensive study information sheet (Appendix 3) that met the guidance of both the National Research Ethics Service (2011) and the Royal College of Nursing (2011) was given to all potential participants and they were given more than 24 hours before being contacted about their willingness to proceed. Prior to each interview / focus group the purpose of the study was reiterated along with issues relating to how I would attempt to maintain anonymity in what was a high profile initiative with a relatively small number of stakeholders involved. I indicated to the participants that I was very aware of potentially identifiable elements of the study and that I would work hard to address these. Each participant signed a consent form prior to recording commencing (Appendix 4). Participants were assured that they were free to withdraw from the interview at any time or decline to participate in any future data collection. Where field notes were recorded at the type of events which will be described in Section 4.11 my presence both as participant and study researcher was announced at the outset along with a commitment to the preservation of anonymity of any field data used in the analysis and findings.
- **Beneficence** (positive help): It was not anticipated that the subjects in this study would receive direct positive benefit from participation other than being able to reflect honestly on their involvement in the Programme knowing that confidentiality was assured.
- **Non maleficence** (do no harm): As indicated in the ethics applications form I was aware that there was a potential that discussing issues relating to the provision of compassionate care could be distressing to some participants, particularly in light of some of the prevailing criticisms that had been levelled both locally and nationally. My other major concerns were preservation of confidentiality/anonymity and data security. Many of the stakeholders were known to each other and it was essential, therefore, that any findings were attributed anonymously using pseudonyms and that any emerging findings that I discussed were attributed broadly rather than specifically to individuals<sup>45</sup>. All information including digital recordings and

---

<sup>45</sup> My reflective notes indicated throughout that this was a challenge for me. There were situations when members of the LCC Team were keen to know what I was 'finding' and I had

computer files were protected by password. Digital recordings will be destroyed on completion of the study.

- **Justice** (treat fairly and equality): there were no major issues in this area other than all participants would be treated with respect according to their age, gender, race, disability and sexual orientation. Given the nature of the sampling strategy there were no specific exclusion criteria.

#### **4.10.2 Ethical approval process**

Securing formal ethical and management approval is an integral component to any research study being conducted within NHS services. The governance mechanisms for this involve completion of an NHS Research Ethics Committee (REC) form that incorporates the issues of ethics, sponsorship and organisational approval for the study to be conducted. Given that this study was occurring simultaneously with the LCC Programme itself a decision was made at the LCC Evaluation Steering Group that a single ethical application would be made covering all aspects of evaluation of the four strands of the Programme outlined in Section 1.1 along with the action research element of the programme itself.<sup>46</sup>

Given that the LCC Programme had the potential to involve adults with incapacity (who may have been present in the wards where the Senior Nurses were working) the REC form was submitted to the Scotland A Research Ethics Committee which includes consideration of all studies that may come under the terms of the Adults with Incapacity Act (Scotland) 2000, and specifically Part 5 of the Act relating to research (Scottish Government, 2008b). The application (07/MRE00/120) was submitted on 26<sup>th</sup> November 2007 and a response received 17<sup>th</sup> December 2007 which indicated that 'a substantial part of the application was service development and did not require ethical review by and NHS ethics committee', and that therefore these elements could proceed<sup>47</sup>. The Committee were concerned, however, that the elements

---

to reiterate maintenance of confidentiality. The only external parties that I did discuss findings with at any specific level were within the protection of supervision meetings.

<sup>46</sup> My reflective notes at the time indicated that my preference would have been to submit a single application for my own study, but consultation with both my supervisors and the Evaluation Steering Group led to agreement to proceed as a co-investigator within this much wider submission.

<sup>47</sup> This included my own component of the application, a decision that was reiterated in an email by the secretary of the Ethics Committee on 6<sup>th</sup> February 2008.

concerning patient participation (i.e. the LCC Programme itself) required further clarification and resubmission. This put a delay on aspects of the Programme within the Beacon Wards (such as observation and collection of patient stories) and altered the timeframes for the Programme by several weeks.

Concurrent with making a REC application is the submission for management approval, which includes site-specific assessment (necessitating signature of the Director of Nursing giving approval to proceed) and agreement for sponsorship of the study (in this case joint sponsorship by NHS Lothian and Napier University<sup>48</sup>). NHS Lothian's Research and Development Office granted management approval for the whole LCC Programme (including my own study) on 6<sup>th</sup> December 2007 (R&D ID Number 2007/P/UO/03), subject to the approval of the appropriate research ethics committee(s).

For the purposes of my own study I was also required to submit an application to Napier University's 'Faculty of Health, Life and Social Sciences Research Ethics Committee'. The main ethical dimension identified in the application was whether participants would find the exploration of aspects of their role in delivering compassionate care personal, and potentially distressing. This was something that was raised in the subject information sheet, with the proviso that if this was the case they would be able to talk to me in confidence without being recorded<sup>49</sup> and if needed be offered the opportunity to speak to someone in occupational health. The ethics committee requested that I extend this to being able to offer someone to debrief who was independent and competent to hear of the issues concerned. I made contact with NHS Lothian's Staff Support and Confidential Counselling Service who agreed to be identified in the participant information sheet should this need arise. I was, therefore, granted approval by Napier University to commence data collection on 8<sup>th</sup> April 2008.

---

<sup>48</sup> The application was made prior to Napier becoming Edinburgh Napier University and so the formal paperwork reflects this.

<sup>49</sup> This did, in fact, happen on one occasion during an interview and I therefore terminated the recording in order to discuss the participant's views in a confidential manner.

#### **4.11 Data Collection**

The majority of the data were collected through semi-structured interviews (n=39) or focus groups (n=3), which were digitally recorded and transcribed verbatim. Semi-structured interviews were selected for the first interview with most stakeholders on the grounds that I was seeking individual perceptions of the nature of compassionate care, experiences and expectations of the Programme. The exception to this was Ward H where there were three key 'subject' stakeholders (manager, nurse specialist and charge nurse) and therefore I sought to interview them as a focus group to gain a collective understanding of their setting and experiences.

Two other focus groups were held: the first with the LCC Team at the end of Phase 1 of the Programme and the second with the three remaining Development Site Charge Nurses one year after their direct involvement in the Programme. Focus groups were chosen in these instances, partly for pragmatic reasons on my part, but also as the topic guide was much more reflective in focus and I was interested to capture shared experiences and differences in thinking that could best be brought about within a focus group context.

The interviews and focus groups ranged in length from 57 minutes to 2 hours. The ones with the Beacon Ward and Development Site Charge Nurses were all conducted in the clinical areas themselves. This allowed me the opportunity to tour the ward with the Charge Nurse and review some of the visual elements of the LCC Programme. These included 'Compassionate Care' notice boards with quotes from patients and relatives obtained from stories; staff rooms with evidence of outputs from the beliefs and values clarification sessions; folders containing a range of patient, relative and staff stories; and in some of the wards the positive care practices displayed in digital photo frames. Through these visits (which generally occurred twice during my data collection process) I was able to develop a sense of the 'presence' of the LCC Programme in the ward.

Interviews with the Policy Maker stakeholders took place in their own offices and with the LCC Senior Nurses either in my office, their host clinical site or a neutral office space depending on convenience for both parties. In all cases

the spaces were private and as far as possible the interviews were not interrupted. If this did occur I paused the recording.

In addition there was a range of other sources and opportunities open to me by virtue of my position in the organisation that permitted the generation of formal and informal data. These included:

- Ongoing engagement with the LCC Programme Team, including attendance at routine team meetings during Phases 1 and 2.
- Access to some elements of the data analysis from the LCC action research that led to the generation of the six compassionate care themes outlined in Section 1.3.4.
- Attendance at seminars in 2009 that focussed on exploration of the LCC Programme in relation to other initiatives focussed on enhancing person-centred care, compassion and dignity (outlined in Figure 7 overleaf).
- Participation in the 'Celebration Days' that marked the completion of the LCC Leadership Programme and involved project presentations by participants between 2009-2011.
- Participation in the three International Conferences on Compassionate Care hosted by the LCC Programme in June 2010, 2011 and 2012<sup>50</sup>.
- Participation in an NHS meeting in 2011 focussed on lessons learned from the LCC Programme alongside other related programmes such as Releasing Time to Care™ and Leading Better Care.
- From 2011 membership of the 'Delivering Better Care' Steering Group established by the Nurse Director to develop a strategy for nursing and midwifery that would meet the quality and care governance objectives.

---

<sup>50</sup> I presented papers at each of these conferences. The full list of conference presentations related to my study is outlined in Appendix 5.



**Figure 7: Initiatives linked with the Leadership in Compassionate Care Programme**



In all cases field notes were recorded during the events, with the 'Celebration Day' notes written up as formal evaluation reports for the LCC Programme. Where appropriate, data from these events that were transcribed were selected as they represented a formal or public presentation of individual's perceptions or experience of the programme, as opposed to my own accounts in field and reflective notes. Thematic analysis was then employed in the same way described in Section 4.12.1, with the data being managed using QSR NVivo 9.

#### **4.12 Analysis**

Green and Thorogood (2009) emphasise that the aims of most qualitative analysis are to both reflect the complexity of the phenomena studied, and present the underlying structures that make sense of that complexity. They suggest that the task of the researcher is dual, and can be contradictory. On the one hand there is a need to 'tell the story', whilst at the same time unpacking that story in such a way that a broader meaning can be elicited. This observation carries particular resonance within my study.

In a longitudinal study, which in itself is based on action research, there is by definition a narrative component to the analysis: in this case to tell the emergent story of the LCC Programme itself. This component of the analysis focussed on the action research processes that led to the LCC Team's articulation of their framework for compassionate care outlined in Section

1.3.4. The realistic evaluation (Pawson& Tilley 1997) approach that underpinned the study set out to establish answers to the questions of 'what works, for whom in what context?', and, therefore, the aim of the analysis was to develop explanations of these phenomena, with the potential to generate new ideas and theories that would have application for similar complex interventions.

The analysis was directed towards addressing the aims of the study, which were to:

1. Develop an understanding of the concept and expression of compassionate care within the participating services.
2. Critically analyse the impact of the LCC Programme within the organisation.
3. Examine the interplay of context and process that are seen to influence the project outcomes in order to understand *why* the Leadership in Compassionate Care Project works, for *whom* and in *what* circumstances.

#### **4.12.1 Thematic Analysis**

Howitt and Cramer (2008) suggested that thematic analysis is one of the most commonly used methods of qualitative analysis. It involves an analysis of the content of the data firstly through the identification of codes, which are then linked into categories that are subsequently formulated into themes. Boyatzis (1998) distinguished two levels of themes: i) manifest, that is directly observable in the data, and ii) latent, the underlying meaning of the data. Such themes, he suggested, can be generated either inductively, that is purely from the raw data or deductively, from existing theory or a priori research.

Boyatzis (1998) described thematic analysis as a 'way of seeing', which he locates within an interpretative social science paradigm. He presented a sequence to the overall analytic process that conveyed both simplicity and complexity. He suggested that when looking at the data 'observation precedes understanding' and went on to suggest that 'recognising something as an important moment (seeing) precedes encoding it (seeing it as something),

which in turn precedes interpretation' (p.1). He argued that thematic analysis moves you through these levels of inquiry<sup>51</sup>.

In a paper detailing an approach to thematic analysis in a study on self-assessment in nursing practice, Fereday and Muir-Cochrane (2006) emphasised the fact that whilst data analysis may often be presented as a linear process, it is by its nature an iterative and reflexive process. They drew on the principle of 'goodness' described by Tobin and Begley (2004), which is founded on an interactive process of concurrent data collection and analysis. As will be discussed in Section 4.12.3 within the context of this study the second and subsequent stages of data analysis were informed by the developing themes that had emerged from the original data, both from my interviews and field notes.

Howitt and Cramer (2008) stress that essential to the process of thematic analysis is becoming immersed in the data through careful reading and re-reading of the data. They indicated that code development normally involves a process of:

- a) immersion in data, e.g. repeatedly reading transcripts;
- b) generating tentative codes;
- c) applying and developing codes - refining, elaborating, defining, rejecting, splitting or combining.

The primary approach to my own thematic analysis was inductive, in that I did not have an a priori research or theoretical framework available to create a code manual at the outset. I used the realistic evaluation framework (context, mechanisms and outcomes) and my five research questions to create an overall structure to organizing my data as it was being initially coded within NVivo 9, which by the end of Phase Two of the data collection led to five primary categories for more in depth thematic analysis. These are presented in Table 13 overleaf.

---

<sup>51</sup> Review of my reflective notes at this stage of my study reveal that in the early stages of analysis I found myself 'seeing' multiple important elements in each transcript, which as will be illustrated in Section 4.13.2 generated a huge number of tree nodes within NVivo before I was able to begin interpreting the overarching themes that will be outlined in Chapter Five, Sections 5.4 – 5.6.

**Table 13: Relationship between research questions, primary code and concepts associated with realistic evaluation.**

<b>Research Questions</b>	<b>Primary Code</b>	<b>Realistic Evaluation Concept</b>
1. What were the underlying organisational and professional contexts for the Leadership in Compassionate Care Programme?	History	Context
2. How is compassionate care recognised and expressed by different participating stakeholders?	Expressions of Compassionate Care	Outcomes
3. What are the views, experiences and perceptions of participating stakeholders of the impact of the Leadership in Compassionate Care Project?	Stakeholder Views	Mechanisms and outcomes
4. How are the mechanisms used in the LCC Project seen to influence the outcomes in different clinical settings?	Mechanisms	Mechanisms
5. What are the early signs of sustainability of the work of the LCC Programme?	Sustainability	Context, mechanisms and outcomes

#### **4.12.2 Data analysis process**

Given the nature of the longitudinal study and the three principle phases of data collection, data analysis was commenced at the end of the first phase. It was conducted in five stages:

Stage 1: Repeated reading of transcripts (n=42) and recording of preliminary codes in margins.

Stage 2: Open coding of transcripts with data management using NVivo 9. This commenced following each phase of data collection and led to the development of primary, secondary, tertiary and quaternary codes. A total of 833 open codes were generated following this process<sup>52</sup>.

---

<sup>52</sup> There was duplication of some of the tertiary and quaternary codes within the primary and secondary structures.

Stage 3: Thematic coding of secondary, tertiary and quaternary codes to create an analytic framework for the outcomes of the LCC Programme in each setting.

Stage 4: Analysis of thematic codes across each Beacon Ward and Development Site to generate eight case studies utilising realistic evaluation framework.

Stage 5: Cross case analysis to generate overall themes within the realistic evaluation framework.

#### **4.12.2 Example of Coding**

Table 14 overleaf presents one example of coding in order to illustrate the systematic process adopted in the first phase of analysis previously described. It presents detail from the NVivo 9 coding tree within the primary code 'Expression of Compassionate Care' which relates to the second research question. This contained six secondary codes: i) Definitions; ii) Delivering Compassionate Care; iii) Examples of Compassionate Interactions; iv) Influencing the Delivery of Compassionate Care; v) Nurses Valuing Care; and vi) Role-modelling Compassionate Care. The secondary code 'Definitions' is also illustrated and contains eight tertiary codes: i) Beacon Stakeholders; ii) Consultant Nurses; iii) Other Charge Nurses; iv) Patients (from Practitioners); v) Practitioners; vi) Development Site; vii) Nurse Managers; viii) Policy Makers. Finally the Tertiary Code 'Beacon Stakeholder' is illustrated with its nine Quaternary Codes: i) Being there for; ii) Caring as wish to be cared for; iii) Communication; iv) Flexibility of routines; v) Friendship; vi) Giving of self; vii) Patient perspective; viii) Seeing the individual; and ix) The little things.

The number of examples drawn from the data for each code is illustrated in brackets and gives one perspective of relative weighting.

**Table 14: Examples of secondary, tertiary and quaternary codes arising from LCC Phase 1 analysis within primary code of ‘Expressions of Compassionate Care’; secondary code ‘Definitions’; and tertiary code ‘Beacon Stakeholder’<sup>53</sup>**

Primary	Secondary	Tertiary	Quaternary
Expressions of Compassionate Care (223)m	Definitions (112)	Beacon Stakeholder (16)	Being there for (2)
			Caring as wish to be care for (2)
			Communication (2)
			Flexibility of routines (1)
			Friendship (2)
			Giving of Self (2)
			Patient perspective (1)
			Seeing the individual (2)
			The little things (2)
		Other Charge Nurses (15)	
		Patient (from Practitioner) (15)	
		Practitioner (33)	
		Development Site (10)	
		Nurse Manager (1)	
		Policy Maker (17)	
	Delivering Compassionate Care (79)	Beacon Wards (62)	
		Development Sites (17)	
	Examples of Compassionate Interactions (16)	Compassion towards each other (1)	
		Dignity (1)	
		Humour (3)	
		The little things (3)	
	Influencing delivery compassionate care (2)		
	Nurses valuing care (10)		
	Role modelling compassionate care (4)		

<sup>53</sup> Quaternary codes do exist for each of the other eight tertiary codes but for reasons of brevity are not illustrated here.

### **4.12.3 Stage 3**

The coding process within NVivo 9 involved extracts from the transcripts being stored within the coding tree, which permitted a subsequent stage of more detailed analysis of the verbatim content associated with the tertiary and quaternary codes. The contents of each secondary category were re-read and annotated to identify both the manifest and latent themes (Boyatzis 1998) emerging in relation to each research question. This process was conducted manually through note taking and mind-mapping rather than using NVivo 9 to manage the emergent findings. This process was adopted to examine each of the six research questions and led to the development of an analytic framework for examining the outcomes of the LCC Programme. By this stage the concept of 'level of adoption' that will be discussed in Section 6.2.1 emerged from my scrutiny and shaped the remaining analysis.

### **4.12.4 Stage 4**

Having arrived at a definitive thematic framework I was then able to proceed to the application of my analysis by generating the eight detailed case studies from the Beacon Wards and Development Sites. It was at this stage that Pawson and Tilley's (1997) realistic evaluation framework came to the fore, in that I was able to examine the CMO configurations in each of the study sites, including any shifts in 'regularity' in the way that they described (and was outlined in Section 4.5.8). Having completed the analysis of the eight study sites I was then in a position to examine a core element of the final phase of data collection, which was to analyse the responses to the questions regarding 'lessons learned' that I posed to the 12 participants were involved at this stage.

### **4.12.5 Stage 5**

The final stage was cross case analysis of the realistic evaluation summaries and outcome frameworks for all of the study sites. This allowed me to address the key realistic evaluation (Pawson & Tilley, 1997) question of what works, for whom, in what context? This was the key analytic element that framed the development of a model for enhancing organisational capacity for compassionate care that is presented in Chapter Six: Discussion.

#### 4.13 Rigour

In discussing the concept of rigour (or trustworthiness) in qualitative research Koch (2006, p.92) draws on the work of Guba and Lincoln (1989) when she presents a framework for examining three dimensions that draw parallels between scientific and constructivist paradigms. These are outlined in Table 15 below.

**Table 15: Dimensions for examining rigour in qualitative research**

	<b>Scientific paradigm criteria</b>	<b>Constructivist paradigm criteria</b>
Truth values	Internal validity	Credibility
Applicability	External validity	Transferability
Consistency	Reliability	Dependability

Koch (2006, p.92)

Koch (2006) argues that credibility is enhanced when researchers describe and interpret their experiences as researchers. As previously discussed in Section 1.5 I have been mindful throughout the research process of my position as insider-outsider in this research study and this was an important element of my reflective diary. My position presented many opportunities to test the internal validity of my analysis and emergent findings through participation in formal seminars and conferences related to the LCC Programme as well as informal discussions or observations during wider meetings.

In order to maximise the trustworthiness of the data all interviews were digitally recorded and transcribed verbatim. An external party undertook transcription and I checked each one against the original recording during first reading. Although I did not directly share the written findings with my research participants as the study progressed there was opportunity for some verbal member checking within the events and opportunities described, as well as formal critique of elements of my work that I presented at the three Leadership in Compassionate Care conferences and three Edinburgh Napier Post Graduate student conferences (the titles of these presentations are detailed in



Appendix 5). A number of the research participants attended these presentations, whilst others were experts in the field including those undertaking relevant work on compassionate or person-centred care in other part of the UK or internationally. This type of critical dialogue increased my reflexivity in terms of self-analysis of my role as an insider-outsider researcher and also self-critique of my emerging themes.

Establishing the transferability of the findings is reported to depend partly on the provision of sufficient contextual information about the research setting in order that judgements can be made about its applicability elsewhere (Koch, 2006, p.92 citing Guba & Lincoln, 1989). Given the nature of Pawson and Tilley's (1997) realistic evaluation there has been a strong emphasis on context within this study. Ryan-Nicholls and Will (2009) argue that threats to external validity (or transferability) of qualitative research are reduced because the research itself is conducted in its natural 'habitat' with less controlled conditions. There was no attempt to control the conditions within the study site either by the LCC Team, or myself, however, influences on each ward were recorded in reflective notes if they did not emerge in the interviews themselves. As will be seen in Section 6.3 the presentation of the views and experiences of stakeholders across the eight contrasting wards builds up an important narrative of each case study site. This is followed in Section 6.5 by a cross-site analysis that leads to articulation of contextual factors influencing the adoption of the LCC Programme. It should be possible, therefore to trace my decision-making processes from the thematic analysis and construction of the findings.

The final component of Koch's (2006, p.92) framework is dependability that relates to the auditability of the researcher's decision-making regarding the theoretical, methodological and analytical choices made throughout the study. My decisions regarding these elements have been detailed in Section 4.4 where I came to a decision about the underpinning theoretical framework for my study and in Section 4.7 in relation to the actual research methodology based on Pawson and Tilley's 'New Rules for Realistic Evaluation' (2007, p.215-219). Finally in Section 4.13 I described the five stages of my data analysis, including the use of QSR NVivo 9 as the primary mechanism for

managing the data and instituting the preliminary coding of the large volume of data. All of these elements have been discussed in depth with my supervisors. A selection of the early transcripts was shared with my supervisory team who each independently reviewed and coded them in order to provide the opportunity to discuss emergent themes and how these reflected my developing thinking.

Having described in detail my underpinning research methodology, methods, data collection, analysis and measures to ensure the rigour of this process I will now present the study findings in what constitutes the most substantial component of this thesis.

Given the volume of data collection in this study and the breadth and detail of the findings these will be presented in two separate chapters. Chapter Five focuses on the first aim of the study which was to develop an understanding of the concept and expression of compassionate care within the participating services. This involved an initial examination of the history of the Programme, which offers an important perspective to the prevailing local contextual influences and responses to its initiation.

Chapter Six addresses the second and third aims of the study that involved a critical analysis of the impact of the LCC Programme and an examination of why the Programme worked, for whom and in what context. In addressing the three associated research questions the findings are initially presented as eight case separate case studies of the four Beacon Wards and four Development Sites. This is followed by a cross case analysis which synthesises the findings to examine the key outcomes of the LCC Programme for following stakeholders: patients, relatives, individual staff members, the ward team and the ward leader. This synthesis leads to the generation of a series of propositions relating to the contexts and mechanisms that were seen to positively enable the achievement of the Programme aims and at the end of the data collection period pointed towards sustainability.

## Chapter Five: Findings Part 1

### 5.1 Introduction

This chapter and Chapter Six draw on the range of data from interviews, participation in meetings, attendance at presentations and observations during visits to the participating sites. The findings correspond to the research questions below and are framed within the longitudinal context of the study. Accordingly elements of the findings and specific examples are annotated to indicate whether they emerged in Phase One (P1), Phase Two (P2) or Phase Three (P3).

1. What were the underlying organisational, professional and practice contexts for the Leadership in Compassionate Care Programme? – Primarily P1, but also P2 and P3.
2. How is compassionate care recognised and expressed by different participating stakeholders? - P1 and P2
3. What are the views, experiences and perceptions of participating stakeholders of the impact of the Leadership in Compassionate Care Programme? – P1, P2, P3
4. How are the mechanisms used in the LCC Programme seen to influence the outcomes in different clinical settings? – P2 and P3
5. What are the early signs of sustainability of the work of the LCC Programme? Primarily P3 but also P2.

Phase Three of the Programme involved implementation of the LCC Programme across services of up to five wards rather than single wards or departments. Whilst there are some important findings relating to Phase Three the focus of the findings will be on the four Beacon Wards involved in Phase One and four Development Sites involved in Phase Two<sup>54</sup>. The settings under examination varied considerably and to support contextualisation of the

---

<sup>54</sup> The reasons for this are two-fold: firstly I was unable to interview many stakeholders in Phase Three of my data collection for reasons discussed in Section 4.9.5. Secondly, as one of my key research questions was on issues of sustainability, the Development Units were not at a stage in Spring 2011 where conclusions in this area could be drawn. As my analysis proceeded and it became clearer how I would approach presentation of my findings (most specifically those in Chapter Six) I decided to focus my attention on the Beacon Wards and Development Sites.

reported findings Table 16 overleaf summarises these in relation to their specialty, location, team characteristics, management support and leadership during their involvement in the LCC Programme. These characteristics were derived from personal knowledge, observation during visits, interviews with the range of stakeholders and review of the abstract and portfolios submitted for selection to participate in the LCC Programme.

**Table 16: Summary of key context and characteristics of each Beacon Ward and Development Site**

<b>Ward</b>	<b>Stage in LCC Programme</b>	<b>Patient Group</b>	<b>Location</b>	<b>Team Characteristics &amp; Involvement in Programme</b>	<b>Management Support</b>	<b>Experience of Leader</b>
Ward A (24 beds)	Beacon Ward	Older people Acute medicine Medium stay	Within acute hospital	Established team Strong involvement small multidisciplinary team	Mainly stable but some change Supportive at higher level	New Charge Nurse
Ward B (30 beds)	Beacon Ward	Older people Mental health Long stay	Isolated purpose built unit	Established team Minimal multidisciplinary involvement	Stable and supportive at immediate and higher level	Established Charge Nurse
Ward C (22 beds)	Beacon Ward	Mainly older people Acute medical specialty Medium stay – transfer to rehabilitation	Within acute hospital	Established team Stable multidisciplinary team – but lack of medical staff involvement	Variable and number of changes during programme Supportive at higher level	Very experienced Charge Nurse at time of application but new Charge Nurse appointed at outset of Programme
Ward D (46 beds)	Beacon Ward	Mixed age Acute & long term medical specialty Variable length of stay	Within acute hospital	Established nursing team Large number of medical staff inputting to clinical work Minimal multidisciplinary involvement	Variable and number of changes during programme Supportive higher level	Experienced during year 1 Two changes of Charge Nurse during year 2 & 3
Ward E (25 beds)	Development Site	Mixed age Mental health rehabilitation Medium stay	Within mental health hospital	Established nursing and multidisciplinary team Strong involvement	Strong at all levels up to Chief Nurse	New Charge Nurse
Ward F (34 beds)	Development Site	Older people Frail health Long stay and palliative care	Isolated old hospital	Established nursing team Minimal multidisciplinary involvement	Stable and very supportive at immediate and higher level	Experienced Charge Nurse
Ward G (72 beds)	Development Site	Mixed age Acute assessment Very short stay	Within acute hospital	Very large team Regular turnover of medical and nursing staff Partial involvement	Mainly stable but some change Supportive at higher level	Three Charge Nurses, only one directly involved in Programme.
Ward H (19 beds)	Development Site	Mixed age Rehabilitation National centre Medium stay	Isolated from management, within large mental health hospital	Small established multidisciplinary team Good involvement	Good local management support	Changes in leadership during course of Programme New Charge Nurse

## **5.2 Understanding the Context**

Central to the realistic evaluation approach (Pawson and Tilley 1997) is a focus on context. In Phase One of the data collection process there was, therefore, a strong emphasis on eliciting the stakeholder's perceptions on the underlying organisational and professional contexts for the LCC Programme and the degree to which they mirrored the portrayal of care delivery outlined in Chapter Two. These would be supplemented by the individual contexts of each of the eight case studies. There were four main elements to this inquiry:

1. The history of the project
2. The perceived situation for the profession of Nursing
3. The prevailing context of care delivery
4. The perceived need for the project

The findings have been synthesised to create a series of contextual influences and an emerging definition and framework for compassionate care. Whilst the primary purpose of my study is not to develop a model for compassionate care this emergent thinking had an important contribution to make to my understanding and will feature in the model for enhancing organisational capacity for the delivery of compassionate care that I will present in Chapter Seven: Discussion.

### **5.2.1 History of Project**

During my Phase One interviews in 2008 each of the Policy Maker Stakeholders was asked to describe the history of the project from their own perspective. This created a clear sense of the rationale, vision and some insight into the explicit focus on compassion rather than using broader terms such as 'caring', 'person-centred care' and 'dignity' that were more common place at the time.

The benefactor's involvement stemmed from personal experience and awareness of media focus on core care issues, through the Jarvie report in NHS Lothian (2006) in particular. Her own perceptions of the root of the problems at that stage were twofold: firstly, the move of nurse education to universities and secondly that NHS organisations '*were too busy to remember to be compassionate*' [Molly, Policy Maker, P1]. Her principal aims were to provide funding that would address some of the specific concerns highlighted

in the Jarvie report and would lead to the creation of a learning tool that could be applied across Scotland. The benefactor and the other Policy Maker Stakeholders expected tangible outcomes in the form of some kind of compassionate care 'product'. Susan, one of the Policy Makers reflected that Lothian was chosen to receive the donation partly because of the specific issues that had been raised and also because the benefactor recognised that the leaders had the vision, commitment and ability to deliver her objectives; *'She invested in us because she believed we were bright enough, committed enough, able enough, whatever to actually do something with the money that would be useful'* [Susan, Policy Maker, P1].

The Policy Makers' recognition of the need for the project stemmed from their strategic positions in their respective organisations, (particularly as they were the recipients of complaints about care), their personal experience of care as a patient or relative and also through discussions with front line staff who were telling them that they were aware and concerned that *'they weren't delivering optimal care'* [Molly, P1]. Jack reported that he had recognised as far back as 2005 that the organisation had a *'fragile reputation'* and that nursing values were *'the thing that was missing'* [Jack, Policy Maker, P1], something he specifically linked to quality of patient care, co-operation and working relationships.

The Policy Makers had responded to the benefactor's perception that the shift of nurse education to universities was at the root of the problems by giving her the opportunity to meet some student nurses and hear firsthand about their training. This had a profound effect on those involved and Jack acknowledged that, in fact, it was clear that student nurses *'wanted to come in, they cared, they wanted to provide good care but something was going wrong'* once they were in the organisation. He emphasised the challenge of holding on to professional values *'in quite tough surroundings'* [P1], which highlighted that organisational context within the NHS was going to be a crucial factor in the Programme.

Susan had clear aspirations for excellence and reported that her ambition was to put Lothian on the map as an exemplar of compassionate care, partly to counteract the serious concerns that had been expressed in 2006.

*'I was keen not just to look at solving the problems that there were, but aspiring to excellence, and actually trying to move things to the very top end of the scale rather than just acceptable'.*

[Susan, Policy Maker, P1]

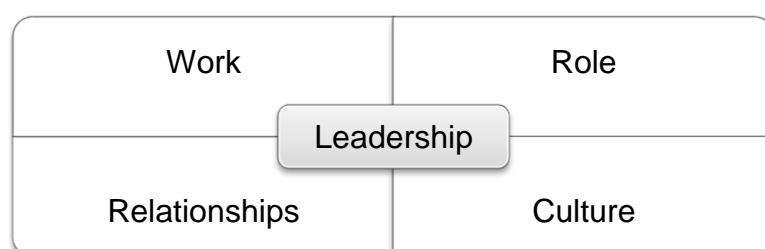
Reflecting on the 'situation in nursing' Susan conceded that *'it's not a huge surprise that we've lost the plot of what we are trying to do and what is important'* [P1]. She did acknowledge, however, that turning this around would require resources in the form of space, time and support. It was recognised that improving the quality of nursing care had become a strategic priority for the Board, on the basis that they had acknowledged that the situation in Lothian was, in parts, sub-optimal.

### 5.2.2 Situation in Nursing

Many of the stakeholders from Phase One and Two of my study described what they saw as substantial change for the Nursing profession in the previous 10 years that impacted on their care delivery. These perceptions could be categorised into the following five areas, which are illustrated in Figure 8 below.

- *Change in work*: stemming from increased acuity of patients, pace and workload, increased paperwork.
- *Change of role*: role expansion and substitution, focus on technical care, lack of role definition for nurses.
- *Change in relationships*: between team members, increased complexity of relationships between professionals, patients and families.
- *Change in culture*: a suggestion of a subliminal workplace culture which did not always place value or reward on aspects of caring, rather there being messages about what is important (patient flow, technical care).
- *Change in leadership*: diminution of clinical leadership; competing demands, senior nurses not confronting poor care.

**Figure 8: Key areas of change affecting the Nursing Profession in the past 10 years**





In the main, these respondents associated these changes with a deterioration in the work environment for nurses, which they felt in turn impacted on patient care. Specific examples of these changes described by the stakeholders are illustrated in Table 17 below and overleaf.

**Table 17: Examples of perceived changes in the Nursing Profession**

<b>Change in Nursing</b>	<b>Examples</b>	<b>Stakeholder's perspective</b>
Work	Acuity of patients	<i>Because we only take acute, sick patients. So you don't have this lovely balance of well and unwell patients. [Claire, Other Charge Nurse, P1]</i>
	Pace and workload	<i>And we've gotten to this stage, 10 years on, that nurses are run ragged, doctors are run ragged. [Claire, Other Charge Nurse, P1]</i>
	Increased paperwork	<i>Nurses have become paper-wielding technicians [Elisabeth, LCC Senior Nurse, P1]</i>
Role	Role expansion and substitution	<i>We've been railroaded into taking on bits of other people's jobs without realising it. And unfortunately now that we have done it, there's no way back [Elisabeth, LCC Senior Nurse, P1]</i>
	Lack of role definition	<i>I know for a fact that some of my nursing colleagues are not absolutely positive about what their role is. [Diana, LCC Senior Nurse, P1]</i>
	Striving for professionalism - not saying no	<i>So we've never stopped and said 'no, we're not doing this, because yes we will do it, it looks good and we want to be professionals so we'll take it on. [Diana, LCC Senior Nurse, P1]</i>
Relationships	Between team members	<i>We've ended up with lots of individuals who are called teams, but actually don't interact as teams and don't have particular relationships with each other. And that also then impacts in terms of how professionals don't then interact with their patients and develop relationships. [Susan, Policy Maker, P1].</i>
	Complexity of professional relationships	<i>And in this environment you have 12, 13 consultants, you have 50 beds. [Claire, Other Charge Nurse, P1]</i>

**Table 17: Examples of perceived changes in the Nursing Profession (continued)**

<b>Change in Nursing</b>	<b>Examples</b>	<b>Stakeholder's perspective</b>
Culture	Subliminal culture which does not value or reward aspects of caring	<i>Almost a dismissal of everything that was to do with caring and the softer side of issues, and the touchy feely stuff which was always up to nursing.</i> [Sophie, Policy Maker, P1].
	Wider societal culture	<i>Compromise and share are not such positive words in current society, and that therefore has an impact on what happens in wards as well.</i> [Ruth, LCC Senior Nurse, P1]
Leadership	Clinical Leadership	<i>They stripped out virtually all clinical leadership that was around. And some of it needed clearing out because it was hierarchy, not leadership, but none the less, it got stripped out.</i> [Susan, Policy Maker, P1].
	Expectations on managers	<i>When you are pulled and prodded and all kinds of things are expected of you, it was easy to see how the nursing role, the nursing leader almost got side tracked somewhere else.</i> [Diana, LCC Senior Nurse, P1]
	Challenging poor standards	<i>I would say that senior nurses these days are much less likely to confront staff than they used to be, about basic standards of social conduct never mind nursing. Maybe there is an element of fear and embarrassment.</i> [Melanie, Consultant Nurse, P1]

Whilst most stakeholders recognised the changes, many emphasised that this did not mean that there should be any resultant change in compassion, nor that being busy was any excuse to not be compassionate. Sophie, one of the Policy Makers acknowledged that nursing had become more technical, but stressed that *'you don't leave fundamental behind you, you actually take it with you'* and *'You can be as compassionate and do it as kindly, as empathetically if not sympathetically, doing something technically with compassion, as doing something more fundamental with compassion'* [P1]. One of her primary concerns, and therefore, expectations of the LCC Programme was that nurses needed to be able to describe this aspect of their work *'You never lose the bit ... but you have to be able to describe it'*. This, she saw, as being vital to counteract what she had seen as a lack of respect for nursing within the organisation.

*Entries in my reflective diary both during the data collection and analysis around this question indicate that I was not very surprised at the responses. They fitted with my own experience clinically and through interaction with clinical staff during practice development activities. What was striking perhaps was the degree of overlap between the clinical staff and senior managers; in particular recognition of the influence of general management principles in the 1990s and the expansion of nursing roles from the late nineties onwards.*

### **5.2.3 Context of Care Delivery**

During the course of interviews several participants described the context of their working environments or specific instances of care that were seen to have particular relevance to a study based on realistic evaluation (Pawson and Tilley 1997) where there is an important focus on context. A number made reference to organisational drivers that were seen to influence and potentially create what Doug, Consultant Nurse described as a '*deep dilemma within compassionate care*'. His overall assessment was that the NHS is a system that is essentially '*outcome-focused, process-driven*' [P1]. There were two overriding themes that were particularly associated with the acute hospitals: the first was the challenge of maintaining what is known as 'patient flow'; and the second was a perception of an increasingly complex care environment as a result of a range of medical, social, economic and organisational changes in the previous few years. A third theme that was relevant for two sites in particular were the poor standard of the actual ward environment.

#### **5.2.3.1. Challenges of Maintaining Patient Flow**

A key organisational driver is the maintenance of 'patient flow', which is the balance of patient discharges from the wards to permit patient admissions, particularly emergency admissions from the 'front door' such as Accident and Emergency and admissions units. The introduction of the 4-hour waiting time target in 2006 was the most frequently cited issue. Whilst there was acknowledgement of the importance and benefit of the target, most participants viewed the associated activity it demanded as extremely challenging and something that at times that took ultimate priority '*you have to keep the system moving*' [Helen, Other Charge Nurse, P1]. What became apparent was that the drive to discharge patients by 10am (or even earlier) had shifted the balance between the delivery of direct and indirect nursing

care. Some nurses felt this created a tension that could impact on other patients:

*But I think what people forget is that there's other sick people on the ward that need nursing care. And concentrating on getting somebody home and deal with their tablets and their transport and everything else that needs to be done, means that somebody else isn't getting attended to, getting some part of the nursing care that they need at that time of the day'*

[Sarah, Charge Nurse Beacon Ward D, P1]

Participants used language such as '*pushing people through the system*' [Elisabeth, LCC Senior Nurse, P1) and '*anything on earth will get moved to prevent someone breaching*'<sup>55</sup> [Catherine, Charge Nurse, Beacon Ward A, P1], whilst at the same time stressing that this in itself should not prevent them being dealt with in a compassionate manner.

### **5.2.3.2 Complexity of Care**

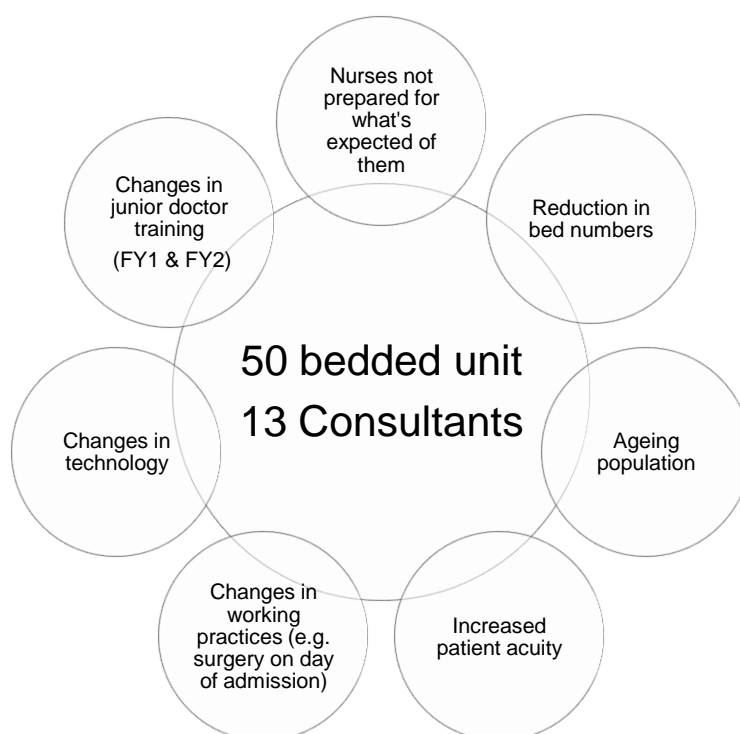
Claire, Charge Nurse in one of the 'other' wards who was very pessimistic about her ability to deliver compassionate care and painted a picture of her sphere of responsibility that was highly complex (summarised in Figure 9 overleaf). Her overall assessment of the situation was that her clinical environment had fundamentally changed in the last 2-3 years, and that the combination of all these factors '*has just got us in the mess we're in*' [P1]. The main factors that she cited included the aging population and increased acuity of patients, which alongside the size of her unit, but with an overall reduction in bed numbers for the speciality had led to changes in working practices including patient admission on the day of surgery. Whilst this in itself was perceived to be beneficial to the patient in many ways, Claire felt that it impacted on the nurses' ability to get to know their patients before their care needs became paramount. Coupled with the recent introduction of the new post registration training period for junior doctors (known as Foundation Year 1 (FY1) and Foundation Year 2 (FY2)) she felt that in some situations her staff were not fully prepared for what was now expected of them (such as preparing

---

<sup>55</sup> Breaching is the term used if a target is not reached, for example if a patient remains in Accident and Emergency for more than 4 hours or has not been discharged by 10am they are marked as a 'breacher,' and this is recorded as a failure to meet the target. In Phase One of my study the 'fear' of breaching was mentioned regularly by Charge Nurses.

and administering intravenous medications and performing other procedures traditionally undertaken by the junior doctors).

**Figure 9: Description of complexity of care by one Charge Nurse**



Whilst this was perhaps the most complex single example, there were common elements found within most of the other sites involved in the Programme.

### **5.2.3.3 Environment of Care**

Poor physical environment was an important issue for two of the Development Sites that were housed in very old hospital buildings (19<sup>th</sup> Century) that were recognised as being not fit for purpose. As one manager described it:

*So when you have staff coming into an environment where some of our rooms look like prison cells ... I think we're delivering compassionate care in an appalling building.*

[Sean, Manager Development Site, Ward H, P2]

The other Development Site (Ward F) was cramped, with no call bell system and minimal bed space, which was seen to impact on patient privacy and the nurses' ability to deliver care.

A few of the charge nurses cited lack of day-to-day resources as compounding some of the environmental factors, or mitigating against their ability to deliver compassionate care even when their environment was good. Claire, one of the Other Charge Nurses, described her own recent experience that exemplified some of the challenges faced on a regular basis.

*I was on all weekend, Sunday morning we had no sheets, not one sheet did we have. How can you make 25 beds and give patients clean sheets with no sheets? How can you do a bed bath on a gentleman who weighs 20 stone with one towel? You need three. Those are what makes your life difficult because the resources aren't there. So you're away off the ward and you're trying to beg towels from other areas.* [Claire, Charge Nurse, Other Ward, P1]

#### **5.2.4 Need for the Programme**

Taking the factors outlined in Sections 5.2.2 and 5.2.3 as a whole, there was consensus amongst the majority of stakeholders that a Programme with this focus was both timely and necessary. Lucy, one of the LCC Senior Nurses summed up that the reason why the Programme was needed was '*Because patients want it. Patients are constantly saying that they are not being listened to*' [P1]. Susan, one of the Policy Makers, recalled that the benefactor's concern, which had been influential in determining the name of the Programme, had been that '*we were too busy to remember to be compassionate*' [P1].

There was agreement by most of those questioned at this stage that many of nurses recognised that something was 'wrong', and felt genuinely concerned about the kind of changes described in Section 5.1.3 which as, Molly, Policy Maker stated meant they knew '*they weren't delivering optimal care*' which made them '*very uncomfortable and very sad*' [P1]. She went on to substantiate these statements with the following examples that had been brought to her attention:

*Examples like patients being admitted through the front door, being processed more quickly, and being moved on to the next destination before the people at the receiving area had had time to make the person feel welcome. Incidents like an elderly person falling and banging her head, requiring suturing to her scalp, being progressed from the [admission ward] to clinical ward and being sent to the ward not having had their breakfast and not having their hair washed. Little things like that.* [Molly, Policy Maker, P1]

Claire, the Charge Nurse from the ward illustrated in Figure 9 clearly felt that her ability to be a 'compassionate nurse' had been compromised by the changes in Nursing described in Section 5.2.3 and cited numerous examples where she knew that care in her ward was sub-optimal. Whilst this was not typical of any of the other charge nurses involved in the study, her assessment of her own situation perhaps reflected what was being said more broadly and reflected elements of what is described in the literature on compassion fatigue in Section 3.20.

*I love being a nurse and I take pride in my work and I'm very privileged to do what I do. And I'm very proud to be a ward sister. But I feel over the years you're grinded down and down and down and now all the goodness has gone. And there's the odd day that a patient will make you feel like you're doing a good job, whereas years ago it was a pleasure to walk away knowing that you've done a good days work. And that doesn't happen nowadays because .. all last week I was doing a double shift, I got nothing to eat, just because I knew I'd be here until half past eight, nine o'clock if I didn't keep going'*

[Claire, Other Charge Nurse, P1] <sup>56</sup>

### **5.2.5 Causes of the problems?**

The stakeholders put forward five key reasons for the existence of these problems, which summarised from the data can be viewed as:

- *Who's coming into nursing* – change in demographic profile of entrants and their motivation to enter the profession.
- *How student nurses are being prepared* – the move to higher education and focus on academic work.
- *What nurses are doing* – taking on other people's roles and valuing technical care over fundamental.
- *Reduced time with patients* – as a result of changes in role, increased turnover, changes in models of care, pressure of targets and increased paperwork.

---

<sup>56</sup> I came away from this interview feeling quite challenged by the experience. I resonated closely with Claire's position as I had worked in this ward on my last clinical post 15 year previously. I was familiar with the specialty and nursing care needs and yet what I was hearing in terms of care processes and demands on nursing staff represented a clear shift from my experience. I was concerned about Claire's well-being and was not surprised, therefore, when I got in touch with her few months later found out that she had left her job.

- *Something going wrong in practice* – lack of confidence in newly qualified nurses, poor role models, lack of challenge on poor practice by charge nurses and a pervading culture of general management.

The perception of the nature of the ‘problem’ appeared to be shaped by organisational position, with the more strategic stakeholders focussing on the changing context of healthcare, the shift in professional roles between doctors and nurses along with changing public expectations. The shift to models of general management in recent years was highlighted by most of the Policy Makers as having had a definite effect on the culture of care within the organisation. Sophie went as far as to say *‘I am absolutely certain the introduction of general management destroyed the element of care and caring’* [P1]. Doug, one of the Consultant nurses, argued that nurses were too ready to take on other professional roles, without agreeing to the implications for their own.

*The reality is because some other people asserted themselves and said they weren’t going to do it. And because we thought it needs to get done and it is important-ish, we’ll sigh and we’ll do it. Other professions are very quick, not even to sigh, and just say ‘we will not’.* [P1]

Those closer to practice (particularly those not directly involved in the Programme) placed a clear emphasis on the problem relating to those coming into nursing, their expectations of the role, their focus on technical aspects of care and some clear questions about recruitment and student nurse training. However, this view was not universal, with Jack, Policy Maker challenging this perception *‘I really don’t think it is the students that are letting us down’* [P1], whilst Melanie, Consultant Nurse suggested whilst there was a popular perception that students *‘are less ‘caring’ than the generations before’* she had no evidence for this in her experience.

*I’m absolutely clear that I’ve never seen any objective evidence, but I’ve never looked for it. Nobody’s ever shown me any objective evidence that this generation of nurses is less caring or less devoted to caring needs than previous generations.* [P1]

There was clear recognition by all stakeholders that the reality of healthcare delivery with increased acuity of patients, significantly shorter lengths of stay and workforce changes such as reduction in junior doctors’ working hours



have played a part in challenging opportunities for direct patient contact for many registered nurses. Rachel, Nurse Specialist working in Ward H one of the Development Sites linked this situation to the wider political nature of the health service:

*The NHS is very politically driven, there's targets to be met and the focus has changed. The focus changes depending on what's happening, what the climate is .. for an example, waiting lists need to be reduced and in order to do that we need to do X, Y and Z. And in order to do that we have to drop, we can't spend that extra 10 minutes with the patients or something, we need to do A, B and C to process the patients and move them on. [P2]*

It was evident these perceptions, albeit with different emphases, were shared across all stakeholder groups. Many felt that it was a 'pity' that a Programme of this nature was needed, but virtually all agreed it was necessary. Susan, Policy Maker articulated clearly what the Programme was designed to achieve in terms of placing value on caring.

*So if you throw all that together, I guess it's not a huge surprise that we've lost the plot of what we were trying to do and what was important. So now we're trying to say, 'Actually all these things are important and valued, and we're going to try and create the space and the time and support mechanisms to get them back'. [P1]*

### **5.3 Recognition and Expression of Compassionate Care**

One of the key research questions in the study was to examine how compassionate care was recognised and expressed by different participating stakeholders. This was a particular focus in my Phase One interviews with the Policy Maker, Practitioner and Subject Stakeholders from the Beacon and Other Wards, and subsequently in Phase Two with the Development Site Charge Nurses. Through this process of inquiry it was possible to synthesise an emerging definition of compassionate care and to illustrate its delivery in practice. Furthermore, it was possible to identify the key factors within the Beacon Wards that influenced their ability to deliver the high standard of compassionate care that had been recognised through the selection process for Beacon status, even in the face of the contextual pressures identified in the preceding section.

The LCC Team were also focussing on these questions and Phase 1 of their work within the Beacon Wards was devoted to generating data from patient, relative and staff stories, through the range of practice development activities and observation described in Section 1.3.2. Rather than generating a specific definition of compassionate care, their analysis led to the identification of the six themes for compassionate care<sup>57</sup> that became the foundation for subsequent refinement and testing within the Development Sites and Units.

### 5.3.1 Defining Compassionate Care

The Policy Maker and Practitioner Stakeholders emphasised the active nature of compassionate care, seeing it as a direct response to the identification of suffering or need. All stakeholders talked about compassionate care extending to families as well as patients.

The four Policy Maker stakeholders interviewed in Phase One of my study saw compassionate care as involving staff demonstrating that care '*actually truly matters*' [Susan, Policy Maker, P1] and placed an emphasis on the outcomes of compassionate care for patients. In particular, these centred on instilling a sense of safety and security and being cared for and cared about. They were concerned, however, that in many instances staff describe compassionate care as being the care that *they* would wish to receive, rather than it being truly person-centred and being defined by the patient. Compassionate care was linked to healthcare professionals inspiring confidence in patients and relatives through being knowledgeable both about the person they were caring for and also about the care they were receiving. They also recognised that compassionate care is founded in the interaction between people.

The LCC Senior Nurses focussed on the feelings of the patient as a result of receiving compassionate care, in that the person should feel that they matter and that the way that it is delivered '*makes them feel like they are a human being*' [Lucy, LCC Senior Nurse, P1]. They emphasised the connection between patients and staff as being core to compassion, which then demanded interpersonal sensitivity on the part of the healthcare professional in a way that would '*help them have a positive feeling*' [Diana, LCC Senior Nurse,

---

<sup>57</sup> These themes are: Caring Conversations; Person-centred flexible risk taking; Feedback; Knowing me, knowing you; Involving, valuing and transparency; Creating spaces that work – the environment (Edinburgh Napier University & NHS Lothian 2012, p.59.)

P1]. Sam indicated that this sensitivity needed to be directed to the whole situation, not only the patient, but their family and indeed themselves.

*I think with compassion there is a bit more, you really understand the whole thing, the whole situation, the whole context that you're working in. What it means to you, the person, the family.* [P2]

They also emphasised the importance of knowing the patient as an individual and understanding their needs, and suggested therefore that ultimately compassionate care could only be defined by the patient. Communication was seen as fundamental to compassionate care '*if we don't communicate with people, we mean nothing*' [Elisabeth, Senior Nurse, P1].

The Beacon Ward Charge Nurses emphasised the actual delivery of care, and in particular, having time to spend with patients and their families. They also focussed on the importance of communication, with recognition that patients and families really appreciated '*being kept up to date, knowing what's happening, knowing what's going to happen next, what might happen in the future*'. [Gordon, Charge Nurse, Beacon Ward C, P1]. The Charge Nurses described the 'little things that make a big difference' as being an essential component of demonstrating to patients and families that they matter.

*Doing the patient's hair and nails, making them a cup of tea, making them a slice of toast, getting a comfortable chair for them, getting a comfortable chair for their relative who may have been in with a patient that was dying.*

[Catherine, Charge Nurse, Beacon Ward A, P1]

The Charge Nurses in the Development Sites placed a strong emphasis on the importance of forming relationships as a means of delivering compassionate care, which may include staff giving of themselves.

*Seeing that some of the best results had come by just opening up a wee bit, you don't have to tell people where you live or your innermost thoughts but just give a little and you can get back a lot'*

[Tom, Charge Nurse, Development Site, Ward E, P2]

The need to build trust was seen as key, particularly in two of the Development Sites where the patients had potentially complex mental health and/or behavioural challenges. Sean, Manager, Ward H indicated that this trust should lead to the patients '*believing that you are doing things for them that*

*are going to benefit them'* [P2]. Again there was recognition that compassionate care extended to the patient and their families, with the emphasis on giving individualised care and support, *'whatever that happens to be at that given time'* [Rachel, Nurse Specialist, Development Site Ward H, P2].

All these stakeholders had engaged with the LCC Team to examine their understanding of compassionate care by the time I interviewed them. The Charge Nurses in the Other Wards all admitted that prior to the interview they had not specifically considered their thoughts on the meaning of compassionate care. Two specifically linked it to end of life care, rather than being core to all care delivery. Caroline stressed the sense of *'being with the person at their point of need, rather than forcing yourself on them'* [P1], in recognition of the need to provide individualised care. There was a strong sense that a 'really' caring attitude was fundamental to compassion.

*You care about other people and you really want to do the right thing for them. You really care about what you are doing to help other people.*

[Helen, Charge Nurse Other Ward, P1].

### **5.3.2 Emerging Definition and Model of Compassionate Care**

There was strong commonality in the definitions of each stakeholder group, particularly the sense of delivering care that really matters to patients and their families. However, it was evident that each group placed their own emphasis on particular dimensions of this care.

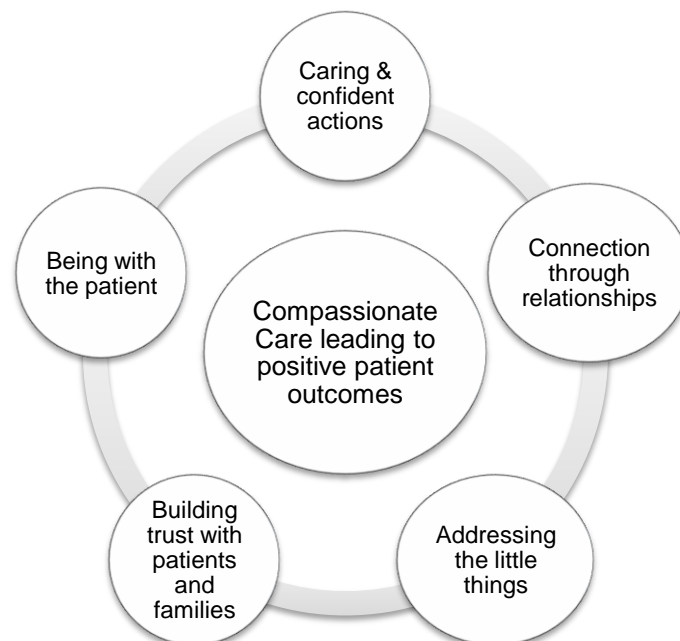
- Policy Makers – caring and competent action leading to positive patient outcomes.
- Senior Nurses – making a positive connection founded on relationships.
- Beacon Ward Charge Nurses – having time with patients to focus on little things that make a big difference.
- Development Sites – building trusting relationships with patients and families.
- Other Charge Nurses – being with the patient to meet their needs.

Taking these five perspectives together I was able to construct an emergent definition of compassionate care for my study.

*Compassionate care is delivered when caring and competent practitioners make a positive connection with patients and their families, leading to the development of trusting relationships directed at meeting their needs. These needs are met through attention being paid to the 'little things that make a big difference' as well as healthcare needs, and contribute to ensuring positive patient outcomes.*

This definition was solely based on the stakeholder perspectives during Phase One and Two of my data collection, rather than any subsequent analysis of the delivery of compassionate care or other Programme outcomes that illustrated examples of compassionate care. I have developed Figure 10 below to illustrate the five core elements of compassionate care that the stakeholder identified as contributing to positive patient outcomes.

**Figure 10: Five core elements of compassionate care from each stakeholder group**

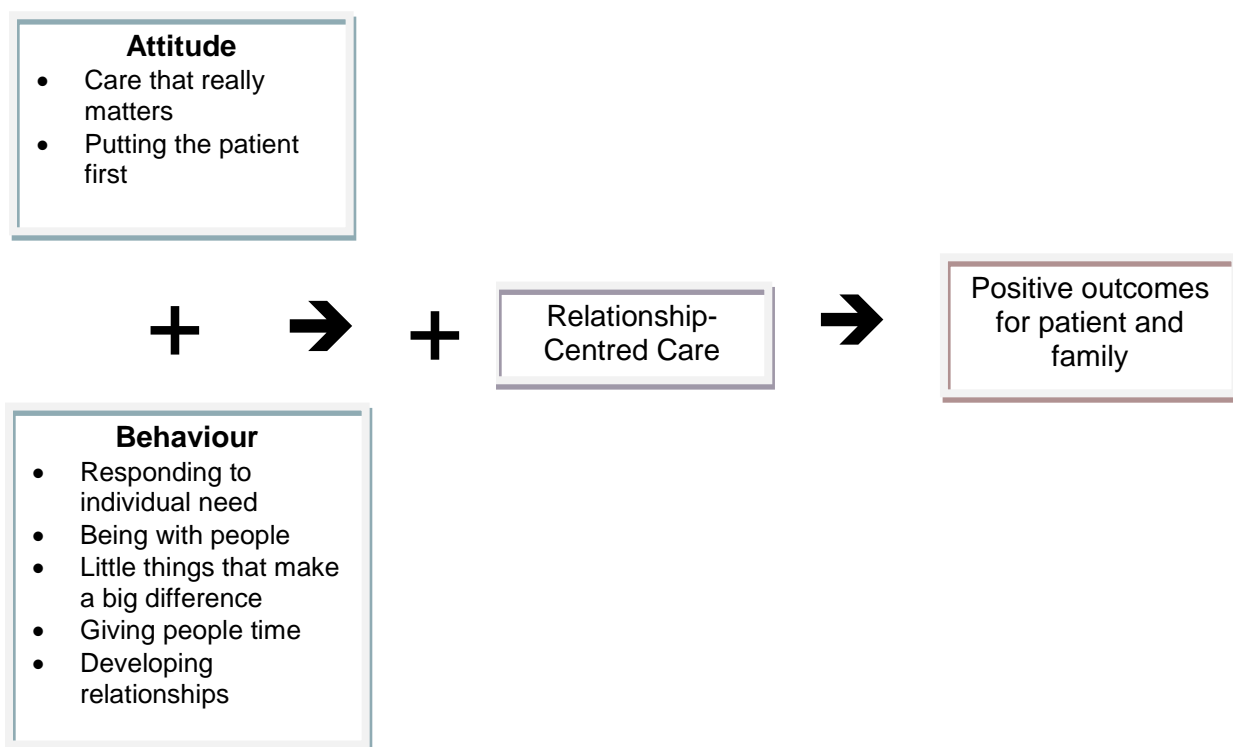


These perspectives, along with the subsequent illustrations of compassionate care that will be detailed in the following section, were synthesised to construct an emerging model for compassionate care presented in Figure 11 overleaf. It centres on the interplay between the attitude and behaviour of the healthcare professional, leading to the establishment of a meaningful relationship between themselves and the patient (and his/her family) that permits a

genuine understanding of that person's individual needs, resulting in key outcomes for the patient of feeling safe and secure, cared for and cared about.

As stated in Chapter One, the approaches adopted within the LCC Programme were strongly influenced by the concept of relationship-centred care (Tresolini 1994) that recognises that the nature and quality of relationships between professionals, patients and relatives are instrumental in establishing and maintaining 'enriched' environments of care (Nolan et al. 2006, Brown et al. 2008).

**Figure 11: Model of Compassionate Care based on the definitions of the different stakeholder groups.**



### 5.3.3 Compassionate Care in Practice

During the course of the interviews all of the stakeholder groups cited examples of care delivery and ways of working that helped shape and evidence this emergent model of compassionate care. These examples came primarily from the Beacon Wards and Development Sites, however, there were also examples from the Other Wards. Analysis of these examples emphasised the significance of attitude and behaviour presented in the model above in the delivery of compassionate care.

### 5.3.3.1 Attitude

#### a) Care that really matters

The emphasis on 'care that really matters' came from a number of sources. For example, Susan, one of the Policy Makers felt that it was evident that the motivation of the Charge Nurses to put forward their wards for Beacon status was not for personal gain or glory, but because they felt that '*this is what matters*' [P1]. The centrality of care delivery within the Beacon Wards was recognised by one of the LCC Senior Nurses when she reflected that the Charge Nurses had:

*'.. a great desire to look after patients. They really care. We've been doing action learning with the Charge Nurses and I would say that patient care is central to these units. Absolutely central. Core'*

[Diana, LCC Senior Nurse, P1]

Ruth, another of the LCC Senior Nurses highlighted the fact that this type of care, focussing on the dignity and comfort of patients, was something that was 'ordinary' in the Beacon Wards, and she cited the example of a patient using a commode behind bed screens:

*There would be an expectation that there would be as much privacy as possible around that difficult situation that couldn't be avoided. I think those are their expectations and probably are quite ordinary, and quite human, one human to another, but I think they are quite important.*

[Ruth, LCC Senior Nurse, P1]

#### b) Putting the patient first

Care that really matters was seen to relate strongly to the needs of the patients being seen as paramount in each of the wards. There were a number of components to this, which were mainly exemplified in terms of behaviour and will be discussed below. In terms of attitude, these were illustrated at both an individual and ward level. Firstly an emphasis from Caroline, one of the Charge Nurses from the Other Wards who stressed the need for staff to remain focussed throughout their shift:

*You leave your troubles at the door because these patients don't need to know what your problems are. If you've got problems you leave them there.*

[Caroline, Charge Nurse, Other Ward, P1]

Tom, Charge Nurse in Development Site, Ward E discussed the need to have an attitude that illustrates preparedness to alter established routines and ways of working in order to respond to patient need.

*Working out the needs of the patient first and then changing how the ward actually ran, so changing the timing of things, listening to people. Basic things like getting rid of the breakfast trolley and just having a breakfast buffet in the morning so that people don't have to be up at such and such a time to have breakfast. Drug rounds became a bit more flexible. Not doing drugs at breakfast times or lunch times, all that sort of stuff.*

[Tom, Charge Nurse Development Site, Ward E, P2]

### **5.3.3.2 Behaviour**

#### **a) Responding to individual need**

There were numerous examples of staff responding to individual need, both for patients and relatives. Giving people time, or conveying a sense of having time for that individual, was emphasised on a number of occasions. This was most often linked to the delivery of personal care, which most of the Charge Nurses felt was an important component of their role, particularly when it gave them the opportunity to work with an individual patient.

*You've not got time to speak to them, you can maybe take them to have a bath, and it's all part and parcel of the fact that you are giving them a wash, or they're getting washed, but you are spending time with them. And they're able to, in a different atmosphere, express their concerns and problems and what areas they have a worry in.*

[Caroline, Charge Nurse, Other Ward, P1]

Another example, involving caring for woman after her husband had just died within minutes of being admitted to the ward, exemplified the need and ability to recognise and respond to individual need in very challenging circumstances.

*They'd just arrived and he died almost straight away. I made a point of going out and meeting the family and spent a good time first thing in the morning dealing with that, so much so at the end of it when the wife of the patient that had died, left the ward later in the morning, she said 'Thank you very much, you've been kinder than I can describe'. And then the family went off and I knew I wouldn't see them again or hear from them again.*

[Gordon, Charge Nurse, Beacon Ward C, P1]



The importance of responding to relative's needs was repeatedly emphasised in the Beacon Wards and Development Sites, and the example of feedback from a relative given by Christine, Development Site Charge Nurse in Ward G, illustrated the impact that this had.

*She thought bay six was wonderful and the staff and everything and it's all about that communication, making her a cup of tea and I think she said it's about staff spending a few minutes with her and concentrating on her and not anybody else.*

[Christine, Charge Nurse, Development Site, Ward G, P2]

## **b) Being with people**

The concept of 'being with' people in terms of staff's actual behaviour and presence emerged strongly in the descriptors of compassionate care. Such 'being' was directed both towards patient care and also in relationships with colleagues. The Charge Nurse was recognised by all stakeholders as being particularly relevant in this sphere. There was an emphasis on their role modelling compassionate care in two key ways, through their leadership qualities and also them actually being involved in delivering personal care. Gordon, one of the Beacon Ward Charge Nurses reflected on this quality in one of his peers:

*She set a damn good example, I think. Not by standing and directing people and saying 'this is how it should be done, or you should be doing this'. But by going out as well and doing it herself.*

[Gordon, Beacon Charge Nurse, Ward C, P1]

The Beacon Ward Charge Nurses all saw working with patients and delivering personal care as absolutely essential to their role. It was clear that they gained personal satisfaction from this activity, but also saw it as key to their relationship with their staff.

*I make myself be in that ward four days a week, no matter what. Because I think that's so important. I work along with staff and we all work together, and I feel that's really important because it would be easy for me to be off doing other stuff like meetings and reading policies and protocols, and I do have to do that. But not at the expense of not working with patients.*

[Emma, Charge Nurse, Beacon Ward B, P1]

### **c) Little things that make a big difference**

The Charge Nurses in the Beacon Wards recognised that addressing the 'little things that make a big difference' were a central component of compassionate care. This had been raised within their definitions, but also emerged through their reflections on ways of working within their wards. Emma and Catherine gave particular examples that focussed on personal care and nutrition, both of which had been highlighted as areas of concern in the Jarvie Report (NHS Lothian 2006).

*We also make sure people feel good, they feel their hair's one, and their nails are done and their make-up's done. Just because you are over 65, doesn't mean you're not going to want that. That's what our nursing's about. It's just things we do every day.*

[Emma, Charge Nurse, Beacon Ward B, P1]

For Catherine, this ability to respond to patient need was as a result of having the right resources in place, which in this example of being able to offer toast on demand, would have required negotiation with managers and the catering department, along with agreement of funding.

*A small thing like a nurse brings in a whole load of cereals and if a patient has missed breakfast or likes Rice Crispies, we've got them in the back. And it's looking at things like we've got a loaf of bread up on the ward and we've got jam and marmalade and butter. So if someone's hungry, just toast. Having things in place, again it's all the small things.* [Catherine, Charge Nurse, Beacon Ward A, P1]

### **d) Giving people time**

Another essential component of delivering compassionate care was being able to give people time, or at least to convey the sense that you have time for them. In his reflections on assessing the applicants for Beacon Ward status, Molly one of the Policy Makers, focussed on what she had observed staff doing in those wards that were selected.

*Make a commitment to do something with patients and carrying it through, and not allowing things to detract. For example, taking patients out, not letting patients down. Saying you're going to do something and carrying it through.* [Molly, Policy Maker, P1]

Offering a cup of tea to patients and relatives was described as routine practice in Ward G one of the Development Sites, a very busy admissions unit.

Christine, the Charge Nurse recognised the importance of this activity in terms of building relationships and creating that sense of personal time.

*We know from our patient stories and relative stories that that cup of tea appears to make a big relationship thing with a patient or a relative. Because I think they feel that you are giving them five minutes to go and make a cup of tea.*

[Christine, Charge Nurse Development Site, Ward G, P2]

### **5.3.3.3 Developing Relationships**

All of the stakeholders viewed the relationships between patients, relatives and staff as core to the delivery of compassionate care. A key issue was how to establish meaningful relationships with patients and relatives in a short period of time, when they are unwell and potentially feeling vulnerable. This became a key focus of practice development activities in a number of the wards as will be discussed in more detail in Section 6.3 within the case study findings of the four Beacon Wards and four Development Sites.

There were two particular examples of ways of working that highlighted approaches to developing relationships with patients and illustrated aspects of compassionate care in practice. The first from Lucy, one of the LCC Senior Nurses, focused on the appropriate use of humour, something that demands judicious assessment and sensitivity.

*For instance this morning there was a lot of joking going on in the bays, one of the healthcare assistants ... everyone was laughing, it was all a big joke. You know there was wonderful personality and humour going on in all that.*

[Lucy, LCC Senior Nurse, P1]

Jane, one of the Charge Nurses in the 'Other' wards, reflected on the ability of her more experienced staff in assessing individuals and using different approaches to engage with patients who were perhaps having difficulty expressing their needs.

*I've seen them through in that dressing room, singing with them in the bath. Not something you like to hear really? But I mean that's when they'll loosen up, that's when they'll tell you what's worrying them, if they've got some other pain, if they've got money problems. Things that you can help them with.*

[Jane, Charge Nurse, Other Ward, P1]

### **5.3.4 Factors influencing the Delivery of Compassionate Care in the Beacon Wards**

The four Beacon Wards had been selected from fourteen self-nominations for inclusion in the LCC Programme, and had been through a rigorous selection process involving the submission of a portfolio and an observational assessment by the Policy Makers. It was evident from both the interviews with Policy Makers and LCC Senior Nurses, along with my own observation during site visits that these four wards did deliver the type of care articulated in both the model of compassionate care and the examples of compassionate care in practice that I had drawn from the data.

The stakeholders were invited to reflect on the factors that influenced this approach to care delivery in these wards, and that had been instrumental in them being awarded Beacon status. The question elicited a swift response on each occasion and the responses were consistent across each stakeholder group, revealing four key components:

1. Leadership of Charge Nurse
2. Ward Culture
3. Team Work and Professional Respect
4. Organisation of Care

#### **5.2.4.1 Leadership of the Charge Nurse**

Whilst four components were identified, it was evident that the leadership and role modelling of the Charge Nurse was seen as fundamental and influenced the other three. Within the leadership role the stakeholders identified the importance of the Charge Nurse demonstrating strong, consistent values that would lead to the identification of a common goal. Molly, one of the Policy Makers recognised that this drive and leadership was particularly important in the face of organisational challenges.

*I think first and foremost, the attitude of the Charge Nurse, in terms of their leadership, their drive to deliver compassionate care, their strength in many ways, to stand up for the staff and the patients when they felt things were encroaching on their ability to do something because they feel hurried.*

[Molly, Policy Maker, P1]

These leadership qualities were recognised both by the managers of the Beacon Ward Charge Nurses and the LCC Senior Nurses, with Michael summarising what he had seen simply as *'quite special'*. Liam, one of the Clinical Nurse Manager's description of one of the Charge Nurses emphasised the extent of her drive to take forward the aspirations of the project.

*A highly motivated leader, drive, knows her staff inside out and knew where she wanted to take this, and who was going to take her staff with her whether they liked it or not.*

[Liam, Clinical Nurse Manager, P1]

#### **5.3.4.2 Ward Culture**

It was clear that through this leadership a particular culture had been created and maintained in the Beacon Wards that influenced both attitude and behaviour with regard to delivering compassionate care. The key components of this culture were seen to be the following:

- A can do attitude
- Pride
- Caring for each other

The Charge Nurses themselves articulated a 'can do attitude', where despite external constraints they were determined that their high expectations of the standards of care would not be compromised.

*But there might be money constraints, I try not even to think about stuff like that, we never talk about 'we can't do something because we've got no money', we just find a way to do it.*

[Emma, Charge Nurse, Beacon Ward B, P1]

This was also recognised by the LCC Senior Nurses, who felt that the ability to adopt this attitude was founded on the teamwork engendered within the ward and again the leadership of the Charge Nurse.

*I think it's about the culture .. and that they can just do it, no matter how hard it is. No matter what each day brings or what struggles you come up against there is support and camaraderie within the team. They actually understand how each one functions as a person and they understand how they function together. They understand more of what the good bits and the bad bits are. And*

*how leadership within the ward has focussed on how it is important to create a culture.* [Elisabeth, LCC Senior Nurse, P1]

To some degree, some of the Charge Nurses displayed a non-compromising approach in this sphere, suggesting that if members of staff did not accept the culture of the ward then they had a choice about whether to continue working there.

*I'm quite open with them and say 'well if you don't like this then go and find another job'. I wouldn't say it like that, but it's about being honest with people and saying 'we're all here for the patients, yes we're all here because it's our job'.*

[Catherine, Charge Nurse, Beacon Ward A, P1]

Reflecting on their assessment visits during the Beacon Ward application process, the Policy Makers talked about their sense of the culture of the ward, which Molly described as one of pride, which extended throughout the team.

*The pride the people had, they wanted to work there, they were happy to work there and it wasn't just the nurses. It was the domestics, it was the porters, the clinical staff and even relatives who wanted to tell you how happy they were that their relatives were being cared for in this department. You can't fake that.*

[Molly, Policy Maker, P1]

A further aspect linked to the culture was a strong sense of the staff caring for each other and recognition of the fact that this was an important influencing factor on their ability to delivery compassionate care to the patients.

*On the ward here they definitely talk about feeling cared for ... there's been quite a lot of bereavements and things and different things happening. I know these are quite extreme situations, but they talked about immense support from the staff with that.*

[Michael, LCC Senior Nurse, P1]

Other people recognised how this influenced the atmosphere in the ward, which was particularly important for new people coming to join the team.

*There's an atmosphere within the place ... there's an idea that you are not a stranger for very long.*

[Diana, LCC Senior Nurse, P1]

#### **5.3.4.3 Teamwork and Professional Respect**

The LCC Senior Nurses spent nine months working in the Beacon Wards and were particularly struck by the teamwork and professional respect they observed. They emphasised the fact that members of the team valued each other's contribution both in terms of their opinions but also their practice.

*It's about opening up to other people and checking out their views as well. So everyone has a voice within the team so that everyone is listened to and their opinion being valued as well.*

[Elisabeth, LCC Senior Nurse, P1]

A number of participants reflected on the impact that this teamwork and respect had on patient care, in that there was little demarcation in terms of who would respond to patient needs.

*One of the things that struck me in one of the wards was that a patient asked for something and they just did it. .. They did it, and you could kind of see examples of that around where, it wouldn't have mattered who the patient asked, they were sure that it got done. So there's respect between the professionals in terms of how they were working.*

[Jack, Policy Maker, P1]

#### **5.3.4.4 Organised Care - Sense of Calm**

The final factor seen to influence the delivery of care in the Beacon Wards was the organisation of care itself. A number of the Policy Makers had been struck by this during their assessment visits, and again spoke of the fact that this was something that was immediately apparent walking into the wards. Jack in particular described a pervading sense of calm and again linked this to the leadership of the Charge Nurse.

*The sense of calm just struck you in each of them as you went into them... And compared to the other places ... and they are busy, they're not particularly easy to work in, most of them. .. They were orderly, quiet, they were clearly busy but not rushed and you almost as you went in, got that sense of things being under control. And I think that must be down to leadership.*

[Jack, Policy Maker, P1]

The Charge Nurses themselves gave examples of effective organisation of care within at times very complex care environments. For example, Sarah

stressed how her staff had planned ahead to manage a potentially high discharge workload:

*Five people were due to go home today and they all had their ambulances booked, all had their scripts written, they were organised. So people are thinking ahead, so obviously something's working.*  
[Sarah, Charge Nurse, Beacon Ward D, P1]

The importance of communication in facilitating organised care was emphasised, both in terms of having structures in place to promote team communication and being open and honest in that communication. Sarah provided a specific example and described the introduction of a morning 'hug' meeting, where the team come together to review progress with care and determine the need to adjust work allocation.

*We talk about the amount of discharges that we've got planned for that day, the amount of admissions that are planned. If there's one area in the ward that's got higher dependency than another area, they make sure that everyone knows about it so we can work together. If there's any staffing issues, we would bring it up at that point.*

[Sarah, Charge Nurse, Beacon Ward D, P1]

#### **5.4 Reflections on the context of the LCC Programme**

The findings presented so far were obtained between 2008 and 2009. The perceptions of the stakeholders in my study correspond very closely with those reported in both the national and international literature from about 2005 onwards that there was a 'problem' within the profession of Nursing. Within Lothian, there was agreement that the problem(s) were multifaceted and demanded an integrated response from both practice and education.

Care delivery within organisations like NHS Lothian was and remains extremely complex, and in some settings had undergone fundamental change in the last 10 years. The emphasis on maintaining 'patient flow' is at the forefront of operational pressures, which in acute settings is manifest in a focus on initiatives such as 4-hour targets, early discharge and day of surgery admission. All stakeholders viewed these pressures as presenting challenges to the formation of relationships with patients, which were recognised as fundamental to effective care delivery.



At the outset of the LCC Programme the concept of 'compassionate care' was not in common parlance within the organisation, however, most stakeholders were able to describe its components and recognise its delivery within the Beacon Wards and Development Sites. The emergent definition and model of compassionate care that has been developed are grounded in the stakeholder perspectives. Since the Programme was developed, the concept of compassion has become fully integrated into the nursing and health service literature and strategy, as well as within the organisation itself.

The importance of these findings to the overall study is that in conjunction with the analysis presented in Chapter Six they serve to articulate the core meaning of compassionate care in this particular setting and shape some of the contextual enablers to embed and sustain compassionate care that will be presented in Chapter Seven.

## Chapter Six: Findings Part 2

### 6.1 Introduction

This Chapter is made up of four sections. Section 6.2 presents the analytic framework I developed that introduces the concept of 'level of adoption' as a way of differentiating the embeddedness of the LCC Programme within the four Beacon Wards and four Development Sites. This is further supported through the creation of an outcomes matrix which is subsequently mapped for each ward. Section 6.3 focuses on the four Beacon Wards and the four Development Sites. Taking each in turn it sets out the context<sup>58</sup>, summarises the mechanisms involved in each and examines the outcomes achieved. This includes presentation of the outcomes matrix alongside a critical review of experiences within the ward. A diagrammatic summary of the realistic evaluation of that ward based on the Pawson and Tilley's (1997) illustration of the shift in regularity that was previously illustrated in Figure 3, Section 4.5.8 is used to summarise the analysis presented.

Section 6.4 presents an overview of the whole Programme in the form of the stakeholder's reflections on lessons learned from the three year journey. These insights from a range of perspectives, alongside my own observations at events such as the Celebration Days for the Leadership Programme convey important messages for the sustainability and development of this type of initiative.

In drawing this chapter to a close Section 6.5 synthesizes the cross site findings in order to address Pawson and Tilley's (1997) key question of *what works, for whom and in what context?* It focuses primarily on the evidence from the high adopting wards in order to draw conclusions on the enabling contextual features and key mechanisms that were seen to influence the outcomes. These outcomes are then delineated for the key stakeholder groups that were determined within the analytic framework: patients, relatives, individual staff, staff teams and the ward leader.

---

<sup>58</sup> Where possible data on bed occupancy and length of stay are presented. This was available for Wards A, C, D and G.

Over the course of the implementation of the LCC Programme and concurrent data collection during Phases One and Two of this study, it was evident that, whilst the care delivery within the participating Beacon Wards and Development Sites was of a high standard, engagement with the LCC processes and Programme varied, particularly in terms of longer term sustainability. Given the length of the data collection period between 2008 and 2011 it was possible to follow up the Beacon Wards and Development Sites for three and two year's respectively to gather data and ascertain the extent of this variation.

## **6.2 Analytic framework**

As stated in Section 4.12.1 I did not come in to the data analysis with any a priori analytic framework. My reflective diary and records of supervision meetings at that time indicated that I was toying with a number of potential ways to present my findings. I initially envisioned that I would take a chronological approach following the longitudinal design and describe the implementation and outcomes. This would then lead to a detailed examination of the specific LCC 'interventions', examining the benefits and limitations of each one. On the basis of the structure of my coding tree in NVivo I also thought that I would examine outcomes for different stakeholder groups: patients, relatives, individual staff and the organisation. However, as I progressed through the stages of analysis described in Section 4.12.1 the eventual structure of a case study analysis emerged.

### **6.2.1 Level of adoption**

As I analysed the data I developed the concept of 'level of adoption' as a way of delineating this variation and to shape my subsequent analysis of the interplay of context, mechanisms and outcomes within the realistic evaluation framework (Pawson and Tilley, 1997). By 'level of adoption' I meant the degree to which the clinical area adopted the LCC Programme mechanisms (which Pawson and Tilley (1997) delineated as 'underlying' and 'programme'<sup>59</sup>)

---

<sup>59</sup> As discussed in Section 4.5.7 Pawson and Tilley (1997) presented 'underlying' mechanisms are those that explain how things work beneath the surface, whilst 'programme' mechanisms are more specifically linked to the 'interventions' under investigation.

and sustained them. The criteria for this demarcation emerged from the data and I was able to map over time whether there was continued:

1. engagement with the LCC Programme during the period of intense facilitation;
2. engagement with the LCC Senior Nurse and Team once the initial period of intense facilitation had come to an end;
3. self-association with the LCC Programme, including self-identification as a Beacon Ward or Development Site;
4. the continued adoption of the appreciative approaches outlined in Section 1.3.1 within the setting;
5. the continued use of some of the key LCC mechanisms described in Sections 1.3.1 and 1.3.2 such as emotional touchpoints, positive care practices and real time feedback.

The Beacon Wards and Development Sites were judged to be either 'high', 'medium' or 'low' adopters according to the number of criteria they met at the end of this study (i.e. at least one year post facilitation for the Development Sites and two years for the Beacon Wards).

- High Adopter           meets 4-5 criteria
- Medium Adopter       meets at least 3 criteria
- Low Adopter            meets 2 or less criteria.

Table 18 overleaf presents a summary of the level adoption (and the number of criteria met) relating to each of the eight wards. The rationale for these findings will be explored in the next section when each ward is discussed in turn.

**Table 18 'Level of adoption' of the LCC Programme by the Beacon Wards and Development Sites**

	<b>Stage in LCC Programme</b>	<b>Level of Adoption (number of criteria met)</b>
<b>Ward A</b>	Beacon Ward	High (5)
<b>Ward B</b>	Beacon Ward	High (5)
<b>Ward C</b>	Beacon Ward	Low (1)
<b>Ward D</b>	Beacon Ward	Low (2)
<b>Ward E</b>	Development Site	High (5)
<b>Ward F</b>	Development Site	High (4)
<b>Ward G</b>	Development Site	Medium (3)
<b>Ward H</b>	Development Site	High (4)

For the Development Units, however, it was not possible to follow through this analysis given that data collection coincided with the ending of the period of facilitation by the LCC Senior Nurse and, therefore, issues of sustainability could not be examined. However, what was important for this study during Phase Three was the change in model of implementation of the LCC Programme from individual ward to a unit covering 3-5 wards/departments, and therefore a consequent 'dilution' of the facilitator input.

### **6.2.2 Outcomes Framework**

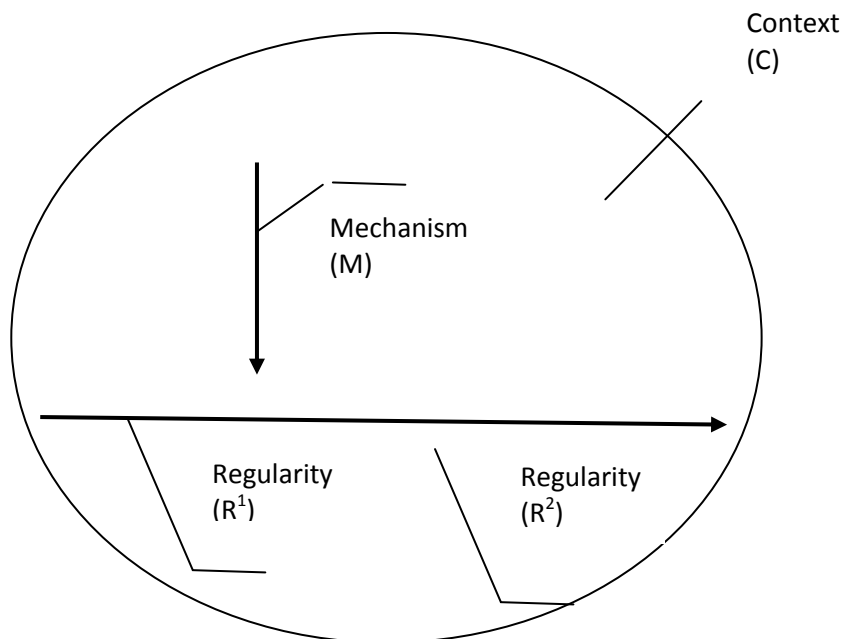
Analysis of the data highlighted three key outcome areas, which were relationships; care delivery; and developments in practice. It was also evident that these outcomes existed for five different groups: patients, relatives, individual staff, the staff team as a whole and the ward leader (usually the Charge Nurse). I therefore developed the following matrix as a way of delineating outcomes within each ward and then later in Section 6.6 synthesised the outcomes across all sites.

	<b>Relationships</b>	<b>Care Delivery</b>	<b>Developments in Practice</b>
<b>Patients</b>			
<b>Relatives</b>			
<b>Staff (individual)</b>			
<b>Team</b>			
<b>Leader</b>			

### 6.2.3 Shift in regularity

Pawson and Tilley (1997, p.72) put forward the term 'regularity' as being essential to the task of social inquiry. Regularity, they argued is the interplay between structure and agency within a particular context that has led to the existence of a certain state that they called  $R^1$ . They argued that the new or underlying mechanisms introduced within the social programme (in this case the LCC Programme) shift that state of regularity to a new position ( $R^2$  and so on). The shift in regularity is what Pawson and Tilley saw as representing the basic ingredients of realist social explanation.

**Figure 12 Shift in regularity from  $R^1$  to  $R^2$  which illustrates outcomes of a social programme**



This diagram will be used to summarise each case study along with a narrative that explains the essential elements and influencing factors for the shift in regularity in each study site. In the main there were two clear positions of regularity as illustrated above ( $R^1$  and  $R^2$ ); however, as will be revealed in two study sites there were three distinct positions of regularity which affected the eventual outcome.

## **6.3 Critical examination of the Beacon Wards and Development Sites**

### **6.3.1 Ward A**

**Context:** This is a modern 24-bedded ward within an acute hospital, caring for older people with acute medical problems. A high proportion of patients have dementia. During the period of facilitation it had a bed occupancy level of 95.1% and an average length of stay of 19.4 days. It is part of large medical directorate, subject to the 'front door' pressures including the 4-hour waiting time targets described in Section 5.1.3.1. During the period of involvement with the LCC Programme these pressures intensified, particularly with the introduction of discharge time targets (for example patients to be moved to the Discharge Lounge by 8am on their day of discharge). The Charge Nurse [Catherine] was relatively new in post at the beginning of the LCC Programme. At the outset she was supported by her manager [Liam] but following some internal directorate changes at both Chief Nurse and Clinical Nurse Manager level she had a new Clinical Nurse Manager by the end of Phase 1 of the Programme. This manager [Abigail] set up weekly meetings with Catherine that included a focus on the LCC Programme. The ward had an established nursing team, although not all staff welcomed or embraced the LCC Programme at the outset. The nurses worked on two 'sides' of the ward on a fairly permanent basis, with minimal crossover during shifts. There was a stable multidisciplinary team who were very supportive of involvement and contributed effectively to the original portfolio, which was recognised by the LCC Steering Committee as being of a particular high standard.

**Mechanisms:** Facilitation and support was provided by an experienced LCC Senior Nurse [Michael], and this was sustained during LCC Phase 2 and to a more limited degree during Phase 3 of the Programme. Alongside the appreciative approach and action research, the main LCC techniques that were successfully adopted included:

- Beliefs and values clarification
- Emotional touchpoints conducted with patients, relatives and staff
- Identification, discussion and display of Positive Care Practices via a digital photo frame
- Encouragement to give and receive feedback including a 'Feedback Fortnight'

**Outcomes:** There was widespread agreement that the LCC Programme had led to recognisable outcomes in this setting, and it became a clear focus for showcasing the work being undertaken within the organisation.

*You walk into [Ward A] you know that it [LCC Programme] exists. It's all around you, there is that sense it's there, the staff on the ward know what it's about, they know what they want to do. Again, that's down to [Charge Nurse] because she's driven it.*

[Liam, Clinical Nurse Manager, P1]

An important feature of this ward was that implementation of these processes led to a high number of action projects designed to develop an aspect of practice that had been highlighted either by patients, relatives or staff. Different members of the nursing team led these with the support of the LCC Senior Nurse.

Table 19 overleaf summarises the principal outcomes that were seen to have arisen during Phase 1 and 2 of the LCC Programme.



**Table 19: Outcome Matrix for Ward A**

	<b>Relationships</b>	<b>Care Delivery</b>	<b>Developments in Practice</b>
<b>Patients</b>	Focus on knowing the person.	Seeing patients as individuals and not just another person in the ward. Focus on the little things e.g. milk jugs for cereal, providing butter and marmalade.	Introduction of 'All About Me' sheets for all admissions. Focus on nutritional care – menu board put up in bays so patients could focus on anticipation of mealtimes.
<b>Relatives</b>	Concerns and complaints dealt with immediately before escalating to formal processes.	Increase sense of involvement through completion of 'All About Me' sheets.	Use of emotional touchpoints to facilitate discussion. Involvement of relatives in LCC initiatives (ward booklet, public presentations).
<b>Staff (individual)</b>	Opportunity to express feelings and ways of coping. Recognition that staff need support.	Giving feedback to others – both praise and highlighting when care has not met standards. Acknowledgement that staff find visiting time a stressful period	Introduction of weekly staff support sessions with chaplain (not sustained in long term due to availability of chaplain). Charge Nurse recording a staff story during Personal Development Planning (PDP) process.
<b>Team</b>	Improved team working – no longer working as two 'sides'. Appreciative feedback from consultants.	Compassion towards each other (e.g. flowers if someone ill, birthday cards).	'Coffee catch up' at 11.30 daily – 5 minute debrief of work, reinforcing teamwork. All staff undertaking patient stories using emotional touchpoints – requirement in Personal Development Planning (PDP).
<b>Leader</b>	Consistent demonstration of values.	Recognition of wider responsibilities (e.g. budgetary) and how these link to delivery of compassionate care.	Personal development – leadership skills.

One of the main issues raised by staff was the desire to 'know the patients better' and this led to the development and introduction of an 'All About Me' sheet (designed by Michael the LCC Senior Nurse) to capture important personal information about each patient that would support the healthcare team deliver person-centred care. Furthermore, it was evident that a key priority for the Charge Nurse had been the emphasis on staff support. Michael had introduced a range of processes for eliciting staff beliefs and values and views on ways to improve patient care and through this had ascertained that, whilst informal support mechanisms were very strong, there was the need

something more formal. This led to the establishment of a staff support session, facilitated by one of the Chaplains closely linked with the ward. This initiative came about in Phase 2 of the LCC Programme and was set up by the Charge Nurse Catherine, rather than the LCC Senior Nurse Michael. Catherine described the way the session worked:

*And that is for staff.. to come for that hour, every Thursday, to talk about how they are, how they cope with the job and how, we're in this situation now where we feel we're all stretched to the limit just now with our patient group and it's an opportunity just to ... it's their time, it's that hour just to say what's causing them stress and reflect on their practice and think, 'What else can we do? What else can we try and do to support you? What else can we try and do to improve the situation? Can we think about the ward next door? Can we utilise them when we've got a lot of demented patients, what's going to happen with sickness?' So the staff really enjoy that and it took a while to lift off but now everyone's keen to go every week.*

[P2]

This initiative was not sustained in the long term, due to staffing issues within the Chaplaincy Service.

### **Key practice development techniques**

The collection of stories through the use of emotional touchpoints was used widely in Ward A and was highlighted by Catherine as something she intended to continue in the long term. Her analysis of the key benefit of this approach was the ability to facilitate deep discussion, citing an example with a member of staff during the personal development planning (PDP) process. In the previous year where the individual had identified a desire to improve her communication skills, her self-evaluation had simply stated 'good'. Using emotional touchpoints to explore two aspects of communication had led a very dramatic response:

*I've never seen someone choose so many words. We got probably 15 emotional words about how she felt she had done with her communication skills and how much she thought she had developed. So that's really strong. I've been trying to think, 'How can I keep this going?' So I thought I'll give this a go, using the touchpoints. So gave her her story back just on communication. And she loved it. So she's kind of hooked now.*

[Catherine, Charge Nurse, Ward A, P2]

Catherine's intention was to integrate her own collation of a staff story using emotional touchpoints in all PDP reviews and to require all members of the

nursing team to undertake patient/relative/student stories using emotional touchpoints as an objective for the forthcoming year. She did, however, acknowledge that this was not a light undertaking and that staff needed considerable support to do so, but that once they were confident they really enjoyed the process.

### **Other Stakeholder Perspectives**

Two of the Policy Makers made specific observations about this ward. Jack highlighted the ward culture, which he felt had been striking at the outset and had been sustained throughout, mainly because of Catherine's strong values base. Martha focussed on the attention to the 'little things' and highlighted the milk jug story which became a celebrated exemplar of responsiveness to a patient experience elicited through patient stories.

*I've always loved the story about the soggy breakfast cereal and people then getting milk in little jugs. What a tiny thing, but I would hate soggy breakfast cereal.*

[Martha, Policy Maker, P3]

Catherine's second manager Abigail recognised that she had changed as a result of participating in the LCC Programme, although there had been some concern that Catherine had 'taken her eye off' core business (such as targets, staffing, budget) for a while as a consequence. Abigail did, however, acknowledge that she had responded to this well when spoken to, something that Catherine herself also referred to in terms of recognising her wider responsibilities as a Charge Nurse.

*... my understanding of my role as Charge Nurse has changed as well. A couple of years ago, this whole thing about 'It's your budget and you've got to manage it.' I was always like, '(Sigh) it's not my budget'. So now I feel more responsible for the budget and I accept that it's in my job description and it is my job. And just to note, last year we came in on budget for the first time since I've been Charge Nurse! [P2]*

Nonetheless, she also said that participation in the LCC Programme had given her the confidence to be very definite in speaking up about concerns relating to 'patient flow' and meeting targets to discharge patients at 8.00am, particularly when breakfast is not served until 8.15am. Attention to 'the little things' and nutrition in particular had become a big focus in the ward.

## Lessons Learned

Although Ward A was seen as a high adopter of the LCC Programme with clear outcomes for all stakeholders, there were a number of lessons learned. It was recognised by the Policy Makers, the Charge Nurse and the LCC Senior Nurse that perhaps the implementation of the Programme had been at too high an intensity, with too many action projects underway at once and, subsequently too much of a demand to keep a ward team of 32 informed about changes. There had been quite a degree of resistance from some members of staff at the outset, which the Clinical Nurse Manager Liam had suggested demanded 'chipping away' largely through the feedback from patient stories and informal observation. Catherine acknowledged that although people did feel involved:

*I think people just felt that it was too much going on at times, and I think that's a fair comment and I think [Michael's] taken that on board as well. But you can get carried away with his enthusiasm. It's difficult if you think, 'Well we know what's going on and everybody else should.' But the reality is not everybody else did. So I know some people felt they weren't informed as much as they'd like to have been. So maybe even just having the wee newsletter that comes out now. [P2]*

She summed up the experience in terms of what had been the main outcomes and learning that would stay with her:

*I think definitely hearing the patients' voice, and hearing the staffs' voice. I think being open to listening and open to trying new ideas, grasping opportunities as they arise, for feedback. Hopefully trying to continue on improving our service, with what we're hearing and what we're learning.*

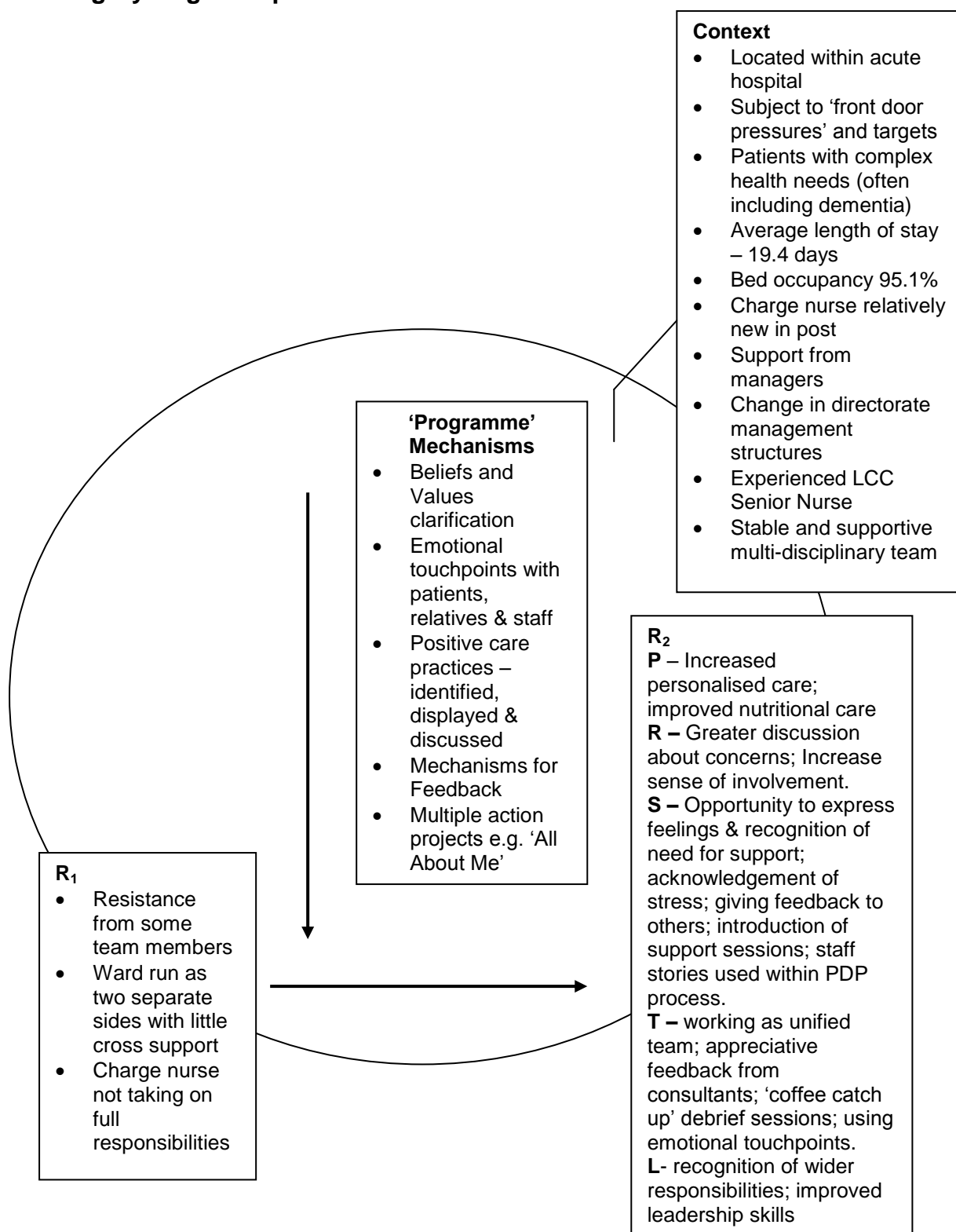
[Catherine, Charge Nurse, Ward A, P2]

## Shift in regularity

Figure 13 on page 191 presents a summary of the change in Pawson and Tilley's (1997) concept of 'regularity' within Ward A. R<sup>1</sup> presented a generally functioning situation operating in a context that presented high challenge in terms of clinical acuity, patient flow, targets and a relatively inexperienced charge nurse but one who had good managerial and consultant support. The introduction of a very experienced Senior Nurse and the adoption of a wide range of practice development techniques (many of them being tested for the very first time in this ward) led to the shift to R<sup>2</sup> where the improved team

cohesiveness and (sometimes gradual) acceptance of the LCC Programme led to tangible and sustained outcomes for all stakeholder groups. Perhaps the most significant 'programme' mechanisms were the use of emotional touchpoints to elicit relative and staff stories and a commitment to act on responses. Whilst there were managerial changes externally in the directorate (which also impacted on Wards C and D) these did not impinge negatively in Ward A.

**Figure 13: Realistic Evaluation Summary - Ward A**  
**Category: High Adopter**



**Key**

R<sub>1</sub> = Regularity prior to LCC Programme

R<sub>2</sub> = Regularity following LCC Programme interventions up to one year after facilitation

Outcomes: P – Patient; R – Relative; S – Staff; T – Team; L - Leader

### 6.3.2 Ward B

**Context:** This is a ward for 30 older people with enduring mental health conditions. It is managed within a Community Health Partnership with strong managerial support, but is geographically isolated from other health facilities. Ward B is a part of a modern Private Finance Initiative (PFI) building that has two wards and is managed by an external agency. The patient group is mainly long term, with some individuals having been inpatients for more than eight years. The Charge Nurse [Emma] acknowledged that there was, therefore, the potential for what she described as 'repetitive care'. Some patients are detained under the Mental Health (Care and Treatment) Act 2003 and several could display a lot of anger towards staff and other patients, which Emma felt created specific challenges in terms of the delivery of compassionate care:

*... I don't think they see us as discompassionate, because they know that it's not the nursing... they know it's a group of people that are detaining them under the Mental Health Act. But we've got to show them that we still see them as people and we're still trying to help them get out into the community and, not that they're ever going to live there, but that they still do stuff. So there's incidents there where it can be quite conflicting as well.*

[Emma, Charge Nurse Ward B, P1]

The Charge Nurse was already strongly committed to the principles of person-centred care following participation in Tom Kitwood's (1997) Dementia Care Mapping programmes 10 years previously. During the period of the LCC Programme Emma had periods of long term absence, which resulted in a change of leadership, which was, in part, provided by the LCC Senior Nurse.

**Mechanisms:** Facilitation and support was provided by an experienced LCC Senior Nurse [Diana], who was previously well known to the ward in a different facilitation role. Her involvement with the ward was sustained throughout the 3 years of the LCC Programme, including the period when she took on the role of Charge Nurse. Alongside the underpinning programme philosophy the main practice development techniques that were adopted included:

- Imagery
- Beliefs and values clarification
- Dementia Care Mapping (Kitwood 1997)

- Emotional touchpoints with patients, relatives and staff.
- Feedback sheets ('Dog and Rose')<sup>60</sup>
- Action Learning

**Outcomes:** Ward B was seen as a high adopter of the LCC Programme and went on to win a number of high profile awards<sup>61</sup>. The ward was notable particularly in relation to the whole team embracing and using the LCC techniques, implementing changes and participating in external presentations to promote their work. The main focus of their compassionate care became the creation of individualised homely environments in each of the bedrooms, as well as communal spaces. Having previously been quite isolated within the organisation Ward B developed a much higher profile, which was sustained. Table 20 overleaf summarises the principal outcomes that emerged during Phase One and Two of my data collection.

---

<sup>60</sup> Simple feedback sheet asking two questions: 'What could we do better?' (symbolised by a picture of a dog) and 'What did we do well?' (symbolised by a picture of a rose).

<sup>61</sup> This included the Patient Experience Network 2011 National Award for 'Environment of Care' and the ward went on to also be voted the overall winner at that award ceremony.



**Table 20: Outcome Matrix for Ward B**

	<b>Relationships</b>	<b>Care Delivery</b>	<b>Developments in Practice</b>
<b>Patients</b>	<p>Stories and emotional touchpoints created mechanism for the expression of emotions that were fuelling aggression.</p> <p>Reduction in incidents of aggression.</p>	<p>Staff explaining what they are doing if unable to respond immediately and the fact they will endeavour to return as soon as possible.</p> <p>Staff using appreciative thinking about individual patients to respond to challenging behaviour.</p>	<p>Use of term 'wait a minute' banned.</p> <p>Use of emotional touchpoints as part of assessment on admission and review process.</p> <p>Creation of individualised bedrooms for each patient.</p>
<b>Relatives</b>	<p>Exploration of real feelings (e.g. guilt, anger, loneliness) about their parent/partner being in care.</p>	<p>Use of emotional touchpoints to address concerns about care delivery.</p>	<p>Charge Nurse being seen as a resource to examine emotional issues with relatives in other settings.</p>
<b>Staff (individual)</b>	<p>Seeking feedback from Nurse Bank staff at end of each shift.</p>	<p>Direct involvement in LCC initiatives – including auxiliaries and newly qualified staff nurses – increased confidence.</p> <p>Reduction of 'hardness' of some staff.</p>	<p>Bank staff arrive 15 minutes earlier so fully included in handover.</p>
<b>Team</b>	<p>Improved togetherness.</p> <p>Valuing each other's opinions.</p>	<p>Working closely as a team for the benefit of patients.</p> <p>Sustained culture change</p>	<p>Change in format of team meetings – more patient focussed to include 10 patient reviews per month.</p>
<b>Leader</b>	<p>Strengthened relationships with relatives and confidence to explore their emotions.</p>	<p>Increased confidence from the challenge within action learning.</p>	<p>Publicity in local presentations and national press.</p>

**Key practice development techniques:** A number of techniques were seen to be particularly influential. The underpinning appreciative approaches adopted by Diana, the LCC Senior Nurse were well received by staff, chiefly in contrast to their previous experiences of audit where there was often a focus on the need for improvement. The use of imagery in the form of post cards with different symbols, photographs and cartoons was very effective during the beliefs and values clarification exercises and led to the development of a new

ward philosophy which was prominently displayed, again with a strong visual component. A great deal of material from the Programme had been collated in the form of stories and posters and was made available in one of the reception rooms for staff.

Given previous experience of using Dementia Care Mapping (Kitwood 1997), formal observation had been undertaken by the Charge Nurse and LCC Senior Nurse, and Emma described a striking example of practice which had led to one of the most important changes in her ward that she viewed as exemplifying compassionate care. She coined the phrase 'banning wait a minute':

*.. we heard the same patient being told to wait a minute by about five different people in 20 minutes. They were going by him in a corridor, 'Wait a minute. I'll be back in a minute.' And a minute never happened, which it never does. So we've banned that and I said, 'You'll never hear that on our ward.' I so don't hear that. And I always say to the guys, 'I bet you all do it when I'm not here.' But they don't, they so don't. Because it's never about, 'I don't want this to happen.' It's about, 'This is the reason why.' And I'll say we work in a ward where a lot of people get angry, would you not get angry if you'd been told, 'Wait a minute, wait a minute, wait a minute.'? And sometimes it's only for a glass of water. And now you see that's the big change now, you'll see folk doing it rather than, 'Aye aye' ... Because people work for people.*

[Emma, Charge Nurse, Ward B, P1]

### **Emotional touchpoints<sup>62</sup>**

These were used extensively with patients, relatives and staff with several examples from Ward B being subsequently promoted throughout the organisation and in external presentations.

**Patients:** Emma described an example where she used emotional touchpoints with a female patient with a long history of anger in order to explore her feelings. Having laid out the positive and negative words, explained the process and gained consent, Emma describes what happened next:

*She put 'boredom', she picked out all these words and at the end of it I was feeling so sorry for her. 'Bored', 'Sad', 'Bitter', do you know what I mean? And she talked them through with me. It was fantastic!*

[Emma, Charge Nurse, Ward B, P2]

---

<sup>62</sup> See Section 1.5.2 (footnote 8) for the description of emotional touchpoints.

In terms of the outcome of this process on this patient's anger in the short to medium term, Emma was confident that it had had impact, although no formal outcome measures had been instituted:

*I would say yes, but could I physically prove that? Yeah I probably could. I couldn't tell you when we last had an incident form or physical aggressive ... I honestly think it has helped her.*

[Emma, Charge Nurse, Ward B, P2]

As a result of this and other experiences, emotional touchpoints were introduced as part of the assessment and review process for all patients. Emma did, however, make an important point that the emotional touchpoints process needed to be adapted appropriately for each patients (for example removing the number of words), as some could find it overwhelming, especially if they had an underlying anxiety disorder. What was also notable during the Phase Two interview was the fact that Emma emphasised that one of the key members of staff involved in conducting emotional touchpoints with patients was one of the care assistants. This individual had gone on to present her experience of doing this at an open day about the LCC Programme.

**Relatives:** Two specific examples were given to demonstrate the potential use of emotional touchpoints with relatives in this context: the first to respond to a situation that had the potential to escalate to a formal complaint and the second to support the emotional well-being of a relative. In the first Emma described a situation with three siblings who were involved in a discussion with staff about the need to move their mother out of her shared room, because of the behaviour of the other person in the room, rather than because of her own. The son was very angry and was not prepared to hear the rationale behind the decision. Emma went on to summarise what eventually happened:

*Anyway, to cut a long story short, I brought him in here and I asked him, 'Just before we have this discussion, can I take five minutes of your time and put some words out telling me how your feeling about this whole situation? And how you're feeling when you go visiting your mum with [the other lady]. And he just, I didn't think he'd do it. And he picked 'embarrassed', because she used to lift her clothes all the time. It was really good ... Her two daughters said they felt sometimes we don't have enough time for them, which is probably true. .. in the emotional touchpoints I said, 'Talking with the staff.'*

*And the daughter said, 'Sometimes you avoid us.' And to be honest we probably did, because you knew there was problems coming.*

[Emma, Charge Nurse, Ward B, P2]

In the second situation Emma was invited to go to another setting to help the staff work with a relative that, they felt, was not coming to terms with her husband being in care. Despite their efforts they felt that they were not getting to the bottom of her concerns. The staff nurse who made the request for support had formerly worked in Ward B. Emma described what happened:

*... it was all about laundering his vests, and [staff nurse] just knew that she had to get right down into the emotions of what she was feeling, because it was really having quite an impact. She's lonely, miserable, missing him, and she said I haven't actually thought about that, and I said, 'No it's pretty sad.' But she kept wanting to turn it on to him and I said, 'No I want to know how you emotionally feel. This is me giving you an hour for you, and it'll help your husband as well.' But she would go in and shout at the staff and [staff nurse] thought maybe emotional touchpoints would help. I think it did. Plus [staff nurse] was having weekly meetings with her. It was good, it was interesting for me, as well, doing it with somebody I'd never met before. Just explaining to her that it was a way of communicating and helping us to think of emotional words that we maybe not come out with all the time.* [P2]

### **Facilitation**

The role of the facilitator was seen as crucial, both in terms of introducing the specific tools described and also as a trusted source of feedback. Emma cited a particular example of Diana 'picking' at the way the team meetings were run so that they became more focussed on each individual patient to '*look at their environment and their life and their mental needs, physical needs, they look at the whole person*' [P2]. The resultant changes led to positive feedback from Diana in relation to the way the staff valued each other's opinions and listened.

### **Action learning**

Emma reflected on her experience of Action Learning with the other Beacon Ward Charge Nurses as having been very influential. Initially she did not enjoy it, partly through not understand the purpose and finding the process challenging. However by the 5<sup>th</sup> or 6<sup>th</sup> session she said it was '*really powerful*', with the LCC Senior Nurse pushing them hard, but in a positive way. By the Phase Two interview the action learning set had expanded to include the

Development Site Charge Nurses and Emma realised how much she had developed personally:

*And it was just like, 'Gosh this is amazing.' And, again, you feel a wee bit of role reversal there, you're a wee bit more like, 'Oh I can ... you can't give advice but I can ask you questions that might ...' [LCC Senior Nurse]'s taught us to ask questions properly. So you're almost like a facilitator, a bit, which is quite interesting. [P2]*

### **Outcome for staff members**

As previously stated, one of the defining features of Ward B was the degree of involvement of members of the nursing team in the LCC Programme. Numerous action projects were undertaken, including seeking feedback from Bank Nurses at the end of each shift using the 'Dog and Rose' forms, which led to a change in their starting time so that they could be more fully involved in the handover. Two newly qualified staff nurses who participated in the Newly Qualified Strand of the LCC Programme undertook a piece of work around what it is like to be a new person in the ward, which they subsequently presented and received positive feedback for. As Emma stated:

*So they were so chuffed with that. So it's developing them. I never did anything like that as a staff nurse. And that's a very important thing to me, it shouldn't just stop at the Charge Nurse, it should be everybody. [P2]*

Care assistants who had been involved in using emotional touchpoints stood up at an open day and talked about their feelings and, despite nervousness, one talked about how she had been '*a wee bit scared of this relative*' and how working with emotional touchpoints had given her confidence to deal with difficult situations.

### **Shift in regularity**

Figure 14 on page 187 illustrates the shift in regularity in Ward B. Their contextual challenges centred on the geographical isolation and the fact that the patient group, who in addition to requiring long term care without necessarily having the prospect of improvement could manifest very challenging behaviour. These were counterbalanced by an experienced, committed Charge Nurse already working in a person-centred way, a supportive management structure and an experienced Senior Nurse. R<sup>1</sup> did,

however, present a situation where some patients did regularly express aggression towards staff, which in turn affected staffs' perception of their role. Furthermore there were some difficult relationships with relatives and as a result staff were cautious in their interactions.

The ward staff particularly responded to the use of imagery as a way of exploring their feelings about compassionate care and how this could be embodied within their ward philosophy and ways of working. Through the adoption of changes in some working practices and an increased focus on personalisation of the ward environment for each patient aggressive episodes reduced by R<sup>2</sup> and staff were able to see how this had a therapeutic benefit. Over time the Charge Nurse became skilled in the use of emotional touchpoints and this had an important impact on relationships with relatives

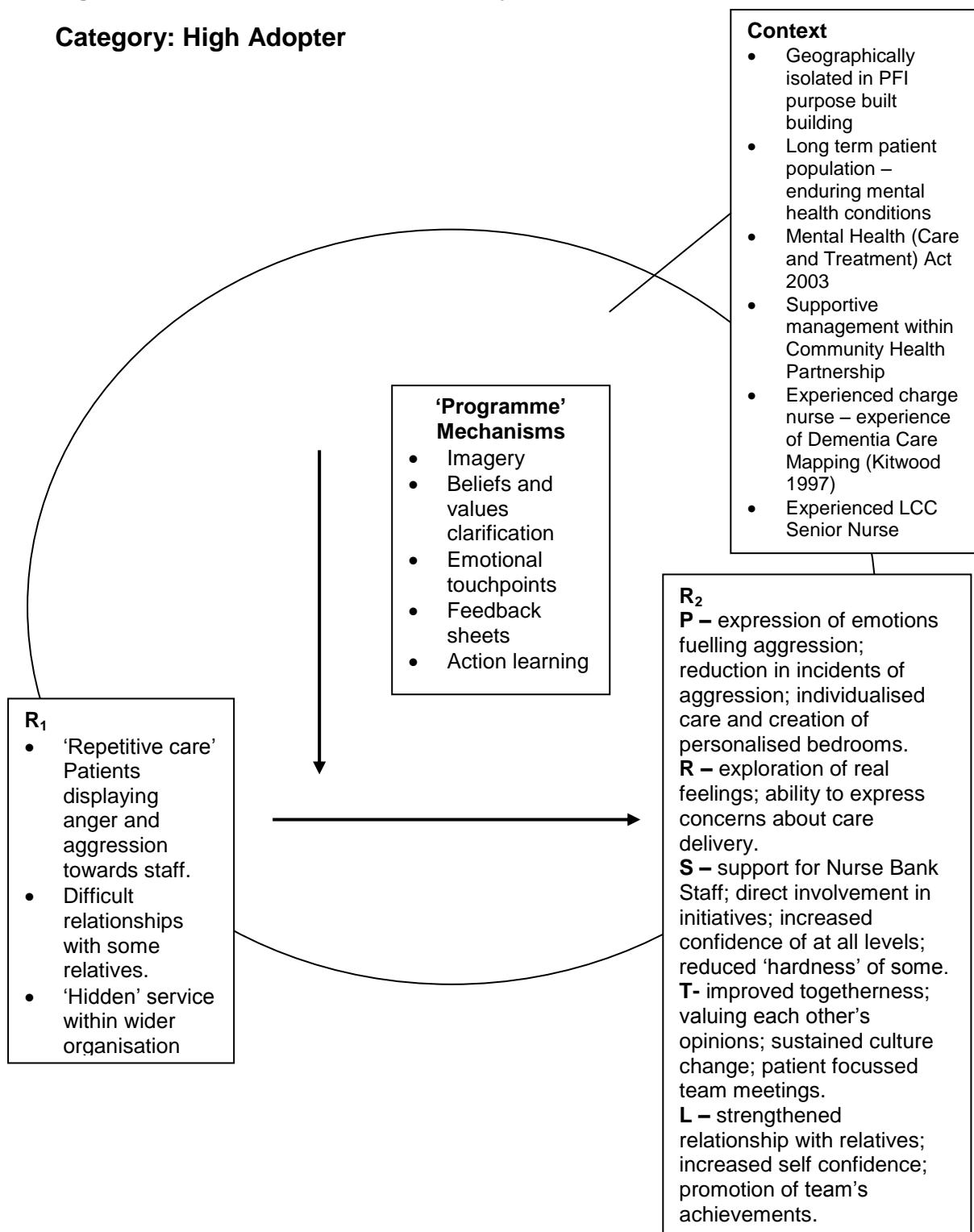
Despite changes in the ward leadership during the period of the Programme the benefits were sustained and ultimately self-perpetuated by the staff.<sup>63</sup>

---

<sup>63</sup> At the time of writing (July 2013) Ward B has continued to sustain their focus on the delivery of compassionate care and have further developed their ward to become a homely person-centred environment. The Charge Nurse and Nursing Auxiliaries have presented their work on numerous occasions at conferences both internally and externally to the organisation.

**Figure 14: Realistic Evaluation Summary – Ward B**

**Category: High Adopter**



**Key**

R<sub>1</sub> = Regularity prior to LCC Programme

R<sub>2</sub> = Regularity following LCC Programme interventions up to one year after facilitation

Outcomes: P – Patient; R – Relative; S – Staff; T – Team; L – Leader

### 6.3.3 Ward C

**Context:** This is a 22-bedded acute medical specialty ward within the medicine of the elderly directorate of an acute hospital, caring mainly for older people who move on to a rehabilitation setting. During the period of facilitation the ward had a bed occupancy rate of 90% and an average length of stay of 8.7 days. The application for Beacon Status was very much led by the Charge Nurse [Elisabeth] who was recognised as being a very strong leader, with clear values that she role modelled both as a manager and through her commitment to being involved in the direct delivery of patient care. There was strong support from the Allied Health Professionals (AHPs), but less direct interest or involvement from the medical staff. Once the LCC Programme was established Elisabeth took up a secondment to the LCC Team as a Senior Nurse and went to work in that role on Ward D. The Senior Staff Nurse [Gordon] was seconded to the Charge Nurse role just as the Senior Nurse for the LCC Programme [Lucy] took up her role. Lucy was new to this Health Board and with a managerial background was also new to facilitation of this nature, although she was experienced in the specialty. Shortly after the LCC Programme commenced the ward was faced with a number of co-existing challenges: the change in leadership of the Charge Nurse; staff shortages through sickness; an establishment review that led to a change in skill mix and overall reduction in numbers on each shift; a financial overspend that led to close scrutiny; and restructuring in the directorate that led to both change at Clinical Nurse Manager and Chief Nurse level. At the end of the first Phase of the Programme Elisabeth resigned her post as Senior Nurse and resumed her role as Charge Nurse, and Gordon relocated to an acting Charge Nurse role in another ward. Lucy gradually withdrew from the ward after Phase 1 of the LCC Programme and by the end of Phase 2 contact had ceased completely.

**Mechanisms:** Alongside the appreciative approach and action research, the main LCC practice development processes that were successfully adopted included:

- Beliefs and values clarification
- Observation
- Action Learning
- Theme for the Week – this was unique to this ward and involved staff selecting a particular issue to focus on (discussion and action). Themes



were posted on the Compassionate Care Board and included examples such as communication, running of the ward, patient care (mouth care, personal grooming) and patient monitoring (using the Scottish Early Warning Scoring System – SEWS).

**Outcomes:** There was recognition from all stakeholders that whilst engagement with Lucy had been very positive at the outset there were limited demonstrable outcomes, and from some perspectives it was felt that the experience had, in some ways, been counterproductive.

Abigail, Clinical Nurse Manager suggested that *'they never got a chance to deliver'* [P1] recognising that the ward had gone through *'a period of flux'*, whilst Liam, the second Clinical Nurse Manager agreed that *'We had major issues in the ward, completely, and this was still going on at the same time'* [P1]. Gordon himself argued that he had *'inherited the ward right at the wrong time'* [P2]. Liam described the staff ultimately disengaging from the Programme, whilst Gordon used the term *'fizzling out'*. The range of co-existing pressures was seen as impacting to a large degree, as Liam described:

*I don't think it was their priority. It stopped being a priority for them and it stopped being something they're doing. And any positive that were potentially there, they didn't see any more because they were so much ... the clouds were much darker on this side so they were more worried about the dark clouds here than they were about anything else.*

[Liam, Clinical Nurse Manager, P1]

On her return to the ward as Charge Nurse, Elisabeth was quite critical of the process, citing feedback from her staff team. *'I feel that we've been a Beacon Ward and no-one gives a damn anymore'* [P2]. Even Lucy reflected on her experience in Ward C as being *'like an albatross round my neck'* [P3]. However, Gordon, the acting Charge Nurse did feel he had benefitted personally in relation to his capacity to reflect on his own practice *'which is quite good'* [P2].

In terms of the outcomes matrix (Table 21 overleaf), it was notable that from my own data collection and in contrast to Wards A and B, it was relatively unpopulated, particularly for patients and relatives. Again, it is important to emphasise that the relative lack of tangible outcomes from the Programme

does not mean that the quality of compassionate care in the ward had itself been compromised.

**Table 21: Outcome Matrix for Ward C**

	<b>Relationships</b>	<b>Care Delivery</b>	<b>Developments in Practice</b>
<b>Patients</b>		Personal grooming Mouth care	Theme of the week
<b>Relatives</b>			
<b>Staff (individual)</b>	Giving (some) feedback and thanks to each other at end of shift	Renewed enthusiasm for practice following beliefs and values clarification	Band 6 induction programme (used within directorate)
<b>Team</b>	Good relationships and response when Senior Nurse present on ward (but not sustained)	Reflection on practice	Theme of week
<b>Leader</b>	Support from LCC Senior Nurse during transition into new role	Increase confidence to give care compassionately	Skills to reflect Use of open questions with staff as alternative to solving their problems

The focus of the interviews and subsequent analysis shifted, therefore, to the possible reasons for this situation. A number of key themes emerged:

- Leadership: the change of leadership at the beginning on the LCC Programme and subsequent calibre of leadership were particularly highlighted as having caused instability by the Clinical Nurse Managers and were also recognised by Gordon the new Charge Nurse himself.
- Lack of ongoing managerial support: this was perceived as an important contributory factor by Gordon who suggested that the initial enthusiasm '*waned very quickly and at some points it even looked as though it was a bothersome thing for the directorate*' [P2]. Lucy also supported this view when she commented that the new Clinical Nurse Manager did not engage, perhaps because he '*didn't really find that it [the LCC Programme] pressed his buttons*' [P1].
- Lack of support from the full multidisciplinary team: whilst there was a lot of involvement from one occupational therapist, this did not extend to the wider team. Gordon reported that he felt that the medical staff were not really interested '*there was a lot of jesting and joking, in all honesty the medical staff never took it that seriously at all*' [P2].

- Experience of the Senior Nurse: Lucy reflected at the end of Phase One of my study that her relative inexperience of practice development and facilitation skills associated had been a factor, particularly in relation to undertaking activities such as observation of care and gathering patient stories, which did not occur until the final few weeks. This was perhaps reflected in the outcomes for Ward C where there were few practice-based projects leading to distinct patient and relative outcomes as their own views had not been directly sought in the same ways as in other wards.
- Relationships in the ward: the team dynamics were recognised as having become complicated, which Lucy reported as the *'complex issues around relationships in the ward'* [P1].
- Sickness rate: it was emphasised that this was not related to the LCC Programme but was a factor because of the pressure that the staff became under. Liam, Clinical Nurse Manger suggested that *'the project .. was there, but that was not what was important to them. It wasn't a big thing for them, they weren't focused on it, and didn't really care about it'* [P1].
- Staffing review: this was carried out across the directorate and involved benchmarking against other equivalent NHS organisations. It led to a reduction in numbers on each shift, something which the staff found difficult to reconcile, particularly in relation to being a Beacon Ward.
- Lack of clarity on project outcomes: Gordon felt that a factor influencing staff's engagement in the Programme was the relative lack of clarity in the Beacon Phase of the direction it would take and the expected outcomes for them as individuals and the ward as a whole. He suggested that staff's primary concern would be:

*'How's this gonna affect me? Is it going to make my job any easier?'  
And I think it's them not having all the facts about ... I suppose it's a funny thing to say when I don't know what the end result ... the entire result of the project will be as well, but I suspect that people are dragging their feet because they're not sure why it's being done or what's going on.*

[Gordon, Charge Nurse, Ward C, P1]

### **Key practice development techniques**

Despite this apparent negativity there were some positive elements,

particularly in relation to the practice development processes used by Lucy during Phase 1 of the LCC Programme. As in all settings beliefs and values clarification was key to the introduction of the LCC Programme. Gordon reflected on the impact of being given time to '*stop[ing] and think[ing] about what they were doing, why they were doing it*' rather than simply '*coming in and going through the daily grind*' [P1]. He cited the example of one staff nurse who had been very negative about the LCC Programme

*I've seen an example of that already, just simply doing beliefs and values changed one staff nurse ... miserable, miserable person into someone who came out of that meeting going 'Wow that was really good, I sat there for half an hour to 40 minutes, all this stuff came out, I feel really enthusiastic because words were pouring out, it was really very good.' That's just one example, one person.*

[Gordon, Charge Nurse, Ward C, P1]

Lucy reflected later in Phase Three of the Programme that this process was about giving people licence and freedom to think and even went as far as suggesting '*it's making them more human*'.

Gordon reported that he had embraced the principles of appreciative inquiry and although initially being quite reserved in offering direct feedback and appreciation to staff, that he had been able to integrate it into his way of working and was recognising benefit.

*So I make a point at the end of the shift of saying to one of the nurses .. 'You did a great job today with Mr Smith's wife, when she came in. Or Mr Jones looked brilliant today when you finished washing and dressing him, and he was really happy, well done!'. Hopefully they'll pick up on that from me and do it themselves as the other new staff come in as well.*

[Gordon, Charge Nurse Ward C, P2]

Gordon had not enjoyed the action learning component of the Programme, on the grounds that he liked to solve his own problems '*it might just be male pride and ego*' but also because it felt like '*some kind of therapy*' [P2]. He did, however, see the value in having the direct support and input of Lucy as a critical companion and someone who gave him focussed feedback. In particular, he was surprised at the element of being encouraged to probe patients about their care when they offered thanks. Rather than simply saying thanks, the conversation should be directed to asking '*why?*' and getting some detailed feedback. Gordon recognised from his discussions with Lucy that he'd

*'missed lots of options to learn from what it was that I was doing, and get the information out. That's what Lucy was there to do, get it out of us. But she made me think along those lines as well'* [P2].

The relationships that Lucy built up with staff during Phase 1 were seen as vital, particularly as the challenges emerged. Gordon recognised that these had come about as a result of Lucy's personality but also her skills in *'draw[ing] people out'* [P2]. The fact that she *'got mucked in'* in terms of activities such as bed baths was seen to be essential in developing relationships. Gordon did recognise during this process that Lucy was simultaneously *'trawling information out at the same time, in a very good way'* [P2]

Elisabeth, LCC Senior Nurse and former Charge Nurse in Ward C maintained contact with the staff during their participation as a Beacon Ward and presented a view that they felt the primary focus of the Programme was between Gordon and Lucy rather than with the wider team. When she resumed her role as Charge Nurse during Phase 2 of the LCC Programme she was very despondent about her ward's experience:

*And I felt quite let down, and I felt that was my fault because I was part of this project and how had I not seen that this was happening? And I look around and I think I was looking for stuff displayed on walls or in folders ... I felt the staff here were a bit cheated because there's none of that [folders, wall mounted materials on compassionate care] here. There's nothing for me to go and get and say to ... this is what happens on the compassionate care project when I've been away.*

[Elisabeth, Charge Nurse, Ward C, P2]

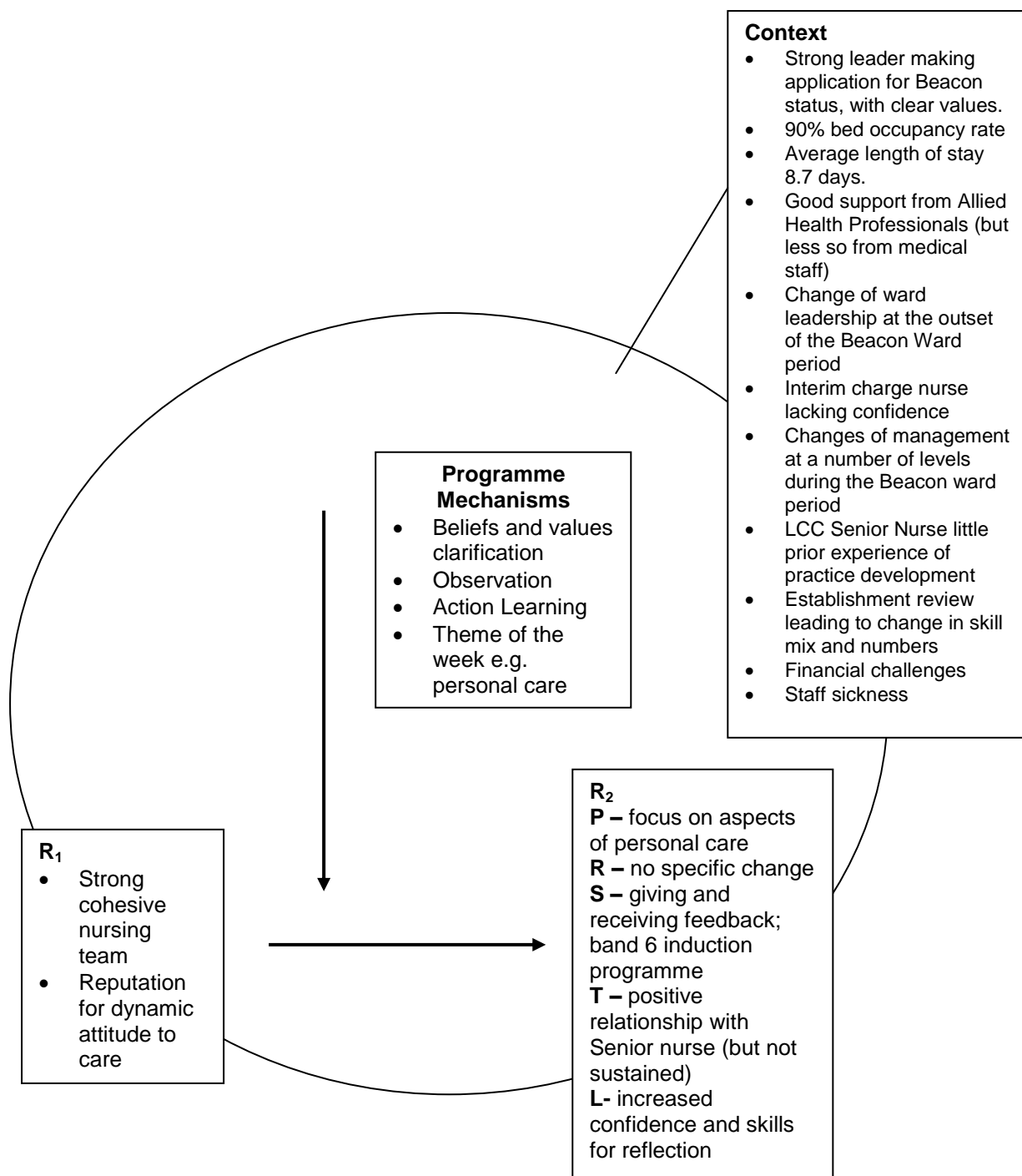
### **Change in regularity**

Figure 15 on page 195 illustrates the shift in regularity in Ward C. R<sup>1</sup> was a very strong starting point; the ward had an excellent reputation for its clinical care and the effective leadership of the charge nurse. The contextual challenges were like many within the acute hospital, however, around the time that the Programme was actually implemented the changes in leadership within the ward and directorate above had a significant impact on any potential

benefits and outcomes that the LCC mechanisms might offer. Sitting alongside these challenges there was the situation of a comparatively inexperienced facilitator taking up post of Senior Nurse and the interim charge nurse lacking confidence (and perhaps support) to take forward elements of the programme. The R<sup>2</sup> position reflects comparatively little progression and if a R<sup>3</sup> had been recorded this might have demonstrated a position further behind R<sup>1</sup>.

**Figure 15: Realistic Evaluation Summary – Ward C**

**Category: Low Adopter**



**Key**

R<sub>1</sub> = Regularity prior to LCC Programme

R<sub>2</sub> = Regularity following LCC Programme interventions up to one year after facilitation

Outcomes: P – Patient; R – Relative; S – Staff; T – Team; L – Leader

### 6.3.4 Ward D

**Context:** This is 46-bedded mixed medical specialty acute, long term and palliative care ward within a modern acute hospital. During the period of facilitation the ward had a reported bed occupancy level of 122.1% (this was as a result of day patients being seen on the ward as well as the high level of patient turnover) and an average length of stay of 6.6 days. At the outset of the LCC Programme it was led by an established Charge Nurse [Sarah] and had a reputation for having a cohesive, stable multidisciplinary team with good communication and a positive approach to care. Sarah indicated that she had no hesitation in applying for Beacon Status, demonstrating full confidence in the quality of care. She was at pains to stress that *'it's just the way we are. It's just, that's what we do'* [P1], nevertheless there was an openness to develop further. Their LCC Senior Nurse was Elisabeth, former Charge Nurse in Ward C who was previously known to many of the staff but she was new to both facilitation and research. Like most wards within the acute hospital Ward D was strongly influenced by targets and patient flow. Sarah talked about pressure to *'clear beds at the back door to make room for people waiting at the front door'* commenting that this *'has changed things on the ward quite dramatically'* [P1]. She went on to stress that it was their teamwork and *'united front'* that supported the staff to deal with these pressures, reflecting on the words of one of the nurses who had described the situation:

*'Well there are good days and there are bad days and there are bloody awful days, but we still stick together and work through it. And we always work through it and we help each other.' And of course when you did see that happen, you see the patients were happy with that too.*

[Sarah, Charge Nurse, Ward D, P1]

At the end of Phase 1 of the LCC Programme Sarah left the ward to go on maternity leave, and after a period of uncertainty around the succession planning, one of the Deputy Charge Nurses was seconded to the Charge Nurse post for a few months, followed by other temporary appointments into that role before a permanent Charge Nurse being appointed during Phase Three. At the same time the ward was influenced by the same directorate management changes that had affected Ward C. The change in local leadership was seen to have a very major impact on the outcomes of the



Programme beyond Phase 1, with the key issue being the influence of the seconded Charge Nurse. This will be explored later in this section, however, Elisabeth summarised the situation that she and the ward were faced with for the final two months of Phase 1.

*When they changed the ward sister they changed the nurse manager, so that was a bit difficult for me because nobody understood it. And then the chief nurse changed in the middle of all that as well. And so you're trying to liaise with all these people to keep them up to speed. And I remember going to the second nurse manager. It was like 'Well (sigh) I don't really understand all this.' And I think people who don't start from the beginning and come through the process actually have difficulty with it. But [Abigail] [Nurse Manager] herself initially, at the beginning, was really bought into it and always wanted copies of all the work that we'd done and feedback. So that was helpful. But she also knew that when [new Charge Nurse] came into the role ... they all knew. They all knew it was going to be difficult. Because I remember bringing it up with [Abigail] about the continual change of leadership and it wasn't benefitting staff at all.*

[Elisabeth, LCC Senior Nurse, P2]

Reflecting on the influence of local change of leadership at the end of the three years of the Programme, Ruth one of the LCC Senior Nurses cited Ward D as an example where it almost became impossible to sustain engagement and development.

*I think leadership remains really critical. Leadership in that it's continuous and consistent, where there hasn't been consistent continuous leadership they've absolutely struggled. I think [Ward D] is a good example, where there's been very ... 8, 9 changes of Senior Charge Nurse, Deputy Charge Nurse and just to try and achieve ongoing contact and keeping up some sort of ... this work does require a sense of pace for it to develop and a beginning and an end and a sort of process. And if that gets cut off at any point and you drop to the beginning again, and start again, it's really, really difficult. And the more that happens, the more difficult it is because people, I think the practitioners in the setting, they don't understand what's happening, they can't see it and it doesn't make sense to them. It just feels confused.*

[Ruth, LCC Senior Nurse, P3]

As previously stated Elisabeth left her role as LCC Senior Nurse at the end of Phase 1 and so the ward also went through another hiatus during an important period of transition. The new Senior Nurse [Sam] came into the LCC Programme during Phase 2 and although he knew the staff in Ward D from his

previous clinical role, working as a facilitator was also new to him. This period also coincided with the outbreak of the H1N1 virus that particularly increased the clinical pressures and acuity of patients in Ward D.

**Mechanisms:** Alongside the appreciative approach and action research, the main LCC practice development techniques that were successfully adopted included:

- Beliefs and values clarification
- Imagery – to generate patient and staff stories
- Emotional touchpoints – with patients

### **Outcomes**

The outcomes for Ward D fell into four distinct phases:

1. During the first five months of LCC Phase 1 when Elisabeth was working directly in the ward and Sarah the Charge Nurse was still present there was high engagement with and adoption of the LCC techniques, with a number of development projects implemented.
2. Following the departure of Sarah and appointment of the new Charge Nurse it was more challenging to keep the momentum of the Programme going, because of direct 'opposition' by the Interim Charge Nurse. However, Elisabeth's continued presence maintained the profile and activity.
3. After Phase 1 and Elisabeth's departure from the Programme, continuation of the programme processes that had seen to be so successful waned. Staff were preoccupied with the clinical pressures (such as H1N1) and the ongoing leadership changes.
4. A new senior staff nurse was recruited to Ward D during Phase Two of this study and she was immediately nominated to participate in the LCC Leadership Programme. However, during her presentation at the Celebration event in January 2011 she stated that *"compassionate care" had become a dirty word in the ward*.

## What worked well?

Elisabeth felt that building relationships with the staff had been absolutely essential in order to seek answers as to how they delivered compassionate care, as initially she believed they had felt that they were being 'spied on'. She therefore placed an emphasis on having conversations with different groups of staff at different times, and for the first two weeks working alongside them. '*I actually did clinical stuff, to gain their trust, really*' [P2]. Sarah echoed these perceptions and reported that Elisabeth made a real effort to get to know everyone in the department and tried to work with the majority of nursing staff and the AHPs and some of the medical staff as well.

Sarah stressed the value of having anonymised feedback from these activities available for all staff to read, suggesting that it made them feel secure to be honest and open. Elisabeth had created Compassionate Care folders that were held in each of the three bays as well as there being a centralised notice board. Sarah acknowledged that initially Elisabeth's appreciative approach was '*difficult*'. This she felt was because '*nurses aren't used to being praised for things they do, they're more used to people being negative and they respond to the negative*' [P1]. However, eventually after a number of stories were generated they were able to see and appreciate all the positive things they did and '*got into it*'.

Elisabeth used imagery in the form of presenting a range of post cards to individual patients to invite them to talk about their experience of care in the ward. She described the impact of this activity, which was something that she presented at a large organisational forum for Senior Charge Nurses. The patient she described was a frequent attendee in the ward with a long-term condition and had chosen an image of a paint pallet.

*I was quite intrigued by this paint pallet she'd chosen, all these different colours and she was the red bit in the middle and all the bits around were different members of the health professions and little trickles of brown were the visitors getting in to see her. And they were minimal, but she felt secure, it was quite bizarre. And I gave the Charge Nurse this, she was, 'Oh my God!' And I took this picture up, there were colours everywhere and it was like, 'Well what is that?' It was quite an enlightenment.*

[Elisabeth, LCC Senior Nurse, P2]

Furthermore she felt that the power of using images was that they instilled *'openness and honesty, because I think when people look at an image and they've chosen an image, they're honest about why they've chosen it. And I think they delve deeper for the words that they're using'* [P2]. Elisabeth felt that the consequences for staff were that it made them think about what they do and realise how they do things, and gave them the ability to express themselves and listen to others expressing themselves. She felt that this was particularly powerful *'Because I think once you start thinking about yourself and how deep you actually think, you begin to realise how deep other people can think'* [P2].

Elisabeth described the use of emotional touchpoints as very eye opening for staff and reported that they were quite taken aback by some of the comments and some of the words that patients used. Examples included a patient revealing *'crying quietly in their sleep'*, which Elisabeth reported having a big impact on the staff when it was fed back to them. A second was a patient describing the doctor's ward round as being, *'like being in zoo, with everybody staring at me'* [Elisabeth, LCC Senior Nurse, P2]. This led to Sarah, the Charge Nurse actually asking medical students to position themselves elsewhere and ensuring that patients were asked if they minded the students being present. Elisabeth reflected that staff and patient stories had a much more powerful impact on the staff than the beliefs and values clarification. She suggested that this was because, to the staff, the stories were real rather than the beliefs and values that were about the idealistic.

Abigail was Clinical Nurse Manager for both Ward A and Ward D during Phase 1 of the LCC Programme and was able to draw contrast in the approaches of the Senior Nurses. In Ward A she had felt that Michael, the LCC Senior Nurse had initiated too many projects whilst Elisabeth had judged the pace of the staff and worked at a slower pace. However, once Elisabeth had left it appeared that there were not many tangible, sustained outcomes.

### **Outcomes**

It was acknowledged by the Senior Nurses and Abigail, Clinical Nurse Manager that the long-term outcomes for Ward D were more limited and this is reflected in Table 22 overleaf.

**Table 22: Outcomes Matrix for Ward D**

	<b>Relationships</b>	<b>Care Delivery</b>	<b>Developments in Practice</b>
<b>Patients</b>		Improved discharged planning Understanding of night time experience	Management of ward rounds Quote of the week – from patients recorded on a white board
<b>Relatives</b>			
<b>Staff (individual)</b>	More powerful understanding about how each other think		
<b>Team</b>	Greater understanding of how each other think (following beliefs and values clarification) Appreciation More openness	Reflection on why things are done in particular way	Hug Meeting
<b>Leader</b>			

### **Successful outcomes**

Elisabeth indicated that during her period in the ward the appreciative approach to the programme definitely had an impact on staff and was mirrored in their own behaviour in terms of listening and giving praise to each other. She felt that this was, in part, directly related to the impact of them having read positive patient stories:

*And I think because they actually read some of the positive stories that had come out, they actually felt that that was really positive and when they did something like that again, or something similar, they realised that that was a positive thing and they would talk to each other.*

[Elisabeth, LCC Senior Nurse P2]

One of the development projects that emerged from the beliefs and values clarification was a focus on improved communication through the introduction of a 'hug' meeting at 7.30am and 7.30pm involving both day and night staff. This type of approach is a 5-minute briefing focussing on three or four different points each day and preceded the more widespread introduction of the concept of a safety briefing associated with the Scottish Patient Safety Programme that became more common in the organisation by 2011. The

content of the 'hug' might include forthcoming events, new policies and/or known workload pressures that day including complex discharges. Sarah reported that there was a noticeable improvement in discharge planning as a result, which to her indicated that staff were not just standing disinterested but were listening and taking issues on board.

### **Challenges**

Abigail, Clinical Nurse Manager acknowledged the tensions that the clinical staff in Ward D experienced directly as a consequence of the pressures of bed occupancy and the four hour waiting time target. She cited the example of a patient due for discharge still being in their bed at lunchtime with another patient in A&E needing admission for specialist treatment. The nursing staff had argued against the movement of the first patient to the day room on the ground that they were a Beacon Ward and this was not a very compassionate act for that individual. Abigail argued that perhaps they needed to '*have a wee bit more of a helicopter view of things*', but recognised that the targets at the front door were seen as a barrier and not their problem, rather than what was best for a particular patient.

Abigail also cited a range of managerial issues that were co-existent in Ward D in Phase 1 and 2 of the LCC Programme and these included financial overspend, sickness/absence and performance issues as well as the continual change of management at Charge Nurse, Clinical Nurse Manager and Chief Nurse level. Abigail emphasised that Ward D was '*a great ward*' that was unduly influenced in many respect by these wider influences.

### **Impact of a leader who does not support the Programme.**

As previously stated one of the distinctive features of Ward D was the fact that for the final two months of Phase 1 and the following year the ward leader appeared not to support the LCC Programme, and at times seemed to work overtly against the involvement either of herself or her staff. Jack, Policy Maker reflected at the end of the Programme that there had become a perception that participation was optional, and that perhaps with the wider management changes this had not been sufficiently challenged. Noticeable manifestations of this included a reluctance to release staff to be involved in Programme activities (e.g. patient stories) and a fundamental shift in tone of

the 'hug' meeting in the morning from a supportive communication mechanism to what Elisabeth described as a 'telling off meeting' [P2]. She reported feedback from one of the clinical support workers who had been very involved in the LCC Programme who told her:

*... that he wasn't listening to it any more, he was leaving the meeting, because there wasn't a thing positive for him, and he walked away. And I think other staff followed him. Because it seemed like a telling-off meeting, 'You haven't done this, you haven't done that.' And the way that it had been done previously with Sarah was that it was about, 'These are the good things.' And in the middle she would put, 'We could have done better x, y and z' and then she would end up with, 'Has anybody got any feedback, anything they want to say about anything else?' But it changed, when [new Charge Nurse] took it, it was like, 'I'm telling you you've done these things wrong.'*

[Elisabeth, LCC Senior Nurse, P2]

One of the outcomes of the change in leadership was seen to be a breakdown in the teamwork that had been a distinctive feature of the ward. With the new Charge Nurse being quite openly resistant to the Programme, Elisabeth indicated that several of the staff 'sided' with her, whilst others were keen to remain involved.

*And I think it was in danger of crumbling for those two months because there were camps. They were quite clear ... what I think they did, actually, was just to draw back into themselves and they were friendly enough with people they wanted to be friendly with, but they actually ostracised people who ... they did actually, when I think about it, like the F grade who was the acting person, her friend they'd stop conversations when they came along. But I think had they not have done that, they might have completely fallen apart as well. Had they not have kept their little camps of people, chivvying each other along, they could have fallen apart.*

[Elisabeth, LCC Senior Nurse, P2]

Elisabeth went on to suggest that this change in leadership and behaviour towards staff did have a direct impact on patient care, in that she observed staff feeling stressed and therefore 'snapping' at patients.

*... what I witnessed sometimes was staff being stressed by this person continually cracking the whip, and not in a nice way. It was the manner in which she did it. ... And I saw staff put their head in their hands sometimes and be ... I won't say snappy with patients, but not compassionate: it was just the way they had just been spoken to too. So it just carried on. And as the day went on and it was forgotten they were ok, but that immediate response was the*

*abruptness. And it was like, role-modelled that so I'm just doing that too. But I think they were unaware of that.*

[Elisabeth, LCC Senior Nurse, P2]

Sam, the second LCC Senior Nurse associated with Ward D reported that by the time he became involved staff were beginning to make statements such as *'We're not able to deliver compassionate care anymore. We're not resourced, we're short staffed, we're struggling'*. Despite the fact that he pointed out to them that their care delivery had not changed they fundamentally linked being compassionate to being part of the Programme, with the associated facilitation and therefore what they were missing was the feedback and the cultural impact of the appreciative approach. In particular, Sam felt that they were not being facilitated to reflect which in turn was making them feel guilty about not being able to do the things they wanted to do. He suggested that in some ways their 'exposure' to the LCC Programme was now being counter-productive and that that they were now left with a sense of *'That's what we used to do, we're not even doing that anymore, we're not being compassionate'* [Sam, LCC Senior Nurse, P2].

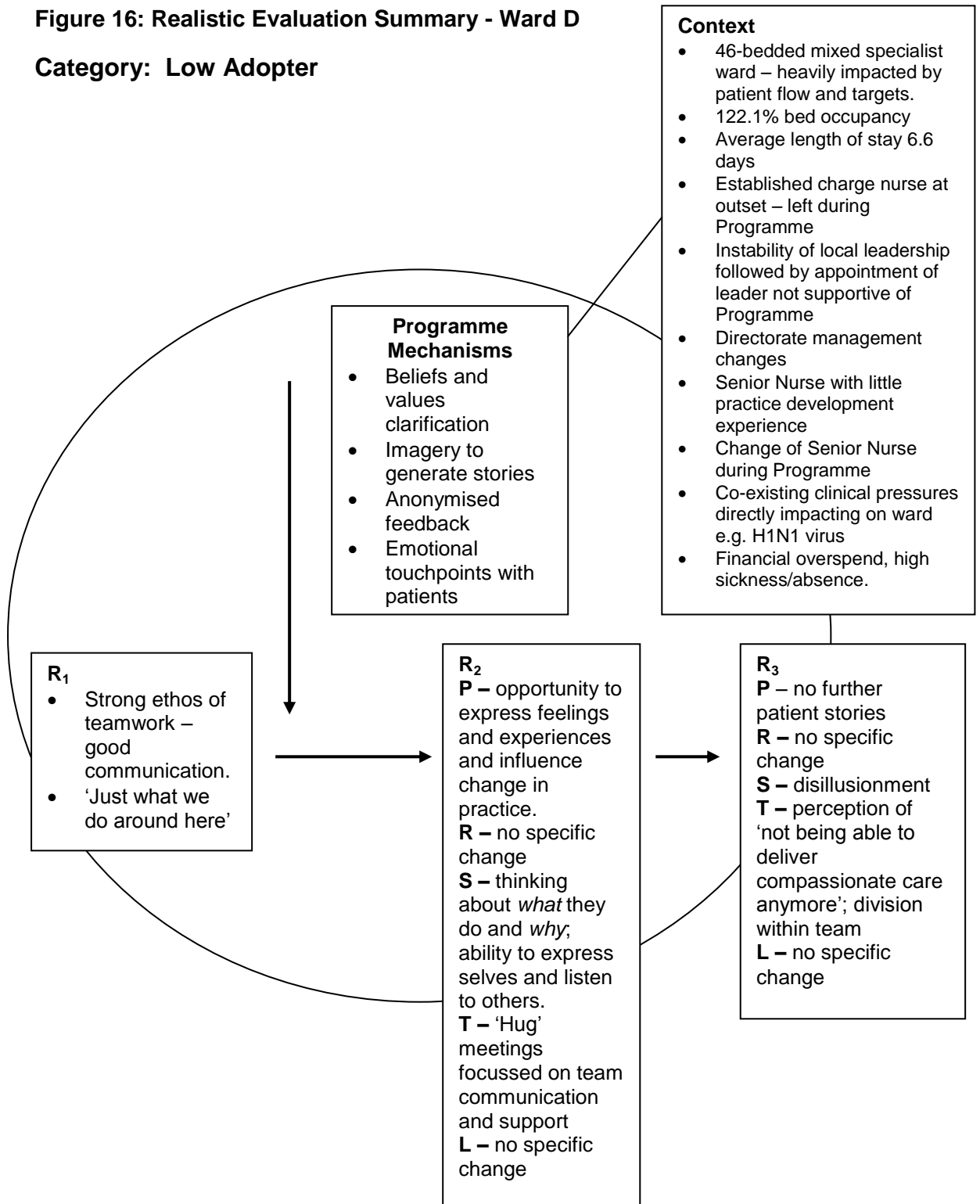
### **Change in regularity**

Figure 16 overleaf identifies three points of regularity rather than the previous two in Wards A and B. At point R<sup>1</sup> the structure and agency was such to present a position of strong teamwork and high quality clinical care. R<sup>2</sup> reflects a point in time where the interplay between the enhancing contextual influences (leadership and team ethos) and the underlying mechanisms (willing participation in the Programme and managerial support) provided the structure and agency to achieve some positive changes in regularity. The more negative influences (unstable leadership and co-existing clinical pressures) combined with a more substantial shift in reluctance to participate in the Programme at all subsequently led to the final point of regularity at R<sub>3</sub> at the point where my data collection ceased.



**Figure 16: Realistic Evaluation Summary - Ward D**

**Category: Low Adopter**



**Key**

R<sub>1</sub> = Regularity prior to LCC Programme

R<sub>2</sub> = Regularity up to the point of departure of the first charge nurse and first LCC Senior Nurse

R<sub>3</sub> = Regularity following LCC Programme interventions up to one year after facilitation

Outcomes: P – Patient; R – Relative; S – Staff; T – Team; L - Leader

#### 6.3.4 Ward E

Ward E is a 25-bedded mixed mental health rehabilitation ward within a large psychiatric hospital. The Charge Nurse [Tom] was in his first post and had been in the ward for about eight months when he made the application to become a Development Site. Whilst he recognised that the ward had some good qualities, in his words *‘there was no real direction, there was no real sense of purpose. Patients were stagnating, needs weren’t been met, doors were locked throughout the day, they were being locked out of their rooms during the day for about five hours. Because that was what they did ...’* [P1]. There was an established nursing team, many of whom had worked in the ward for a considerable period of time. In his first few months Tom had made a number of changes which he acknowledged were *‘fairly unsophisticated and crude, but brought the place back up to a good working standard’*. He felt, therefore, that the LCC Programme was a fantastic opportunity to take his ambitions forward. The ward had a small multi-professional team including psychiatrists, occupational therapists and nurses, many of who were involved in preparing the application. Tom had also involved a number of carers in this application and he reported that one of them had commented at the time:

*‘This is truly aspirational. It’s inspirational, but it’s aspirational.’ So I thought, ok how do I take that aspiration into reality? And coming away from the implicit to the explicit, was the challenge.*

[Tom, Charge Nurse, Ward E, P1]

The LCC Senior Nurse [Lucy] had no previous experience of working in a mental health setting, but was now fully familiar with the LCC Programme and its processes. For the first six months of the Programme Tom worked without a Deputy Charge Nurse in the ward, and so had considerable day-to-day management responsibility as well as overall leadership. He participated in the Leadership Programme, along with the other three Development Site Charge Nurses and they joined an action learning set with the four Charge Nurses from the Beacon Wards.

Tom worked within a well defined and stable management structure in his service with regular contact with his Clinical Nurse Manager and Chief Nurse. There had been strong support from the psychiatrists to make the application to become a Development Site, and this was sustained throughout. Indeed, in

the second year of their involvement one of the psychiatrists actually enrolled on the Leadership Programme.

During the second year of the Programme Tom was seconded to another ward in the hospital that was seen to be in need of strong leadership. He never returned to Ward E as Charge Nurse but maintained effective links with it and the Programme. The Interim Charge Nurse (the relatively newly appointed Deputy Charge Nurse) was fully engaged having already been enrolled on the Leadership Programme, in the same cohort as the psychiatrist.

**Mechanisms:** Alongside the appreciative approach and action research, the main LCC practice development techniques that were adopted included:

- Beliefs and values clarification
- Strong emphasis on gathering stories from staff, students, patients and carers – using imagery and emotional touchpoints
- Emotional touchpoints – with patients as part of their psychiatric assessment and review process
- Generation of positive care practices - displayed in digital photo frames

**Outcomes:** Ward E was regarded as being a very high adopter of the LCC Programme and a setting that had undergone transformation during its period of involvement and beyond. At the end of Phase Three of my study when the Policy Makers were asked to reflect on overall outcomes of the LCC Programme, both Jack and Martha drew attention to Ward E. Jack reflected that the focus on patient stories had had a major impact, particularly as a result of the involvement of medical staff. He indicated that *‘actually listening to patients and hearing what they are saying, in terms of making changes to their management’* was not only beneficial to the patients but also impacted on efficiencies within the ward [P3].

Martha had visited the ward on a number of occasions (often taking internal and external visitors to see the impact of the LCC Programme in practice) and commented that she was always struck that:

*‘the Charge Nurse could articulate how it had changed the whole culture ... the therapeutic environment within that ward area. Because everyone had become involved, the medics, the support staff, the nurses and the patients themselves. And he felt it just had*

*changed the way that they worked completely, and he could demonstrate that, it wasn't just him saying that, it was very, very positive and I think to listen to him speak was very convincing in terms of what it could do' .*

[Martha, Policy Maker P3]

Tom felt that the most important outcome achieved within Ward E was that team became aware that *'people were at the centre of their own care'*, which he articulated as being *'it's about that inclusivity'*. He went on to describe how he and the other members of the team recognised that:

*.. we were talking but we weren't listening, and that was the key. So it was about listening and becoming better listeners. More looking for solutions rather than problems, so a much more appreciative way as well, and actually being quite a lot nicer to people. There was actually a harshness sometimes, there was a them and us, and 'we're the staff you're the patients. We'll decide what's actually going to happen'. We didn't flip it around we just levelled it out. We work together and that was the big key part.*

[Tom, Charge Nurse Ward E, P3]

He did, however, go on to recognise that the majority of the outcomes were anecdotal because they did not have the evidence to back it up [yet], but went on to say *'but hopefully there has been a difference. And they feel much more comfortable in their surroundings because they know that the staff are much more warm and caring'* [P3].

The outcome matrix in Table 23 on page 210 indicates that whilst there was a good breadth, these were very much centred on the relationships between staff and patients and had been largely influenced through the introduction of emotional touchpoints. At the end of Phase Three of the data collection there were few action projects to demonstrate outcomes, however, Tom wanted to emphasise that an important message from the Programme was that the achievement of embedded outcomes would take a number of years to come to full realisation. He stated that it was six or seven months before they realised that there was a lot of planning, a lot of thinking, a lot of deliberation involved in making change:

*It was inadvertently the most beneficial thing that we've done is not rush in to setting anything up. Then all of a sudden it all just started to click. Because you were confident in rolling something out, your team so that you were confident in what you were wanting to do,*

*and even at the end of the day if it didn't work, there was a confidence and an evidence base attached to what you were trying to do.'*

[Tom, Charge Nurse, Ward E, P3].

**Table 23: Outcome Matrix for Ward E**

	<b>Relationships</b>	<b>Care Delivery</b>	<b>Developments in practice</b>
<b>Patients</b>	Honest expression of impact of interactions with staff.	Using stories within review meetings – eliciting information that consultants previously unaware of.	Making people the centre of their care – inclusivity.  Changes to the structure of the ward day – e.g. buffet breakfast, patients having greater freedom to determine their own routine and bedrooms no longer locked.  Use of emotional touchpoints for therapeutic assessment and review
<b>Relatives</b>	Sense of staff 'giving them some investment' through emotional touchpoints	Staff securing deeper information about the patient rather than obtaining it piecemeal	Relatives being more confident about making suggestions for improvements without being seen as being critical.
<b>Staff (individual)</b>	Sharing a little bit of self with patients – 'give a little and get a lot back'	Exclusively work as key workers for patients  Becoming better listeners (going back to fundamental psychiatric nursing skills)	Greater positive risk taking with patients  Confidence of Deputy Charge Nurse to facilitate challenging group discussions.
<b>Team</b>	Openness to make changes (and more quickly)  Clear direction of the multi-disciplinary team	Opportunity to present changes in care delivery at local and national conferences.	Creation of a 'see it, do it' mentality.  Introduction of shift co-ordinators (not necessarily the most senior person)  Development of new student and staff induction programmes.  Integration of imagery into recruitment process to support questioning about compassion.
<b>Leader</b>	With the LCC Senior Nurse – role modelling 'subtle leadership'	Sharing initiatives on care delivery as widely as possible with colleagues within the directorate	'Learning how to take care forwards'.  Involvement in organisational wide initiatives such as review of complaints management.  Recognition of leadership talent and potential.

Undertaking the type of reflection involved in the Programme had allowed Tom and the team to think about what they were doing as nurses. Tom acknowledged that even in psychiatry, nurses were becoming too technical and were not recognising that in their world:

*... you don't have machinery you don't have the bits and pieces, you've got your mouth, your head, and controversially I would say, your heart as well. Because you've got to think and feel about what you're doing. And all of a sudden people are, 'Oh yeah, we're not listening, we've forgotten how to talk. [P2]*

He went on to say that having recognised this situation the staff were now making those interactions with patients much more meaningful

*It's actually just listening more to what the person's saying, rather than just saying, 'Aye, fine, right, grand,' and walking off again. I'm sorry, what's fine mean? Just going into it just that wee bit more so you're starting to see that. And that was the key difference. You can pop the assessments on top of that but it was actually just the ground level conversation was much more effective than normal. [P2]*

Another key outcome was the confidence that was instilled in members of staff to undertake facilitation, or to tackle what might previously have been seen as issues beyond their comfort zone. Lucy, Senior Nurse cited an example of the staff team being keen to undertake an examination of how handovers could be improved and the new Charge Nurse initially looked to Lucy to facilitate the focus group. However, with encouragement she had done it herself. As Lucy remarked *'I think the impact is about people realising their confidence and their ability to facilitate those kind of things'* [P3], which she also acknowledged had been the case with herself when she was new to the facilitation role in the first year of the Programme.

Tom, although relatively junior in terms of years since qualifying as a registered nurse was seen as something of a high flyer who was likely to implement change. Prior to making the application to take part in the LCC Programme he had already made a number of changes to the ward after asking patients what they wanted (something previously unheard of) and then beginning to implement them. When I asked Tom at the end of his first phase of working with Lucy what he thought the ward would be like if they had not been a Development Site he responded:

*I think we'd be trying to do similar things but not necessarily ... doing all the right things but not necessarily in the right order. With the best will in the world I don't think we'd have been as advanced as we are now. I think maybe it would have been quite easy to get sucked in to old ways of working and easier practices, but this just gives us a new focus and really take it forward.*

[Tom, Charge Nurse Ward E, P2]

One of the outcomes associated with making these changes was an increase confidence amongst all the staff to be able to challenge peers, participate in meetings, ward rounds and to hold discussions with relatives as well as with patients themselves. Tom put this down in part to *'Just because they weren't afraid of repercussions. Working within the codes of conduct, yes, but weren't afraid of repercussions if they didn't get it just so. So that was ... just allowed people a bit of freedom'* [P3].

Having been exposed to the use of imagery to express their own beliefs and values associated with compassionate care, Tom and members of his team decided to integrate them into their recruitment process. In one situation where they had 70 applicants for a nursing assistant post they shortlisted 12 of them and then following the standard interview questions asked each candidate to pick an image from six (deliberately selected by the team) that described being compassionate to them. *'And that was the king maker, that was what ... got a fantastic member of staff out of that'* [P3].

### **What worked well?**

The appreciative approach had an important impact in terms of changing the ward culture and Tom believed that this was because over time staff recognised that they were not going to get a *'bollocking'* if they made a mistake. As a consequence there was more positive risk taking than previously, something which Tom felt was important within this type of therapeutic environment. This was partly responsible for the change in atmosphere amongst staff, something that Tom described as *'a positive feeling, a 'see it, do it' mentality both in terms of change to date and receptivity of change to come'* [P2].

The beliefs and values clarification sessions both allowed staff to articulate their values and to express things they would like to change in the ward (for example the staff induction programme and the way shifts were co-ordinated).



10-15 positive care practices were developed in the ward and displayed alongside some of the existing LCC Programme examples developed from other wards. Tom gave an example of an outcome from one particular beliefs and values session that came from a student and had an important outcome for the ward in expressing their underpinning philosophy:

*I remember one student talked about how it was ... working here is like a Rubics Cube, or the patient's life's like Rubics Cube, that not all the sides need to match to start recovering. One side can be fine, but the rest .... and that's all come from beliefs and values and the pictures that we've used. And we're going to use that quote as our ward philosophy. That's just going to be our, that's what we do. We might even have it up framed and say, 'This what we try and do'.*

[Tom, Charge Nurse Ward E, P2]

By the time of the second interview this ward philosophy had been developed to the effect of '*you might come in here jumbled up, if you get one side right then that'll not be too bad then*' [Tom, Charge Nurse, Ward E, P3]

Tom felt that emotional touchpoints had been particularly successful within the ward because they gave staff a structure to a deeper, more meaningful conversation with patients drawing out the skills, that he felt they already had but giving them confidence to use them. In addition he suggested that they prompted the patient to take a bit more control as well. Tom expressed his excitement about this technique very vividly:

*I feel like I've been given a new train set because it doesn't ... silence doesn't matter because you can put the touchpoint on the table and have a word round about it and just sit and look at them for 10 minutes, there's no issue with that. Whilst the person decides what it is they want to bring, or just not talk about it and talk about something else. And if we do an assessment like that then it's not really an assessment, just a conversation, yes about set subjects but .... and that's what's good about it as well, you can't really deviate away from that subject because if you ... you can be quite forceful in that situation and say, 'No this is what we're talking about just now. It's good to cover this because this is part of your care.' So it's about giving people that control. [P2]*

Over time it was recognised within the team that emotional touchpoints had the potential to play an innovative role in the therapeutic assessment and review of patients and therefore they developed a tool involving 7 or 8 touchpoints, which was used not only with patients but also with their relatives. The benefit

of undertaking this process with relatives soon after a patient's admission was that the staff were able to benchmark the carer's perception of the patient's condition, rather than *'the chip chip chip away that we [got] sometimes'*

Tom cited one example when emotional touchpoints were used with a particular patient and that this had given staff a completely different insight into his perspective:

*... Somebody saying that their past is a troubled waistcoat that they wear, and it's all battered and tatty and ripped ... but they feel comfortable. You wouldn't get that anywhere else. They were talking about, 'I have to keep the past because it stops me making mistakes in the future.' Those are things we wouldn't have got just from bog standard, off the shelves, assessment.*

[Tom, Charge Nurse, Ward E P2]

Later during Phase Three of the Programme, Tom reflected on the use of emotional touchpoints with one of the relatives:

*And it was ... everything in it was what I wanted to hear. They felt that their son was being well looked after, that some of the needs she didn't even know existed, were being discovered and met. We couldn't have done that had we not started looking a bit deeper at things and listening a wee bit more. [P3]*

He went on to acknowledge later that whilst people perhaps did talk about emotions before they used emotional touchpoints *'they might have done but not in an appreciative way, or maybe a productive way'* [P3].

Lucy, the LCC Senior Nurse commented that for her a marker of the outcome in Ward E was that when she visited it more than one year after she had formally left all the staff were undertaking emotional touchpoints as part of the patient assessment process, preparation for patient review meetings and other aspects of their practice.

### **Support from the LCC Senior Nurse**

Tom repeatedly emphasised the support provided by Lucy, the LCC Senior Nurse citing her ability to instil confidence in the staff simply through her presence, manner and skills and the fact that when she was teaching them new techniques she had *'just taken one stabilizer off at a time'* [Tom, P2]. He went further to praise Lucy's 'subtle leadership', which was often used to support him in potentially difficult situations:

*..... that sort of leadership thing, that's been brilliant. Absolutely brilliant. For both of us, but for other people on the ward as well because it's ... say one staff nurse who we knew was going to do a touchpoint on somebody it was just drawn ... dragging his heels a bit and [Lucy] would lean on me to gently lean on the person and that's good, it's a nice subtle pressure. Because if we say we're going to do it then we do it, it's that sort of commitment. [P2]*

Additional support was provided through the action learning sets with the other Charge Nurses, which were facilitated by the LCC Senior Nurses. Tom reflected that whilst these sessions could be very emotionally charged for all involved *'at some stage or other that facilitator and that person who would talk with you, but it's just to check that they're alright. Never not known that to happen, so it's that support, as well. It's high challenge, high support, that was certainly the mantra throughout'* [P3].

### **Support and commitment from others**

The strong commitment from the multidisciplinary team was also crucial to Ward E's success. Tom put this down partly to the transparency in their relationships and ways of working (something he had worked hard at developing when he came to the ward), an ongoing commitment to quality improvement and the fact that they had all been involved in the beliefs and values exercises, which Tom stated meant that *'we're clear in what direction we're wanting to go as well'* [P2]. It was evident from a number of sources that Ward E had visible, direct support from both middle and senior managers, including the Nurse Director, Chief Operating Officer and Board Chairman. This was particularly the case because there had been a clear approach to link the outcomes of the LCC Programme with other initiatives such as the Scottish Patient Safety Programme in terms of positive risk taking. A further feature in Ward E was that towards the end of the Development Site Phase there were plans to establish a local Steering Group for Compassionate Care, initiated by the service manager as more wards within the directorate were coming on board as participants on the Leadership Programme. This Steering Group would include the Chief Nurse, Clinical Nurse Managers, Lead and Senior Nurse from the LCC Programme and Charge Nurses. Tom emphasised that the LCC Programme was high on the agenda *'So it's always updating and saying this is what we need, this is what we're doing, and just constantly keeping people in the loop'* [P3]. Through this process Tom felt that he was

trusted to *'[have] that autonomy to go on and make mistakes'* and learn from them. He went on to remark that one of the measures of this support was the investment made by managers in releasing and funding staff to attend and present at conferences both locally and nationally.

### **Longer term sustainability**

As previously mentioned once the initial phase of facilitation had been completed Tom moved to another ward within the same hospital, this time dealing with patients in the acute phase of a psychotic illness. Once again he was working with an established nursing team, and although now a more experienced Charge Nurse, was still relatively junior in terms of length of time since qualification. He commented on his continued use of an appreciative approach, which initially was seen as quite shocking by some people, particularly when mistakes (such as a drug error) had been made. Tom's immediate focus in this case had been to ask how the member of staff involved how they were feeling, something that had never been experienced before. Tom's response to the staff had been *'There's no point getting wound up about these sort of things, because all you're going to be doing now is the next time you do it you'll have no confidence left, you're never going to give an injection again. You need to give [x medication] it's your job'* [P3]. The issue he emphasised was to understand how it had happened and learn from it.

Tom now felt that he was equipped with the skills to facilitate the LCC processes himself (such as beliefs and values clarification and emotional touchpoints) and could work out himself when it would be appropriate to introduce them with his new team

### **Leadership programme**

Tom emphasised that, to him, the Leadership Programme had been invaluable and he would commit to nominating his new staff to undertake it in the future even though he was under-established by nearly 10 nurses. His rationale was *'because that's how great a resource it is. Even if it's just for that individual, if nothing else, it'll still have a wee impact on the service. But I'm more than happy to stretch to that, I'll cover his shifts'* [P3]

### **Maintenance of involvement with Senior Nurse**

After the initial period of facilitation with Lucy contact with the LCC Team was very much maintained by Ward E. This was through a number of mechanisms: the nomination of two members of staff to undertake the Leadership Programme, joint presentations with Lucy at several conferences and supervision for the ward based projects that had been initiated. The contact involved a mixture of physical presence on the ward, phone calls and emails (something which stood in marked contrast to Ward C where Lucy had previously been the facilitator).

### **Overall evaluation**

Tom reflected that the LCC Programme was:

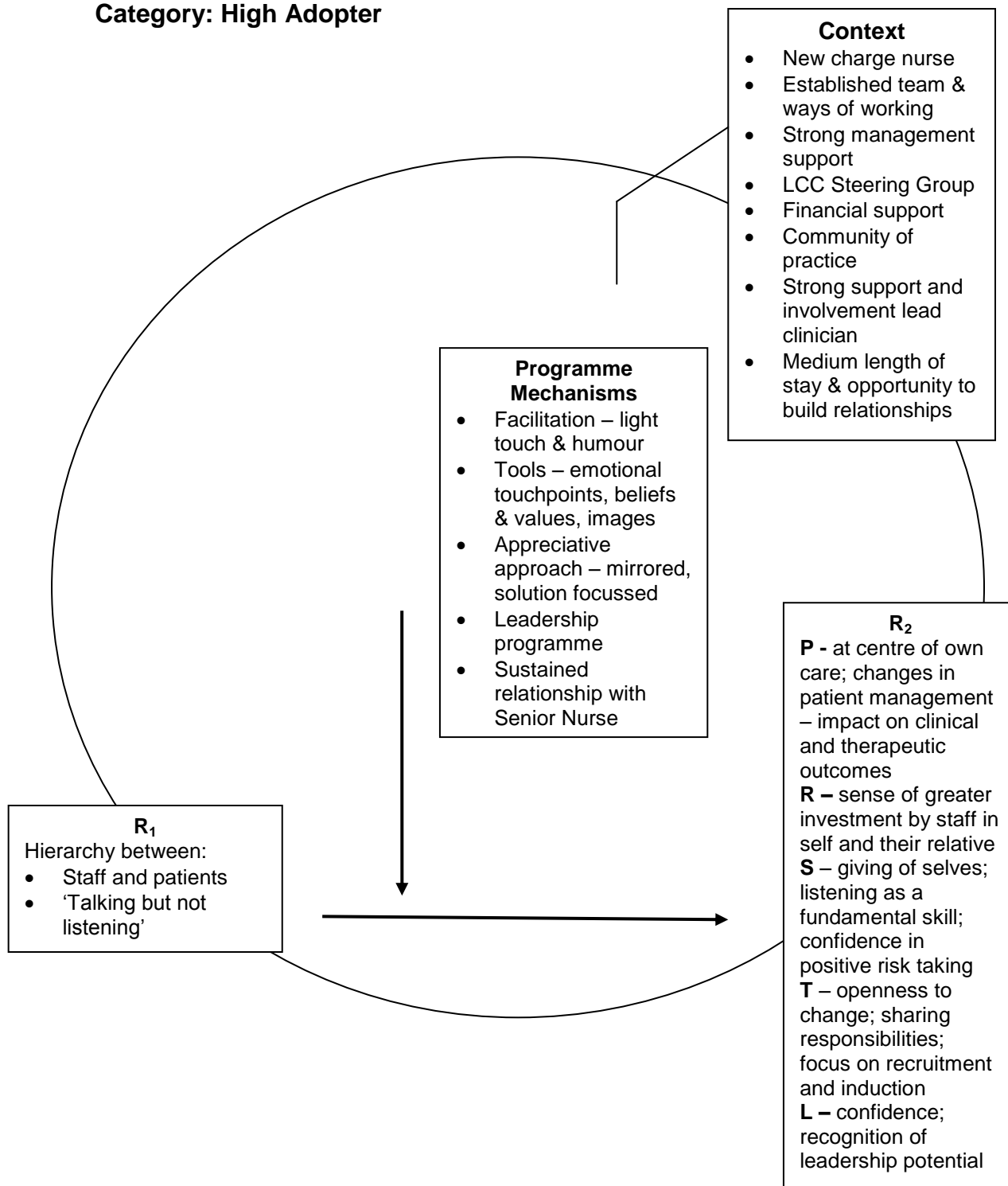
*.. possibly the most important thing I've ever participated in. I think for it to come along at a time where we were trying to develop new initiatives and new ideas and not quite 100% sure what kind of direction to go in, having the leadership course and being a Development Site at the same time, so you had the networking with your peers on one hand, but you also had that intensive support that the other units didn't get. On the other hand it was invaluable.*  
[P3].

### **Change in regularity**

Figure 17 overleaf illustrates the initial period of regularity ( $R^1$ ) that Tom inherited when he was appointed to Ward E. Although there appeared to be hierarchical ways of working that created strong demarcation between patients and staff, the ward did work within a supportive managerial context. There was also strong buy-in and input from the psychiatric and multi-disciplinary team. However, there did not seem to be sufficient focus on patient progression and outcomes from their rehabilitation. Tom was determined to change things, but was relatively junior even as a registered nurse let alone as a Charge Nurse. With the support of a now more experienced Senior Nurse there was a marked shift in regularity to  $R^2$ , with benefits for a number of stakeholders. Although Tom left the ward shortly after the period of facilitation the supportive context and focus on succession planning he had put in place meant this was sustained.

**Figure 17: Realistic Evaluation Summary - Ward E**

**Category: High Adopter**



**Key**

R<sub>1</sub> = Regularity prior to LCC Programme

R<sub>2</sub> = Regularity following LCC Programme interventions up to one year after facilitation

Outcomes: P – Patient; R – Relative; S – Staff; T – Team; L - Leader

### 6.3.5 Ward F

**Context:** This was a 34 bedded continuing and palliative care ward for older people situated in an old, fairly isolated community hospital. The hospital itself was an important feature within the community and most of the staff lived locally and, as well as having worked there for many years, knew many of the patients and families personally. The Charge Nurse [Laura] was well established, having held a number of roles within the hospital, including in the past 'Night Sister'. Despite the ward being geographically isolated from other services within the Community Health Partnership Laura was well supported by her Clinical Nurse Manager. The hospital retained a number of 'old' working practices such as having fairly well delineated night and day staff. This did manifest in the existence of some cliques within the ward and a degree of resistance from the night staff to fully engage in the LCC Programme. There was a small multidisciplinary team, with a visiting general practitioner and palliative care consultant, both of whom provided statements of support for the submission to become a Development Site and developed good links with the LCC Senior Nurse [Michael]. Laura reported that most of the nursing staff were very enthusiastic about taking part in the Programme, particularly after they had attended the awareness sessions and would have been '*gutted*' if they had not been selected.

The relatively poor physical environment was an important feature of Ward F, particularly for patients who were receiving end-of-life care. It had a 'warren-like' layout in places, which meant that some patient spaces were, in effect, corridors for the general movement of staff and visitors (which impacted on privacy). Observation of some patients was difficult and there was no call bell system. During the period of involvement in the LCC Programme the ward was preparing for and then moved to a purpose-built environment in a new community hospital a few miles away that brought together a range of in- and out-patient services. This involved gradually reducing the number of beds to 20 which would be the new compliment. Within the new hospital Ward F was very much showcased within the overall organisation and was used as a test site for other initiatives (such as the introduction of Healthcare Technicians).

**Mechanisms:** Alongside the appreciative approach and focus on relationship-centred care the key practice development techniques that were adopted were:

- Imagery
- 'All About Me'
- Stories – with patients and staff
- Emotional touchpoints (mainly with relatives)
- Encouragement to give and receive feedback (both positive and negative)
- Generation of positive care practice displayed in a digital photo-frame
- Charge Nurse participation in the Leadership Programme and action learning.
- Regular 1-to-1 meetings/coaching between the Charge Nurse and Senior Nurse LCC

**Outcomes:** Ward F was viewed as one of the high adopters and that despite a number of challenges out with its control (the physical environment) and the impact of a major organisational and operational change pending (the move to the new hospital) the team embraced the LCC Programme fully. The main outcomes (summarised in Table 24 overleaf) were seen to be a strong focus on individualisation of patient care, which in turn led to improved relationships with relatives. Involvement in the LCC processes supported staff to become more proactive in their engagement with families through their increased confidence in being able to discuss the individualised care they were providing. An additional outcome was a strengthening of relationships within the nursing team, with better understanding of team roles, a breakdown of the pre-existing cliques, a greater acceptance of expressing emotions (for example when a patient died) and being given support.

Michael, Senior Nurse reported in his final interview that Ward F had a lower staff sickness rate than before it became involved in the Programme. However, it is not possible to say whether this was solely or directly attributable to participation, particularly when Ward A with the same Senior Nurse, high adoption of very similar processes saw an increase in its own rate.



**Table 24: Outcomes Matrix for Ward F**

	<b>Relationships</b>	<b>Care Delivery</b>	<b>Developments in Practice</b>
<b>Patients</b>	Given a voice to express preferences through use of 'All About Me' sheets	Individualisation of care rather than being seen as member of a group  Innovative approaches to some of physical limitations of hospital building e.g. baby intercom system for night time care	Increased choice
<b>Relatives</b>	Confidence that their relative is being treated as an individual and staff are interested in them as a person.		Key partner in use of 'All About Me' sheets
<b>Staff (individual)</b>	Confidence to discuss issues with relatives.  Breaking down barriers with some 'difficult' relatives	Increase awareness of patient's needs.  Not afraid to ask difficult questions (e.g. what clothes should patient wear following death)	Thinking before doing  Feedback to consultant on his performance in case conference.
<b>Team</b>	Support for each other – particularly when a patient dies. Freedom to express emotion.  Understanding of each other's roles: <ul style="list-style-type: none"> <li>• Registered and non-registered</li> <li>• Day and night staff</li> </ul> Breaking down of cliques	Sharing practices e.g. risk taking	Regular discussion about care practices – 'caring conversations'.  Challenging care practices.
<b>Leader</b>	Empowerment through interest taken by Senior Nurse – 'sense of him wanting best for <u>you</u> '	Tackling difficult conversations head on – not phased.	Happier and enthusiastic to take things forward  Personal development and confidence to speak up.  Recognition of self and ward within the organisation.

**What worked well?**

Although Laura was a very experienced Charge Nurse she lacked confidence in some of her abilities to instil change within her own setting and to communicate her voice externally. Michael built in a coaching component into

his facilitation role in Ward F and they would have a one-to-one meeting during each of his visits to the ward. Laura felt that this had been extremely beneficial to her own development and made her *'less afraid to try and get things up and running and more encouraging to staff to be involved'*. In the same way that staff were increasing their individualisation of patient care Laura sensed that she was being treated as an individual and that this level of quite intense interest in her as a person was quite empowering. Laura maintained her contact with Michael and some of the other LCC Senior Nurses by continuing to attend action learning beyond the official 'lifetime' of her involvement in the Programme.

The use of the 'All About Me' sheet was seen by Laura as giving the patients a voice. Due to their often frail condition it was quite difficult to use a more in-depth technique such as emotional touchpoints. Through engagement with the patient and family members the aim became to complete the 'All About Me' sheet within first 48 hours of admission, or at least within first 1-2 weeks. Laura gave one example of the difference that it could potentially make *'a lot of our patients can't vocalise what they would like to wear but we know what their favourite colour is so we can try and put something on them with their favourite colour'* [P3].

The process generally involved a nurse sitting down with the patient and relative to complete the information collectively, rather than asking the relative to take the sheet away and bring it back, and so it was also seen either to establish new or improve existing relationships. Laura described the reaction to this development from relatives:

*Most of them have been very enthusiastic, some have given us lots of information, they've stuck pictures in, it's been amazing what some of them have done. I think they just feel quite pleased that we're taking such an interest in their loved one. And I think they quite like being involved, that they're not just coming in to visit for an hour and they're not involved in what's goes on.*

[Laura, Charge Nurse Ward F, P2]

In terms of relationship-building she went on to say that it had been particularly helpful with relatives that had been previously seen as 'difficult':

*Definitely yes, because we have a couple of quite difficult relatives, and a couple that it's actually helped to see the way they think and where they're coming from.. It also helps to break down barriers as well, because some of the relatives are quite standoff-ish, some of them can be a bit aggressive. Some of them feel quite guilty and you just have a one way conversation maybe about how they've been that day or that week. If you're actually sitting down and maybe having a cup of tea and maybe discussing, they tend to relax a lot more, and so do we. And it helps them get to know us a lot better.*

[Laura, Charge Nurse Ward F, P2]

Some patient stories had been collected by Michael, the LCC Senior Nurse and fed back to staff. Laura reported that, initially at least, the staff always focused on the negative part of the story not the positive. However, she and Michael persevered and introduced a regular 'story meeting' once or twice a week, with a much clearer focus on the positives. Staff stories were also recorded and these highlighted a number of important issues, including good team working. One perhaps unexpected outcome from this process was a focus on taking risks, as Laura reported:

*Also about taking risks, that came out of one staff story that a member of staff took a risk and it worked out ok. And there was a lot of discussion about taking risks, and I think people felt encouraged that they could take a risk rather than ... 'Oh I'm not doing that because that might not work.' But encourage that, 'Maybe I will take a risk and do this. [P2]*

Laura reflected that whilst she hoped that she had always had taken a fairly appreciative stance on facing situations, her exposure to appreciative inquiry in this way had been '*quite heart-warming*' and meant that she felt less '*phased*' when needing to deal with a more difficult issue. She indicated that she was now more likely '*just [to] try and deal with it head on instead of skirt round it*'. Furthermore, if she was having conversation with individuals in these situations she would talk '*about values and things, whereas I wouldn't have been ... before*' [P2].

In Ward F Michael observed a case conference and then gave feedback to individual members of the team, including the consultant. This was something that he [the consultant] had never experienced before '*and he just thought it was absolutely wonderful. ... I think he felt, being a consultant ... the buck stops*

*with him, nobody takes an interest in how he's feeling. And this did and he found it a really positive experience' [Laura, Charge Nurse P3].*

Michael and Laura carried out periods of observations together and from this developed a number of positive care practices, which were added to those that Michael had already developed from his involvement with Ward A. These were displayed in the staff office and on a daily basis at the end of the afternoon handover the team would look at whatever photograph was being displayed at that point (along with the accompanying quotation) and would discuss it. Laura reported that most of the time this activity went down quite well with the team, and it prompted a lot of discussion, because there could be quite strong disagreement about the care practices being described. Laura felt that these conversations were very helpful and allowed people to understand why the different perspectives existed.

Laura emphasised the impact that Michael had made in stimulating the team to think and discuss their practice in a way that they had not done so in the past:

*We really think, and stimulate an awful lot of conversation, and discussion. Lots. Introducing a theme, discussing it, what we can do to take it ahead and really getting everybody on board and involved. [Michael]'s very enthusiastic and that has rubbed off on a lot of staff, not some of the others, but a lot of them it has rubbed off on. [P2]*

Laura described her participation in the Leadership Programme as '*probably one of the best things I've ever done*' [P2]. As well as the content she valued the networking opportunities and felt that it complemented the experience of being a Development Site. She fully intended nominating her Deputy Charge Nurse to attend the next cohort, and in fact also secured a place for one of the permanent night staff, which in turn had an impact on their sense of involvement. What she valued about the Leadership Programme was the style of facilitation by the LCC Team and the guest speakers (including Professor Mike Nolan, one of the original authors of The Senses Framework (2006)) which she felt, in contrast to some other programmes, meant that they were not being told *what* to do but were being given options of what they *could* do. The group work and discussion permitted sharing of what individuals were going to take it back to their areas and how they felt it was going to work in their areas or what challenges they might face. She felt that she was a much

more confident leader, particularly when operating outside of her own setting and reported now being *'able to participate as much as anybody'*.

### **Sustainability**

Laura was confident that the 'All about Me' initiative would be sustained beyond the lifetime of the Programme as it was being integrated into the standard admission paperwork. She did acknowledge that without the ongoing support of a Senior Nurse it was unrealistic to expect to keep everything going. However, she did feel that what they had learned was going to help with the transition to their new environment and the new ways of working they would need to adopt there, given that they were going to working with all patients in single rooms. She had hoped that the caring conversations, stimulated by the digital photo frames would also continue, although when it came to the move to the new hospital the building regulations would not permit the existing frames to be wall-mounted and so they were no longer used.

In the year following the period of facilitation by the Senior Nurse and after the ward had moved to its new site, Laura reflected on the impact of the individualisation of care and how this had been sustained in part because staff were *'no longer afraid'*.

*The ultimate for us is end of life and this is their home until they die. And it makes the staff a lot more comfortable sometimes in asking some very difficult questions because they use their care pathway and they can ask, 'What do you want to wear when you die?' And the staff are a lot more comfortable now asking relatives, or even patients, even patients will vocalise to the staff. We had a lady about a month ago who said to one of the auxiliaries, 'Will you tell my daughter that when I die I want to wear that blue blouse and that blue pair of trousers, can she bring the in?' She couldn't tell her daughter that, but she could tell one of the nurses to tell her daughter that this is what she wants. [P3]*

The relationship with Michael was not sustained to the degree that Laura had anticipated and although she had found it quite intense at times during the Development Site Phase she did acknowledge that both she and the staff missed the direct contact and that it did have some impact on their motivation to keep some of the processes going. Eventually simply focussing on the 'All About Me' sheets in the new setting was as much as they could sustain from the LCC Programme. They were, however, then becoming test sites for other

initiatives such as the Health Care Technician and participating in Releasing Time to Care™.

Laura felt that the individualised care and improvements in the relationships with relatives were sustained in the new setting and that this continued to be directly linked to the use of 'All About Me'. Where in the past enquiries about care from relatives had often had a defensive tone in them, relatives now approached the staff with a much more conversational style and ask why something had happened? *'So I think it gave the relatives the confidence that we were approachable, we were friendly, and they could come and talk to us about anything'* [P3].

### **What didn't work so well?**

Laura reflected that emotional touchpoints had not worked very well in Ward F. There had been some success with relatives but not with staff. She reported that staff were not very forthcoming and found it embarrassing. They were happy to sit and have a conversation but not to pick out the emotional words. They had, however, responded quite well to the use of images in the early beliefs and valued clarifications exercises.

There was some actual resistance to some of the proposals that Michael made, or brought with him from his previous experience in Ward A. One example was the milk jugs (to allow patients to pour their own milk on their cereal, or have it poured immediately before being helped to eat). Another example was the proposal to introduce a 'main nurse' system involving each patient having a main nurse who would meet with the relatives a minimum of once a month to have a discussion about their care. This proposal arose from feedback from a relative that when they asked for information they often simply received the kind of reply 'Oh they're fine. They're fine, they're fine.' This individual felt that the only time a nurse, really sat down and had a good conversation was when something wrong. Laura reported that this idea had not been well received on the grounds that the staff felt that they communicated enough at present, and so it was something she was going to have to work at because she really wanted it to happen.

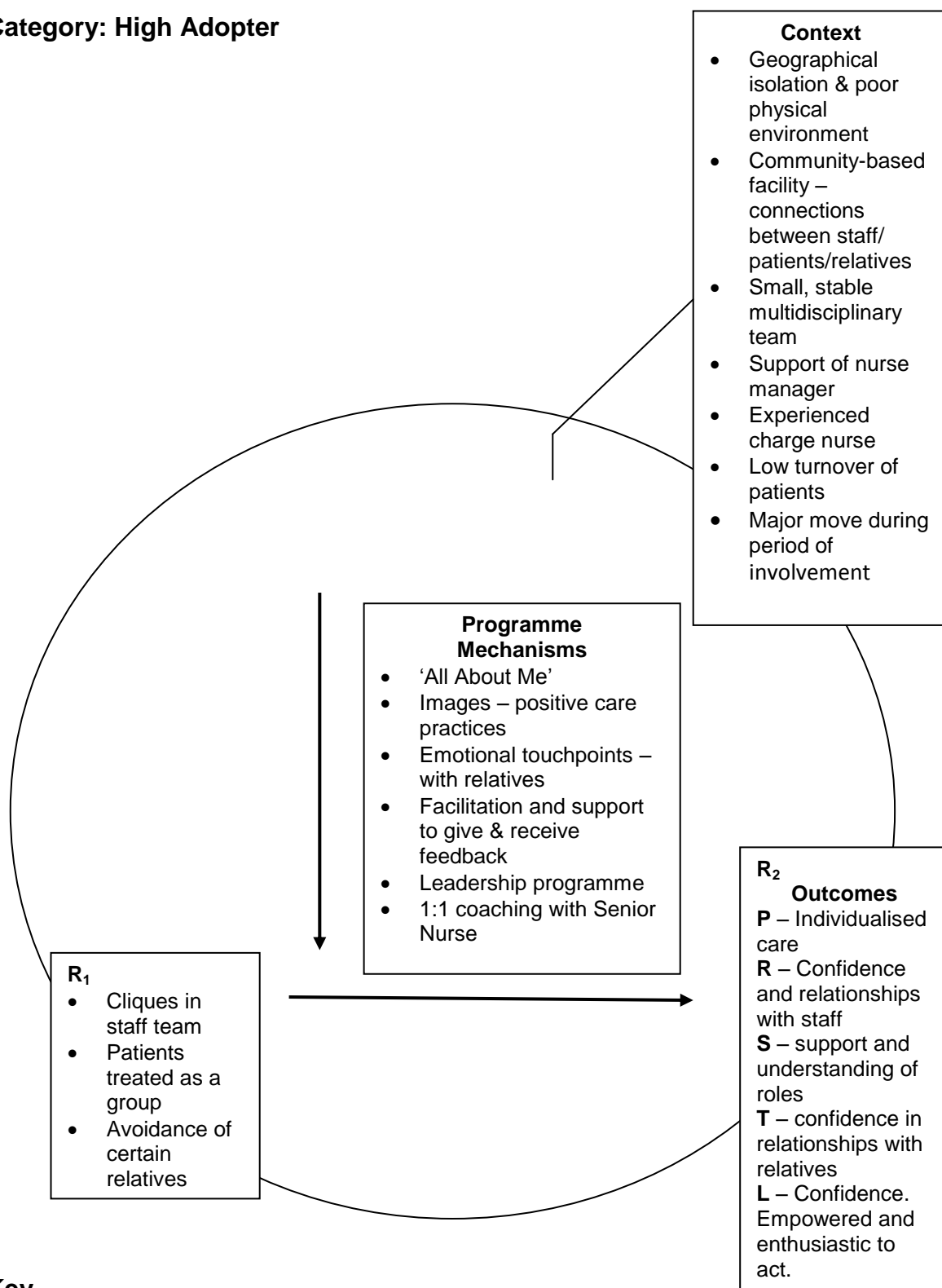
Laura's overall reflection on what that the key to her experience in the LCC Programme was '*relationships with everybody that you come into contact, but also my own personal development and confidence and everything that it's given me to speak up and take things forward*'. [P3]

### **Shift in regularity**

Figure 18 overleaf illustrates the initial point of regularity (R<sup>1</sup>) in Ward F where there were definite divisions amongst the nursing team (particularly day and night staff) and insufficient personalisation of care. As in several other settings there was also an avoidance of proactive engagement with relatives. The emphasis within the period of facilitation was the use of the 'All About Me' sheets that demanded engagement with relatives had an important role to play in shifting to R<sup>2</sup>. What was also important in this setting was the coaching relationship between by the Senior Nurse to the Charge Nurse and how this led to Laura's confidence improving, with resultant sense of empowerment to act.

**Figure 18: Realistic Evaluation Summary - Ward F**

**Category: High Adopter**



**Key**

R<sub>1</sub> = Regularity prior to LCC Programme

R<sub>2</sub> = Regularity following LCC Programme interventions up to one year after facilitation

Outcomes: P – Patient; R – Relative; S – Staff; T – Team; L - Leader



### 6.3.6 Ward G

**Context:** Ward G is a 72-bedded acute assessment unit within the main acute hospital. It has 140 staff and admits on average 29,800 patients per year. During the period of facilitation it had a bed occupancy of 70.6% and an average length of stay of 0.6 days. During that year there were 145 deaths in the unit, which was the highest number in the whole hospital including the intensive care unit. The ward is structured in to six bays with separate teams working in each. Given that staff work 12 hour shifts there are major challenges in communicating with the team as a whole. The establishment included four Charge Nurses during the period of it being a Development Site but only one of them [Christine] appeared to be fully engaged with the Programme in terms of undertaking the Leadership Programme and working closely with the LCC Senior Nurse [Diana]. Diana had no previous experience of working in this type of acute environment where there are on average 80+ admissions per day. The nursing staff work with multiple medical teams, depending on the patient's reason for admission and although there was some continuity the junior doctors rotate frequently.

Ward G had unsuccessfully applied to become a Beacon Ward at the beginning of the LCC Programme and so there was longstanding commitment from Christine and her managers to be involved.

Historically the unit was an area with a relatively high number of complaints, and as a consequence Christine, the Charge Nurse acknowledged that staff worked within '*a culture of concern*' and, in particular, tended to keep away from relatives. In the year prior to becoming a Development Site there had been a serious complaint about staff attitudes. As a result Christine felt their sense of confidence about whether they gave good care was low and that the staff perceived the unit to have a poor reputation, which meant they tended to have a negative perception of themselves. Staff turnover in the unit was quite high and by the end of the period of facilitation seven nurses who had been directly involved in the Programme had left, including the Charge Nurse Christine who had gone to work in a different Health Board.

Diana, the Senior Nurse observed that even at the end of the period of facilitation the local management of the unit impacted on the ways of working.

Her sense was that the four Charge Nurses '[had] *such weird ways of working*' largely down to the fact that '*... there are no conversations... people don't know things .. they depend heavily on email as a way of communication and the majority of staff don't bother reading them. They only recently got on to getting access to their emails and they've not got time in a 12 hour shift. They're working full out. So word of mouth is what happens and if you're not there you never hear about it*' [P3].

Diana felt that during her early days in Ward G the staff expressed that changes in healthcare context (for example 4 hour targets and clinical pressures) had negatively impacted on their ability to deliver care, which was further magnified by the sheer size of their unit. She felt that there was, therefore, a culture of non-engagement, with staff working within their bases, '*heads down*' for their 12 hour shifts. Her initial perception was that it would perhaps take 2 years to change this culture and that a key element would be changing the ways of working of the Charge Nurses who were often office based.

**Mechanisms:** Alongside the appreciative approach, Diana reported that she had to very much adapt her previous ways of working in Ward G to suit this new environment. It was particularly challenging to take staff away from their clinical duties to engage in some of the group discussions that had been commonplace in other settings. As a result the main LCC practice development techniques that were successfully adopted were:

- Work alongside staff to elicit response to question such as 'what makes a good shift?'
- Stories – from patients and particularly relatives. These stories were shared widely within the unit by being presented as a written summary with the addition of a number of 'curious questions' for people consider<sup>64</sup>. It became regular practice to read a patient story at the shift change 'hub' meeting, often with the Senior Nurse reading the story and seeking feedback from the staff. Some of the stories were also shared widely within the organisation (including at Board level) and became quite well known.

---

<sup>64</sup> 'Curious questions' was a term specifically coined by the LCC Team and actively encouraged as an element of 'Caring Conversations'.

- Emotional touchpoints with students
- Imagery to stimulate team discussions

**Outcomes:** These could be delineated into two phases relating to when Christine, the Charge Nurse was in post and after she had left. Christine painted a positive picture of change and a number of key outcomes as a result of participation in the Programme. Diana, the LCC Senior Nurse largely endorsed these views, however had some concerns about the overall spread of the Programme and engagement of the other leaders. Furthermore she was clear that once Christine, the main figurehead had left the momentum waned to a degree and she was not entirely confident that all of the new practices would be sustained. Tom, Charge Nurse in Ward E observed a year following the ending of the Development Site period of facilitation that to a degree this had been the case. He suggested that Christine was a '*formidable driver of the whole thing*', however although only some of '*the stuff*' was still carrying on he felt there was an underpinning there as well, '*so it does leave its mark*' [P3].

Table 25 overleaf indicate that the main outcomes in Ward G emanated from positive stories, which in turn particularly influenced relationships with relatives.

**Table 25: Outcome Matrix for Ward G**

	<b>Relationships</b>	<b>Care Delivery</b>	<b>Developments in Practice</b>
<b>Patients</b>	Direct discussion about concerns/complaints at an earlier stage	Recognition of compassionate components whilst still achieving 4 hour targets	Engagement with patients – in depth but quite rapid questioning on admission to build up picture of patient and their support network
<b>Relatives</b>	Increased engagement with staff  Given information in a professional way	Cup of tea as part of admissions process (already established but embedded)	Working towards introducing relatives' rounds
<b>Staff (individual)</b>	Increased confidence to approach relatives.  Increase in communication between staff members – including expressing emotion	Stronger recognition that acute care delivery is compassionate	Use of emotional touchpoints with students – giving a voice to the quieter ones.  Staff contributing ideas (N=64) for new developments
<b>Team</b>	Formal appreciation from directorate management following review of stories at meetings	Believing they do give good care and having evidence through stories to show it	Evidence from stories that promote changes in practice. Example – involvement of palliative care team.  Sustained belief that do deliver compassionate care.
<b>Leader</b>	Support from Senior Nurse  Expressing personal feelings to individual members of staff	Looking for compassion much more.	Change in approach to dealing with complaints. Hearing and understanding how patients and relatives feel.  Reflection on positives of the day rather than dwelling on negatives.

The Charge Nurse Christine's main view on outcomes related to the staff believing in their ability to deliver compassionate care. She felt that whilst the nurses had initially been very nervous about taking stories from patients and relatives (expecting negative feedback), once it was clear that the majority

were favourable they became more motivated about the Programme and grew in confidence. This perception was echoed by Diana, Senior Nurse at the end of Phase Three:

*.. the change is that now there is a belief that you actually can do compassionate care in an acute area. They have been helped to recognise care that is compassionate, and there is a body of staff there who are absolutely ready to recognise that, and that it takes place. And I would say that when I first went there almost to a person they would say, 'I'd love to be able to do compassionate care but you can't in this place, it's too busy. We've not got time.'*

[Diana, Senior Nurse P3]

Ward G is one of the services directly impacted by the 4-hour waiting time targets in Accident and Emergency (A&E), and this often resulted in pressure to move patients to other wards as quickly as possible in order to free up beds and trolleys to admit patients for assessment. Christine reflected that participation in the LCC Programme had made some impact on how the target was perceived:

*I think if you went back a year ago, I think the staff felt that the target was probably the main thing we talked about in this unit. And we still do at times but I think the caring bit of compassionate care helps the staff to put that in the background slightly, even though we do push the four hour target. But I don't think it's upfront now as much ... I think the staff always felt that we did push patients through quite quickly but now they've got a better understanding that, yes we do but we do it in a compassionate and caring way [P2].*

She indicated that in the early stories that were collected from patients and relatives issues around targets featured in the sense that staff often couched the explanation of their move out of the unit up to a ward within the context of needing to get patients in from A&E within 4 hours. By the following year Christine said that this had changed and that the patient stories did not mention targets at all.

Engagement with relatives was already seen to be an important aspect of the ways of working in Ward G (even with some trepidation) and Christine reported that a key way of initiating this was through making them a cup of tea soon after arrival in the unit. This was not necessarily a new initiative, but became better recognised as it emerged clearly from the stories as something that was very much appreciated *'I think they see that as giving them some of your time,*

*and it's about that caring conversation again, isn't it? Even if it is just about a cup of tea, but people see that as a really important part of the day. And spending that five minutes just giving that ... asking them ...'* [P2]

Two further areas where engagement with relatives had altered were response to complaints and information giving. Christine felt that through the collection of stories she now had *'a real understanding of how patients and relatives feel'* and that this understanding had led her to take a different approach to reacting to and responding to complaints. Whereas in the past she was often very defensive now, regardless of whether the actual facts of the situation the relative was portraying were accurate, *'that was how he/she felt'* and she would make an effort to actually speak to the patient or relative to resolve the issue. She cited one example of an elderly gentleman complaining about a safety issue and when she discussed it with him this led on to further issues about his underlying health concerns and she was able to give him some health advice. The outcome was that rather than taking the complaint forward *'he absolutely thanked me, and I was thinking that's because I saw his complaint in a completely different way'* [P2.]

Having received feedback through the relative stories about how information giving sometimes came across or could be improved in that rather pressurised environment, Christine indicated that the nurses now gave information *'in a professional way, not just throw it out but they do think about what they're giving and who they're giving it to'* [P2]. This she felt was also linked to their increased sense of confidence to approach relatives to ask them if they wanted further information (whereas in the past they were fearful that this question might lead to complaint about care or waiting). At the time of the interview plans were underway to introduce a structured relatives' round.

A particularly important outcome was enhancement of the reputation of the unit both within its own directorate and in the wider organisation. This emanated directly from the shared stories and led to a sense of pride in the unit being instilled at the senior management level, which was fed back to staff. Christine felt that participation in the Programme had changed people's ideas *'they were all quite astonished that we do good care down here, because we only saw patients for a short time'* [P2].

### **What worked well?**

Christine reported that initially staff were '*terrified*' to take stories from patients and relatives as they expected them to be negative. But what quickly emerged was the emerging positive examples led to a '*tipping point*' in terms of staff engagement with the whole LCC Programme. This engagement extended at one point to the lead clinician for the unit being keen for a member of the medical team to participate in story taking. Christine did report, however, that the medical staffs' interest within the stories were the clinical outcomes or clinical requirements of the patient whereas the nursing focus was focussed on what the patient felt and whether there were any area for improvement. She reflected following one discussion with the lead clinician '*So he didn't quite see the point in it all, it was about the patient and not about ... really about what clinical decision were made*'. [P2]

Christine was able to cite examples of where stories had led to changes in practice, primarily because it increased awareness of potential limitations in someone's care and how this could be addressed in a similar situation in the future. One example was that following a story relating to a patient needing palliative care some education sessions were arranged and subsequently nursing staff started making direct referrals to the palliative care team rather than waiting for the medical team making the decision.

Whilst the nurse managers had always been supportive of the Programme taking place in Ward G, Christine and Diana both felt that the stories instilled a sense of pride in the unit and the work being undertaken. This gradually extended to members of staff, with Christine reporting that one had recently reflected that thorough collecting patient and relative stories '*I know that we give good care but now we've got evidence to show*'. [P2]

Christine described that she had derived great personal benefit from participating in the Programme, mainly from the direct support provided by the Senior Nurse as well as direct experience of using the tools through participation in the Leadership Programme. She also reflected that she had changed quite a lot the way she dealt with staff in that '*I think I have a much more open mind, I don't go looking for things that are wrong all the time and think, 'Oh my God!' But what we do well*'. Furthermore she suggested that this

extended to her personal life in that at home she tells her husband '*three things that I do that's good every day*'.

Emotional touchpoints were used effectively with student nurses to evaluate their experience of their placement in Ward G by asking them how they *felt* about the unit. Christine's main observation of conducting feedback sessions with groups of students both with and without the touchpoints was that where touchpoints were not used the quieter students did not have the opportunity to say as much and the sessions did not flow as well.

### **Challenges**

During her interview Diana, Senior Nurse's perspectives on sustained changes in Ward G were not quite as positive as those painted by the Charge Nurse Christine. She felt that the team was still not efficient largely because of the communication issues that she had identified during the Development Site phase and which she felt still largely existed:

*'they do not talk about care, they talk about waiting times, they talk about breaches, they talk about blockers... but they do not talk about care. The only time they talk about care is when a disaster happens. So a 49 year old man who has a cardiac arrest and dies, round the unit in 30 seconds. But they do not talk about day to day care, when they get it right, the fact that ... even if you were to ask them, 'How many of your patients have a positive outcome out of here?'* [P3]

When she asked staff what the hundred of thank you cards in Ward G were for people would simply reply that '*They got out of here alive!*'

One of Diana's frustrations about this was that there were numerous ongoing examples of positive care going on around the staff, but they were not able to see them. Diana picked out an important example of the nurses' ability to make connections with patients in caring conversations.

*So you would see them picking up on people what they were doing and then make things happen so hearing perhaps that a relative who is worried about, or a patient that's worried about their husband who's at home and he's not very able to cope on his own, picking up on these sort of things and very quickly saying, 'Well who could I contact?' 'Well, my daughter.' So going away and phoning the daughter and saying, 'Your mum's worried about your dad.' And doing these things, but they never put that down because, as in other places, the thing that gets counted and marked on is the things that you don't do. [Diana, LCC Senior Nurse, P3]*



The size of Ward G was viewed as a major challenge to implementing the Programme objectives by a number of stakeholders. For example Diana had a lot of positive discussion and feedback as a result of her approach of working alongside staff and asking the question 'what makes a good shift?' The overall response was that a good shift was '*when you talked about care and planned and prioritised care*'. This then demanded consideration of what to do when this doesn't happen, what is missing? And how can it be made possible next time? Diana felt that for those people involved in these discussions it had made a difference to their thinking and behaviour, but in terms of resource questioned how she could achieve this for the 140 staff in Ward G. She did reflect, however, that *they do speak to their friends and talk to their friends about it* [P2]. Nonetheless she talked about '*the people I have touched*' out of the 140 nurses who had demonstrated change. Reflecting back on her original prediction that it would take two years to change the culture in the unit (the '*heads down*' mentality) she reported that when one of the staff nurses participating in the Leadership Programme in the year after Ward G had been a Development Site had invited colleagues to submit ideas for developments that 64 had been put forward.

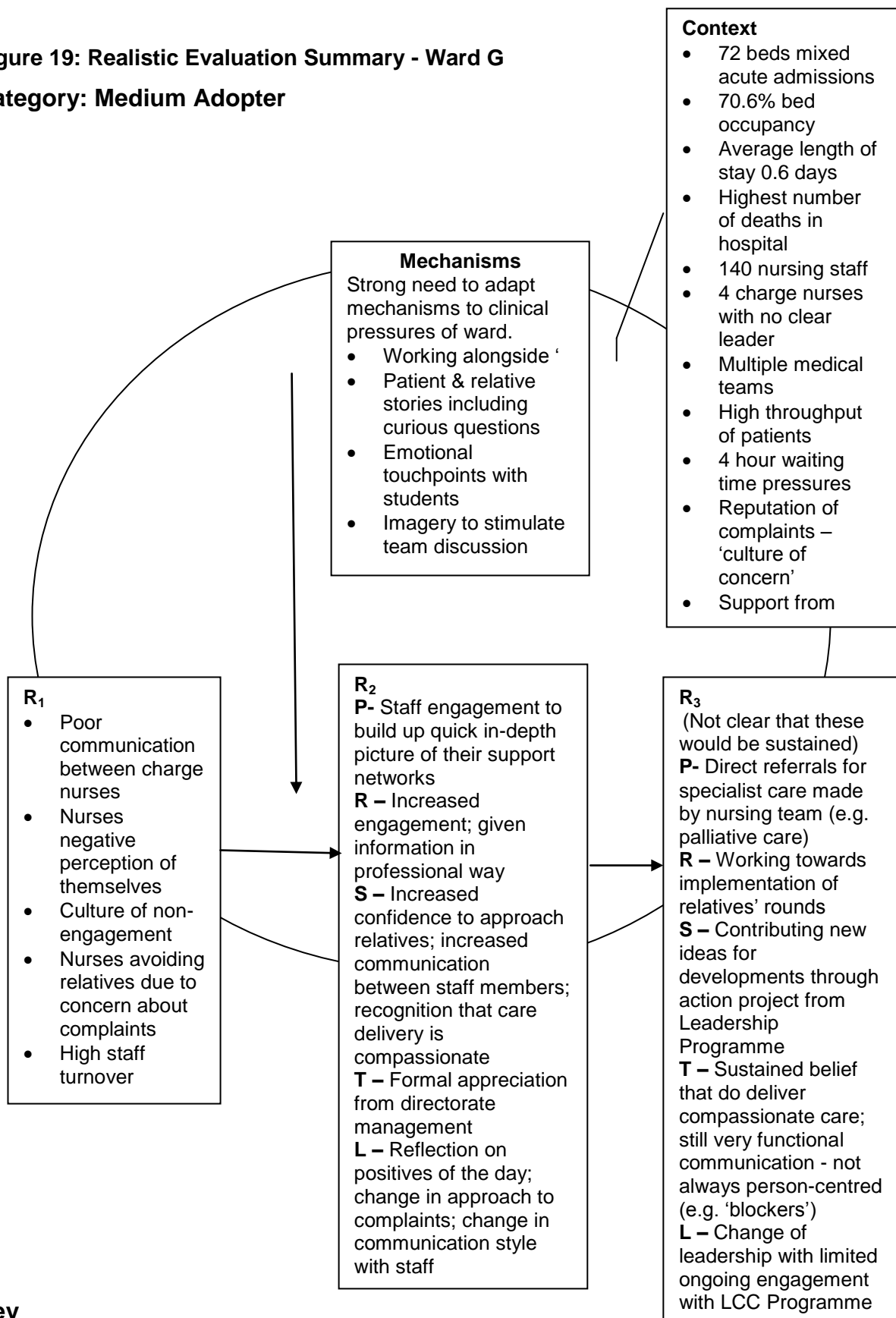
Diana, along with several other stakeholders involved in the Programme, described the concept of 'getting it' i.e. understanding how the underpinning philosophy and practice development processes of the LCC Programme ultimately influence thinking and ways of working. 'Getting it' ultimately depended on seeing something working in practice and in Ward G she cited changing ways to responding to complaints (from the very processed based formal investigation to direct engagement with the complainant). Diana described the power of this and how over time the 'getting it' did spread within Ward G:

*So for some people this has been the jumping off spot, the light bulb moment. 'We know what you're talking about now, we know what you're getting at. It's not about holding people's hands, it's not about smiling.' And again there you are, they've got four, five, Deputy Charge Nurses ... too many Charge Nurses in this ward .. there's one or two who were attending the leadership days and their ability to spread the word. But I'll tell you they're all bought in now.* [P3].

### **Change in regularity**

It was apparent that, like Ward D, Ward G went through three stages of regularity, each of which strongly influenced by the charge nurse. Figure 19 overleaf illustrates that  $R^1$  was a situation where the nursing team lacked confidence and were perhaps insufficiently supported by a rather fragmented group of Charge Nurses. There were undoubted challenges in implementing the Programme techniques in a setting with this level of acute patient turnover and sheer size of the staff team. Diana, the Senior Nurse adapted her ways of working accordingly and in  $R^2$  these appeared to yield results, particularly through the concurrent participation of a number of the staff nurses in the Leadership Programme. However, at the end of the period of facilitation there were important staff changes, including Christine, the Charge Nurse leaving the ward and therefore the final point of regularity  $R^3$ , whilst not back at  $R^1$  had lost momentum and did not show signs of the long term sustainability that had been emerging.

**Figure 19: Realistic Evaluation Summary - Ward G**  
**Category: Medium Adopter**



**Key**

R<sub>1</sub> = Regularity prior to LCC Programme

R<sub>2</sub> = Regularity during LCC Programme whilst Christine, Charge Nurse still in post

R<sub>3</sub> = Regularity following LCC Programme interventions up to one year after facilitation and after Christine had left.

Outcomes: P – Patient; R – Relative; S – Staff; T – Team; L - Leader

### 6.3.8 Ward H

**Context:** Ward H is a 19 bedded specialist rehabilitation services for patients with cognitive impairment and challenging behaviour and provides a national service. On average it discharges 12 patients per year. The length of stay is at least 3 months with an exceptional case being as long as 4½ years. Discharge arrangements are often difficult and protracted as many patients still require institutional care after their time in rehabilitation.

It is located within a large psychiatric hospital in two wards (male and female) that were recognised as being poor physical environments to meet the patients' needs. The service is managed by a Community Health Partnership which although located at a different site is supportive and there are regular meetings. Ward H has 50 nursing staff (including nursing auxiliaries) with a senior team including a clinical manager [Sean], clinical nurse specialist [Rachel] and newly appointed Senior Charge Nurse [Hannah]. There is an extensive multidisciplinary team including clinical psychologists, speech and language therapists (SLT), occupational therapist (OT), physiotherapist, art therapist, dietician, social worker and a psychiatrist. The commitment to apply to become a Development Site came from the whole multidisciplinary team, something that was reflected on by Jack, one of the Policy Makers in his final interview '*it was very clear they wanted to approach this as a team and it was everybody*' [P3]. There is a high turnover of nursing staff.

Part of the senior nursing team's motivation to become a Development Site was a sense that the ward did not have a positive relationship with some relatives and they wanted help to address this. They were also keen to help staff to see that despite environmental conditions and the challenges of the patient group that they did deliver good (compassionate) care. The two wards were, in fact, refurbished during the course of the LCC Programme.

Two further aspirations of the senior team included that staff would have an increased awareness of '*what they're doing and why they're doing it*' and take more responsibility for this (Sean, Clinical Manager). The second from Rachel, clinical nurse specialist was for staff '*to come into their work to focus on their work, their patients and their practice and to leave other issues at the door*'. In addition the senior team were aware that there were misconceptions held

about Ward H and what the service aimed to achieve, particularly with student nurses and they were keen to address this.

The LCC Senior Nurse [Sam] was new to the role, following some staffing changes within the LCC Team. Although he had not been involved in practice development work before he was experienced working with people with challenging behaviour. During the Development Site phase the Manager [Sean] was not directly involved in the LCC processes and admitted that he had taken a back seat but could see benefits, particularly when an incident of poor practice arose that he had to deal with immediately prior to the focus group interview that I undertook. Rachel, who had been the key individual to drive participation in the Programme left to join the LCC Team and Sean moved on to another post. This left Hannah, who was relatively new to her own role to both lead the ward and also to participate in the Programme.

**Mechanisms:** In addition to the appreciative approach and action research the main LCC practice development techniques that were successfully adopted included:

- Beliefs and values clarification
- Reflective processes
- Use of the Senses Framework (Nolan et al., 2006)
- Emotional touchpoints with students (at the beginning and end of placements), with a few relatives and with staff at a weekly meeting (multi-professional group of about 8 people)
- Staff and relative stories
- Positive care practices – used to stimulate reflection/debate at the beginning of goal setting meetings
- Images
- Adaptation of emotional touchpoints with a few patients – which given their cognitive impairment was quite challenging (developed by SLT with use of pictures)
- Participation in the Leadership Programme – first year Senior Charge Nurse, second year Deputy Charge Nurse
- Action Learning

There was a very strong focus on making the Programme inclusive for all the staff and this centred on establishing ongoing weekly meeting to undertake emotional touchpoints or to continue beliefs and values clarification and caring conversations. Outputs from these processes were displayed in the staff room on a 'Compassionate Care' wall and in other places around the ward.

**Outcomes:** Overall Ward H was recognised as being a high adopter of the LCC Programme with good evidence of sustainability, despite facing a number of challenges during the period of being a Development Site. In particular these challenges related to turnover of key leadership figures as well as a critical incident which challenged their reputation for compassionate care. At the end of Phase Three of my study Ruth, one of the LCC Senior Nurses reflected:

*'there's a quietness about what they do, they don't promote it, they don't shout about it, but they've really taken actions, they've done other questionnaires, they've changed parts of their care planning as a result of that. It is part of a process so I was hugely impressed.'*  
[P3]

Table 26 overleaf indicates the principal outcomes for Ward H.

**Table 26: Outcome Matrix for Ward H**

	<b>Relationships</b>	<b>Care Delivery</b>	<b>Developments in practice</b>
<b>Patients</b>	Adapting techniques such as emotional touchpoints to try and permit meaningful engagement on experience.	Increased focus on specific needs to 'move the person on'.	Introduction of progressive treatment plans.
<b>Relatives</b>	Proactive contact prior to admission and at (agreed) regular intervals	Recognition of the potential daunting experience of case conferences.  10-15 minute telephone conversations following ward rounds at the agreed contact intervals	Relatives' questionnaire.  Staffs' recognition of their need to change approach with 'difficult' relatives.
<b>Staff (individual)</b>	Sense of involvement (especially for nursing assistants).	Increase reflection on practice.  Increase confidence to question own and others practice.	Being able to express emotions.  Increase confidence (especially with relatives).
<b>Team</b>	Sense of collective responsibility.  Multidisciplinary team cohesiveness.  Dealing with concerns themselves.  Looking out for each other – increase sense of safety.	Open discussion on the need to balance the allocation of care of particularly 'challenging patients'.	Greater involvement of occupational therapist in ward programmes, safety assessments and outings.  Introduction of debate and reflection about care and positive care practices at the beginning of goal planning meetings  Improved preparation for and working with students.
<b>Leader</b>	Closer working with Practice Education Facilitator as a result of feedback from students.  Increased confidence in new Senior Charge Nurse role.	Confidence to tackle difficult situations	Development of leadership skills and focus on succession planning within ward.

At the time of the focus group interview with the three ward leaders there had been an incident of poor care practice within Ward H that had been observed

by a visiting senior manager. The ward leaders had taken an immediate firm stance on the issue and were clearly very concerned that it had occurred, but did feel that there was a very different reaction to it amongst the staff team than may have happened previously. Rachel, clinical nurse specialist commented that staff acknowledged the wrong doing and the need to move on, but particularly that there was a need to take collective responsibility:

*And I think they probably have now, because there is that very much, 'Yep, we're all in this together. The actions of one, in these sorts of instances, affect us all.' And I think that is markedly different from previous episodes where it's been, 'Why are we being pulled in here?' .. 'Why are we being ... this wasn't me why aren't you speaking to the person concerned?'*

[Rachel, Clinical Nurse Specialist, P2]

Sean felt that the reason for this was the work of the compassionate care programme and the work undertaken by Sam, the Senior Nurse that had got them to think collectively:

*... compassionate care is not about the actions of one or two individuals, it's about the service, it's about a unit, it's about the team. And the actions of one reflect on the actions of everybody. And I think that's probably made ... in my view that's made a difference.*

[Sean, Clinical Nurse Manager, P2]

Given that at the outset one of their areas of main concern was their relationship with relatives, this became the focus of their action project work utilising the LCC process techniques Sam was introducing and Hannah was learning on the Leadership Programme. Given that a majority of relatives lived some distance away from the hospital they used questionnaires, often conducted by telephone to find out what relatives wanted from the service prior to admission, during the period of rehabilitation and in preparation for discharge. Much of the focus of their requests were for information, in terms of what to expect with Ward H, achievement of rehabilitation goals and also more detail of what the patient was actually doing day-to-day. This led to the development and introduction of progressive maintenance treatment plans which included areas the staff needed to discuss with relatives, the goals that had been set, the patient's progress during the last period and the therapies



involved. The final section was to record the families' comments so that this was available with the care plan.

Alongside this new system Ward H introduced a more proactive means of communicating with relatives through assigning a key worker and co-worker system whereby the nurse would agree a period of regular contact with the named relative. The nurse would then telephone the relative at this agreed frequency to provide them with an update and go through the care plan with them.

In the follow up focus group interview with three of the Development Site Charge Nurses Hannah reported that this initiative had been sustained and as well as being beneficial for relatives had positive outcomes for staff. She felt they had a greater sense of ownership, not only for their 'own' patients but a sense of confidence when approached by other relatives to access useful information rather than *'just at times hiding in a corner when a relative comes to ask them'* [P3]

A further aspect of dealing with relatives was recognition by the ward leaders that, in some instances, they were not working well with some relatives who were perceived as 'difficult' by staff. What had changed in the senior team's thinking was that the staff needed to change their attitudes and approaches. Sean acknowledged this situation which he described as follows:

*'I think that's a general problem is that our difficult relatives, we shy away from because we're frightened of what's going to come whether it's a complaint that we can't answer, a volley of abuse that we can't deal with, or an allegation. So if you don't approach and don't engage you don't get. And that's the thing I think we need to change. One thing for me to change with these families that are difficult to engage in, it's a two way thing. We're not particularly doing it that well, I don't think'. [P2]*

Sam, the LCC Senior Nurse recognised these issues and, in addition, through some of his one-to-one discussions with relatives also identified that for them the case conference could be very challenging. He described the scenario of the relative (and where possible patient) walking into a room with a large group of healthcare professionals, being given lots of information, hearing a debate, contributing to some of the decisions and then just leaving. One relative

reported that despite the informality, the amount of information was overwhelming and what would have helped was if she had the information beforehand and somebody had spent a bit of time with her just chatting with her. Furthermore she wanted somebody to come in with her. Sam felt that the challenge in terms of change was embedding that perspective and determining what was right for individual relatives.

Engagement with patients in Ward H was known to be difficult depending on the degree of their cognitive impairment and challenging behaviour. Sam recognised that when he arrived the staff were already very person-centred in their approach to care delivery in the ward, but one area that was perhaps lacking was meaningful engagement with patients into their perspective on discharge from the unit. Sam reflected that he had seen small signs of improvement and gave the example of one patient who was moving to a facility in another city. When he had asked the staff what they felt the patient's impressions of moving on was the staff observed that the patient had recognised all his clothes were folded ready to go and saw this as a positive indication that he had taken elements of the discharge on board. Sam felt that through the work being done in the ward '*there's a bit more understanding and compassion, to prepare people to move on. ...But I think that that's changed*'. Furthermore he felt that in a broader sense there was an increase consideration of the very individual needs and preferences of individuals and a recognition that they (the staff) could be doing more '*rather than just what we're thinking about doing is sitting watching telly, or going to MacDonalds, is thinking well what about that person? Doing a bit more of that*' [P2].

There were two other main areas in Ward H where outcomes were notable. The first related to improving the sense of team cohesiveness, which included giving the nursing assistants a much stronger voice. The second involved the work with students that had been recognised at the outset as an important area for development.

Hannah, the Senior Charge Nurse reflected at the end of Phase Three of my study that the LCC Programme had had more of an impact on the nursing assistants than any other group because it had given them an opportunity to raise issues and discuss things. She reported that she had observed them

getting their thoughts and feelings over, which in turn had made them reflect a lot more on their practice. One example she cited was during a mixed focus group there had been a discussion about the allocation of patients in the ward and the care assistants had spoken up about their perceived need to balance the allocation of the more challenging patients and that the nurse in charge should ensure they had greater oversight over how patients had been allocated whilst they had been off-duty. They also wanted to encourage greater involvement of the occupational therapist in ward activities. Hannah observed that in the past they would not have had the confidence to say this, but may have felt aggrieved about the situation.

The senior team in Ward H were aware that it had a certain reputation with students, who were quite apprehensive about going on a placement as they were often told about their being high levels of aggression there. They wanted, therefore, much greater insight into the students' actual experience and how this could be improved and also to provide much better pre-placement information to prospective students. Sam used emotional touchpoints to this elicit this information, which to some degree did confirm the sense of trauma that students did feel coming into the environment. This was primarily through witnessing people becoming quite distressed, being restrained and being removed from rooms.

Sam described a technique of turning the negative emotional word (in this case traumatised) round by asking the students if there had been times when they had felt comfortable in that situation and what had brought that about and made them feel comfortable (answer was being supported and having a debriefing session afterwards). He then was able to feed back this information to the staff team and the Practice Education Facilitator to ensure they were aware of the importance of these activities. The focus then became on how to prepare students to come into this type of environment and they had suggestions about informal visits, information booklets, dedicated material on the student portal on the university intranet. He emphasised the need for the staff to remain aware of

*... what's normal to staff here, isn't normal for other folk coming in. And we do have to take a big step back and say, 'Are you comfortable with what's going on here?' 'How do you feel about*

*what's happened?' And give them the opportunity to do that. And not adjust to the traumatic times, but just everyday events. You walk into the ward and the shout, the noise, how does that make people feel? It's getting people to get into the discussions with students about what ...*

[Sam, LCC Senior Nurse P2]

In the focus group interview at the end of Phase Three of my study Hannah confirmed that this work with students had been sustained, and had also been extended to the introduction of a weekly education programme for staff and students. This was an hour a week and included opportunities to continue some of the LCC Programme techniques such as emotional touchpoints or a focus on issues such as dignity in care.

For the staff team, Rachel, Clinical Nurse Specialist felt that another outcome had been that the Programme had given them an opportunity to try and understand '*why we do what we do, when we do it*' [P2]. She felt that this in turn meant that the staff were more reflective and this was demonstrated in the way they chose a particular approach with a particular patient. Sam, LCC Senior Nurse supported this view and stated that it was partly achieved through the introduction of caring conversations and regular debate about care approaches and positive care practices.

### **What has worked well?**

One of the reasons that Sam felt Ward H was successful in its engagement with the LCC Programme was the fact that at the outset they had a confidence that they were '*a good place .. and do good stuff*' (despite the environment) but recognised that they could do better (for example with relatives).

Sean, Clinical Manager felt that Sam's skills as a facilitator had been key to the acceptance of the Programme. He was quick to establish trust within the multi-disciplinary team by making it clear that if he did observe 'deficiencies' he was not going to take them back to the manager, rather bring them to the staff team and turn them into a positive opportunity for them to address. In time he also observed that the appreciative approach was resulting in staff coming up with ideas and generating their own suggestions of ways to improve their practice.

Rachel, Clinical Nurse Specialist endorsed this view that using appreciative inquiry had led to staff having very focused discussions about their work and through Sam asking questions such as *'What can you do about that? What would be a way forward?'* was leading to one of the outcomes they had been hoping for:

*And I suppose that's something that we've tried for a long time, is to get them to take more responsibility and we step back. .. And I think that hopefully Sam has ... or the compassionate care project, has enabled them to see that actually they do have responsibility and they do have an accountability and they need to be practicing these things. That you can't just come to the work and have a chat to so and so about last night's party and things like that.*

[Rachel, Clinical Nurse Specialist P2]

Beliefs and values clarification was used in the early stages and was conducted in multidisciplinary groups. One thing that Hannah, Charge Nurse observed was that these sessions gave the staff the opportunity to reflect and see that they were delivering compassionate care *'but not in those words and we didn't really use those words before, but certainly since this project it has given them the opportunity, but I think before we didn't think about it that way'* [P2]

One of Sam's reflections of Ward H was that there were a lot of opportunities for the staff to get together and talk, for example at the goal planning meetings. He used these as ways of stimulating discussion about the feedback from the beliefs and values sessions and posed questions back to staff, for example:

*'You all say you work really good as a team. What does that mean?' You're all working together. You're involved with doing decision making. 'Well how are you doing that? Does that happen all the time?' Those kind of questions.*

[Sam, LCC Senior Nurse P2]

He felt that these types of approaches did have an influence on the team's sense of cohesiveness which had been identified as one of the outcomes of the Programme.

Hannah, Charge Nurse learned to use emotional touchpoints during the Leadership Programme and went on to use them quite extensively with staff once Sam had left the ward. She valued the technique in that it *'allowed the staff to really express how they feel, and feel safe and comfortable to do it. And know that they're not going to get ridiculed for what they've said or they're*

*not going to get told off for how they feel about certain things. It's just a way of feeling safe and managing that' [P3].*

Sam made an observation about his experience of using emotional touchpoints in Ward H that seemed to be in contrast to their use in other of the LCC Programme's wards. In Ward H he found that the staff would use the words and perhaps point to them but not physically take them and place them against the touchpoint. He said that it was *'hugely emotional'* and that were staff were positive about being able to use words they might not have used in everyday language.

Whereas in other wards emotional touchpoints had been used to varying degrees with patients, in Ward H presented the greatest challenge. Sam suggested that where you might sit down in another ward and ask someone with no cognitive impairment what compassionate care means to them, in Ward H to a large degree the staff second guess what people would want. Despite many attempts at engagement with both patients and relatives (many of whom lived at great distance) this had not been overcome. Sam had worked with the SLT to create a form of emotional touchpoints using images but with success with only one or two patients. This was something which he was concerned about, as he said *'kind of two components out of the triangle that I haven't really managed to get to ... So we've learnt what works, it's quite a unique situation, it is quite different. Every where's unique, but it's certainly quite a unique difficulties and challenges'* [P2].

### **Leadership programme**

Hannah had participated in the Leadership Programme at a point where she had just been appointed as a Charge Nurse (having worked in the unit for a long time as a staff nurse) and felt that it made an important contribution in building her confidence. Through Sam's support she began to implement the Programme techniques such as beliefs and values clarification, which helped staff see her in a different role. The Leadership Programme was beneficial in terms of networking, particularly for Hannah and Ward H's position of potentially being isolated from its directorate services

The Leadership Programme is, in part, structured around the Senses Framework (Nolan et al., 2006). Hannah took this forward herself and in her

follow up interview described how she had used it as a way of engaging the staff in a workshop through asking them directly how they felt in their work what gave them the sense of achievement, belonging, continuity, purpose, significance and security. She reflected that the approach had been a very effective in giving staff the opportunity to express more feelings. She had formulated a plan of work as a result and intended to review it again with the staff. As a result of this experience Hannah saw opportunities to use the Senses Framework in relation to their outreach service, working with relatives and placements that they move their patients on to and the degree to which they have a sense of security about that move.

Within the Leadership Programme Hannah was able to access action learning and she reflected that this experience had led her to become a lot more open and confident in a group. Again she felt that she had learned a great deal from hearing about other people's experiences and taking something away from that herself. In her Phase Three Interview, Hannah described her overall development:

*And in the last two years I find myself in a different place, a different role and feel confident to do it. I feel a lot more ready to take on more difficult situations than I would have been. I think because they see me as a leader taking this forward as part of the Development Site, I felt very proud as well, of the work that we've done and I still feel very proud of the work that we've done. [P3].*

### **Sustainability**

The question of sustainability was raised at the first focus group as the senior team anticipated what would happen when Sam, the LCC Senior Nurse left. Sean, clinical manager was concerned since he saw Sam as being instrumental in getting staff to think about their practice. He still felt to some degree that the staff '*can't see that they're actually doing that, and they can self-facilitate that just by asking the questions, reflecting themselves, feeding back to themselves and all these sorts of things*' [P2] and so was anxious that this positive development would fall back. Sam also recognised this concern and the potential need for ongoing facilitation to maintain the level of questioning and reflection that had been instituted. He gave the example of one of the positive care practices that they had developed around involving patients in decision-making. He wanted to be sure that there would be

systems in place to continue to put that statement on the table and talk about it is a positive care practice and how it would be evidenced. He hoped that staff would be able to draw on care plans and their own evidence generated from themselves through observations and stories. However, what he was asking himself towards the end of his work with Ward H was '*how do we do this? How do we challenge it? How do we make sure it happens?*' [P2].

When Sam left Ward H he also left the LCC Programme to take up a new post and so they had only irregular direct input from the LCC Team. However, in her Phase Three interview Hannah reflected that she did not see this as a problem. In the subsequent year her deputy Charge Nurse undertook the Leadership Programme and therefore '*we got used to just getting on with it by ourselves*' [P3]. What did happen, however, was that whilst the support of the multidisciplinary team had been strong at the outset of the Development Site period this was not maintained and it became much more strongly identified as being for the nursing team.

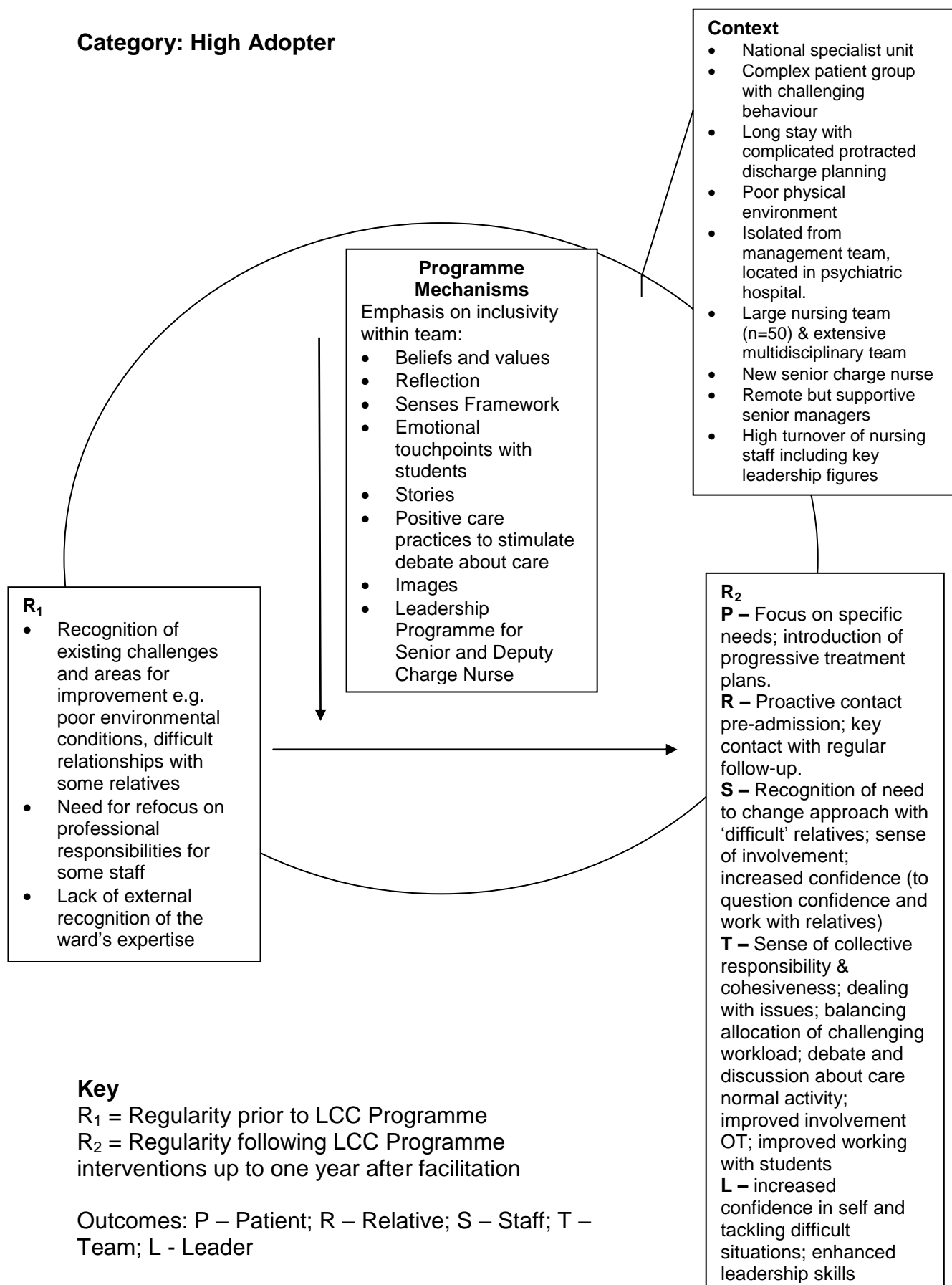
### **Change in regularity**

Figure 20 overleaf indicates a challenging context in terms of environment, client group and remote proximity from senior management support. The charge nurse was also new in post, but had the immediate support of an experienced clinical nurse specialist and multidisciplinary team. The main ward stakeholders were able to recognise the deficits in the initial R<sup>1</sup> position in terms of relationships with relatives and the need for a renewed sense of involvement and responsibility amongst the staff team. One of the key mechanisms that supported the shift to R<sup>2</sup> was the introduction of the Senses Framework (Nolan et al. 2006) as a means both to address engagement with relatives and support for staff to deliver compassionate care. Even in the face of a testing incident in the ward the staff team responded in a very different way to the R<sup>1</sup> mentality, which gave the charge nurse and manager optimism for sustainability.



**Figure 20: Realistic Evaluation Summary - Ward H**

**Category: High Adopter**



The findings presented in this Section will form the basis of a synthesis of findings which will be addressed in Section 6.5. Prior to this, however, I will preface my own conclusions to this chapter with the reflections of some of the key stakeholders that were an important focus of my Phase Three interviews.

## **6.4 Lessons Learned**

These findings relate to the interviews I undertook with twelve stakeholders towards the end of the LCC Programme between December 2010 and May 2011. They address the question of what were the lessons that they had learned from participating in the Programme? The majority had been involved with the Programme since the early days and so were able to give a broad perspective. Six themes emerged: reflections on compassion; a model of taking a Compassionate Care Programme forward; the importance of relationship-centred care; the crucial role that facilitation played in the Programme; the centrality of the Leadership Programme to sustainability; and the need to ‘work without an agenda’ in this sphere.

### **6.4.1 Compassion**

At the beginning of the study in 2008 I had explored the stakeholders’ personal understanding of compassion, and these responses were synthesised into and an emergent definition, which I presented in Section 5.2.2.

*Compassionate care is delivered when caring and competent practitioners make a positive connection with patients and their families, leading to the development of trusting relationships directed at meeting their needs. These needs are met through attention being paid to the ‘little things that make a big difference’ as well as healthcare needs, and contribute to ensuring positive patient outcomes.*

At the end of the Programme when I asked those still involved what they felt they had learned, most of them began with compassion itself. Some wanted to condense the concept simply as ‘caring’ (for example Tom, Charge Nurse Ward E, P3) rather than focussing on the term compassion, or argued that within good caring there are ‘*compassionate caring moments*’ rather than ‘*compassionate care all of the time*’ (Michael, Senior Nurse P3). It was clear that many recognised a change in their thinking; particularly the move away from the idea of caring for people the way *you* would want to be cared for, to

recognising individuality, respecting other's values, and not making assumptions about what compassion looks like. Jack, Policy Maker was amongst several who articulated this idea.

*And I think for me .. whether they be frail, elderly, confused, young, articulate, somebody dying, somebody not dying, everybody has a different need but they all need to be cared for appropriately to their needs and recognising that one individual's values aren't necessarily the same as yours. And it's their values you need to respect not necessarily your own. [P3]*

This was further endorsed by Lucy, one of the LCC Senior Nurses, and she was keen, above all, to emphasise the fact that in some cases healthcare professional's engagement with patients might look to outsiders as being harsh. This was particularly based on her experience of working in Ward E, the mental health rehabilitation unit.

*Acts of compassion can look different in different settings with different people. Something that you don't think is compassionate actually is compassionate because we make assumptions about things and don't check things out.*

[Lucy, LCC Senior Nurse, P3]

Monica, a manager from one of the five Development Units acknowledged that some staff were not inherently compassionate but that the Programme had demonstrated that if you could 'find the way in' then they could be supported and developed. She went on to cite herself as an example, in that through her participation she had learned:

*That I'm actually quite compassionate. What have I learnt about compassion? That it's something that can be taught, definitely. You might not have thought you're compassionate.. but that it's there. Everybody's compassionate in some way or form, and even the ones who are a bit bolshy at times have compassion there but it's just not been tapped properly. So if you can find a way of getting in there, you've sorted it.*

[Monica, Manager, Development Unit J, P3]

Most people acknowledged that within the NHS the delivery of compassionate care was complex and did require ability and skill that they had perhaps not recognised before.

*It's not just about smiling and being nice, it's about the ability and skill, huge skills, in being able to respond to someone as a human being rather than a patient.*

[Lucy, LCC Senior Nurse, P3]

Diana, Senior Nurse used the image of '*finding the recipe*' for compassionate care within this complexity through '*understanding what people [staff, patients, relatives] need*' [P3]. Martha, one of the Policy Makers also drew on this metaphor when she contrasted the LCC Programme with Releasing Time to Care™, which comes with a very prescribed 'recipe' in terms of a structured toolkit.

*Releasing Time to Care is a manual, it is prescribed, it is a way of doing things that's just doing it by the recipe really. Whereas compassionate care is ... we've been making the recipe up as we're going along. And I suspect you'll always be making the recipe up a bit because it depends on the situations that you find yourself in. [P3]*

#### **6.4.2 Taking the LCC Programme forward**

Six main themes emerged from this phase of my study, which have implications for taking the Programme forward. Many of them had been reinforced earlier in the study.

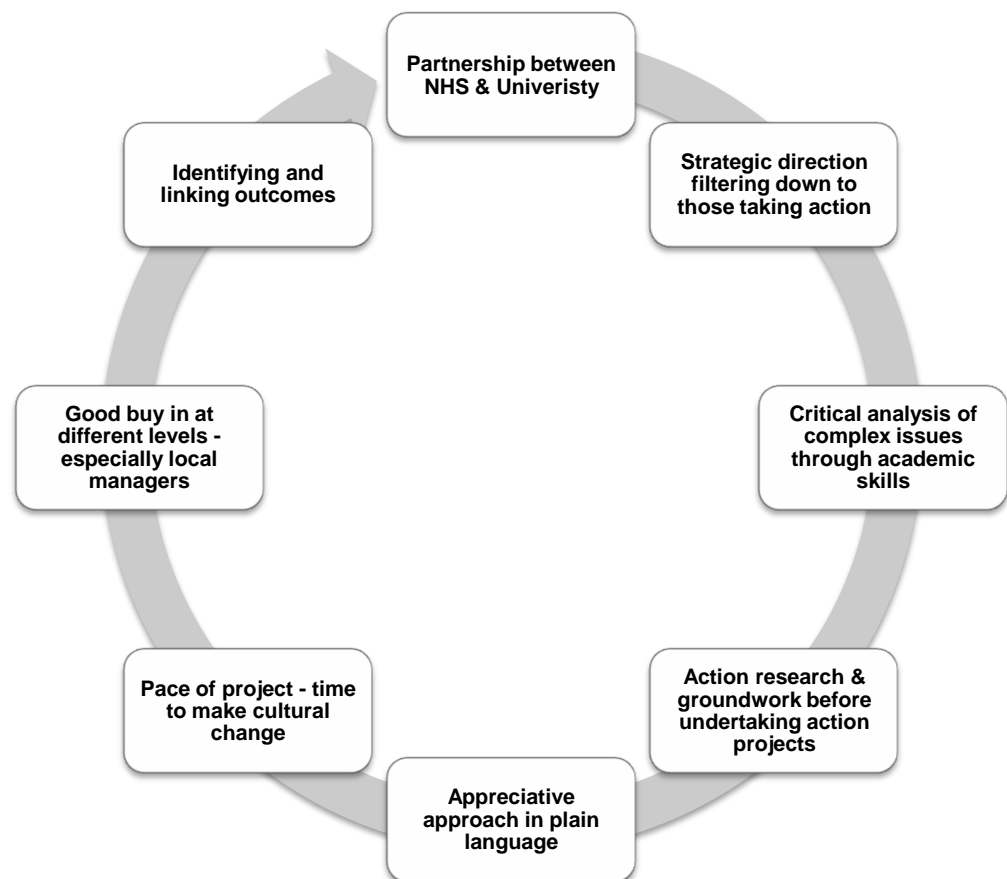
1. A model for a compassionate care programme
2. The role of relationship-centred care
3. The importance of facilitation
4. The centrality of the Leadership Programme
5. Working without an agenda

##### **6.4.2.1 The Stakeholders' Model for a Leadership in Compassionate Care Programme**

When the LCC Programme was initiated in 2007 its uniqueness was both the focus on compassion (which some people both internally and externally were sceptical about) and the fact that it was an action research study in itself with no predefined outcomes or measurement tools. At that point in time the adoption of appreciative inquiry and relationship-centred care as core theoretical underpinnings on this type of scale was limited. By 2010 the stakeholders were in a position to look back and reflect, whether they been

involved for the full three years or one. A number of key ideas emerged which taken together can be seen to represent a model for the design and delivery of this type of programme. Ruth, one of the Senior Nurses used the term '*brave*' to describe the approach they had taken to tackle what was seen to be a difficult subject (i.e. compassion) at the outset, and to some degree something that remained difficult at the end of the three years. Figure 21 below summarises the components of the model, which is then described in some detail.

**Figure 21: The Stakeholders' Model for a Compassionate Care Programme**



- a) **Partnership:** The partnership between NHS Lothian and Edinburgh Napier University was probably seen as the most important feature and it was acknowledged that this had led to wider benefits at both strategic and operational levels.
- b) **Strategic direction:** Clear direction from the top, particularly at Executive Nurse Director / Dean of Higher Education Institute level (which there was

in this case) was seen as paramount and this needed to be filtered down to those taking the Programme forward. The challenge was sustaining this over time amidst other competing pressures.

- c) **Critical analysis:** The input of academic researchers in addressing a practice based 'problem' was recognised by Jack, one of the Policy Makers who declared that he would take this approach in future initiatives.

*I've learnt that actually people coming in with an education level that is perhaps a little bit above routine actually is probably helpful because they've maybe got the ability to distil information and look at how you might take that information and put it into practice, or how you might analyse what's happening and come back with solutions that maybe people at a particular level might not do. They [clinical staff] might see it but they might not know how to interpret it or analyse it. ... If I was embarking on a piece of work now I would look for an academic researcher in the team.*

[Jack, Policy Maker P3]

- d) **Action research:** Adopting an action research approach allowed the emergent design of the Programme, whilst providing rigour to the method and analysis. This was something that was emphasised by Michael and Joanne, two of the Senior Nurses. Michael, the more experienced researcher of the two welcomed the '*benefit of not necessarily having hard, clear outcomes, and going with emergent design*', whilst Joanne (who joined the Programme in Phase 3) reflected that the analysis and development of the framework for a compassionate care model (Edinburgh Napier University & NHS Lothian 2012 p.159-161) '*in a way puts on paper things that you think of instinctively*' [P3].

- e) **Appreciative approach:** The appreciative inquiry approach, especially the emphasis on groundwork within the participating wards to elicit beliefs and values and obtain patient, relative and staff stories were seen as essential. These promoted trust and were very much valued prior to undertaking action projects, rather than jumping in and trying to 'solve' problems immediately. Starting from what is working well was seen to have a major influence compared to embarking on looking at what is not working. This point was emphasised by two of the Senior Nurse, Diana and Joanne: Diana remarked that the biggest lesson for her had been '*that if you go*

*from working on what works well, it's a far better place to start than what we're not doing'*, whilst Joanne stated *'I think the appreciative approach is absolutely crucial to the project and the way it's done'* [P3]. Learning to take an appreciative stance was something that was new for many of the Senior Nurses and took time to develop in the Beacon Ward phase, as Lucy stated despite reading about it extensively *'you have to feel it, live it, that reality is quite different'* [P2].

It was clear, however, from a number of stakeholders that appreciative inquiry was not initially easily accepted by staff with some being suspicious that the Senior Nurses were trying to catch them out whilst others were embarrassed when they were given praise. Laura, Charge Nurse in Ward G reflected that at first her staff had found it difficult getting feedback stating *'that's just my job'*, however she did comment *'but you can see they've got a smile on their face'* [P2]. Gordon, Charge Nurse in Ward C said that for him, the appreciative approach initially was like *'being asked to strip off naked'* [P2] however he gradually got used to it and began to use appreciative language with his staff.

Although the appreciative approach was recognised as a defining positive feature of the Programme, there was a word of warning from one of the Clinical Nurse Managers from the Development Units. This was around the LCC Team's occasional style of language and whether or not this would put staff off. Monica was quite direct about this when she stated:

*If they're going to continue ... they have to talk in plain English because that irritates us nurses beyond belief. You know all that sort of flowery .. I'm just trying to think, like when you're saying the appreciative stuff, I know exactly what you mean because I've just described it to you... you've used the words to describe what I've said. [Senior Nurse] talks like that, so does [other Senior Nurse] and it gets the back up of people, like nurses on the shop floor and charge nurses, because they don't talk like what we would talk ... walking textbooks.* [Monica, Clinical Nurse Manager P3]

- f) **Pace:** In contrast to many initiatives in the NHS such as the Scottish Patient Safety Programme and Releasing Time to Care™ a number of the stakeholders reflected that the pace of the Programme was important; in

that it should be given time. In addition there was a need to take stock along the way, particularly in areas where there were some co-existent challenges such those that had emerged in Wards C and D. Jack acknowledged this when he said that there was a need:

*... to stop and take stock and think actually how much more of this can we do? ... do we need to think where we're going? Because I think initially we had this picture of everything would be wonderful, but actually everything had to be sorted first in some areas before you could even start to rebuild it. And I think we had a couple of areas whereby that maybe was the situation, that actually they were picked but when you started to dig in to what was happening in the clinical areas, there was a need to fix some things first before we could start building something new.*

[Jack, Policy Maker, P3]

Martha, one of the other Policy Makers suggested that the need for a more gradual pace for this Programme was '*because this is a very deep and fundamental thing it needs time for people to be able to appreciate, understand and get to grips with it on a personal level in the ward and areas*' [P3].

- g) **Management support:** Locally it was absolutely vital that there was buy-in at different levels and this was an area where it was acknowledged that there was variation, which did have an important effect. In particular, if the Clinical Nurse Manager was not engaged then it was felt that no matter how much the Charge Nurse and LCC Senior Nurse were aiming to drive the Programme forward, sustainable change was limited. Joanne, one of the LCC Senior Nurses who came into the Programme in Phase 3 faced this challenge in Development Unit M. She described the impact that the Clinical Nurse Manager's lack of interest in the Programme had on staff and her ability to make progress:

*You can influence so far and people can see that some of the work that you've been doing is useful but that without immediate managerial support, there is no real support and interest and when things are quite hard in terms of staff time and things like that, and nobody thinks that ultimately management is going to be interested in what happens, then you can achieve so much but you can't achieve more because they know that their manager isn't interested.*

[Joanne, Senior Nurse P3]



In contrast, however, an example of successful buy-in at local level was Ward E and Tom, Charge Nurse explained how a supportive infrastructure beyond the ward emerged had contributed to their motivation and success:

*The more we were doing, the more we wanted to .. share it but you also wanted to compare it with other people so you could have a critique and a discussion, see how effective it was in your area, can you try it in your area and see how it goes with you. We've not quite got to that yet but we're setting up a Compassionate Care Steering Group ... that will have fingers in most areas, anyone who's been involved in the leadership programme or somebody who's got a specific interest in it. .... Everyone had a different take on things so you could ask, or talk, or end up discussing goodness knows what. But all relevant to compassionate care. [Tom, Charge Nurse P3]*

Within Ward E the Charge Nurse met regularly with the Service Manager, Chief Nurse, LCC Senior Nurse and Lead Nurse. Tom emphasised the importance of this was *'always updating and saying this is what we need, this is what we're doing, and just constantly keeping people in the loop'* [P3]. This type of approach was mirrored in Development Unit I, which had the same LCC Senior Nurse.

h) **Identifying and linking outcomes:** A number of participants specified that working with managers who were looking for outcomes was vital and that as well as these being communicated widely they needed to be linked to other initiatives (such as the Scottish Patient Safety Programme or Releasing Time to Care™). Examination of the high adopter wards signified that this had been an important contextual factor, whilst in areas where support was lacking such as in Development Unit M, there was little expectation that much of the work would become embedded. Joanne, Senior Nurse described her experience when she said *'when the day to day support, interest isn't there... I'm inclined to think that it will never really be embedded because .... they don't have to say to people what's gone on, nobody's looking for a result.'*[P3]

Martha, one of the Policy Makers, summarised her overall perception when she stated *'Here's a good model to follow. Good partnership with university, good buy-in at different levels, moving slowly and surely along'* [P3]

### 6.4.3. Relationship-Centred Care

One of the three underpinning theoretical approaches to the LCC Programme was relationship-centred care, strongly informed by the concept of the Senses Framework (Nolan et al. 2006). What became clear in the Programme was that the stakeholders who had initially expected it to be primarily patient-centred recognised that compassion towards staff was absolutely fundamental. Many, particularly the Senior Nurses, saw this being lived out in a number of the settings through the collation of staff and student stories. Joanne, one of the LCC Senior Nurses indicated that she was now able to put across to herself and others a concept that she had always had in the back of her mind but had not been able to express.

*I couldn't articulate, perhaps, the thing about relationship-centred care, without having read the stuff before. But would actually have strongly argued that we needed to consider all those people and that staff were as important as relatives and patients had to understand that they were cared for in an environment where there are other people being cared for. And that we were all part of something together and we had to negotiate what was possible and what wasn't possible. [P3].*

The relationships between the LCC Team and staff in the wards/departments was fundamental to the success of the programme. This was evident throughout the study and many stakeholders argued that building relationships takes time and should, therefore be given time. Lucy who had been very new to facilitation when she joined the LCC Team in 2008 reflected that now three years later she knew exactly how to approach relationship-development and gaining trust when going into a new area, especially when this was now being done on a unit basis. She described her approach with the maternity services (Unit I):

*The one thing that I've tried to do is make us feel like a team, like a group that's working together. One of the things that I was very encouraged to do was to, rather than focusing on all the practice development aspects of this, was really to be there and chat to people and get to know people in the first stages. And also to give that impression, or to put across that appreciation rather than anything else. So let people settle in to me and me into them.*

[Lucy, Senior Nurse P3]

Tom, Charge Nurse in Ward E reflected that for him the importance of relationships had been the most important learning from the programme and it

was essential, therefore, that these were open and positive and '*were never allowed to go stale*' [P3].

#### **6.4.4 Facilitation**

The importance of facilitation was emphasised repeatedly and was one of the most highly endorsed aspect of the Programme. Lucy, Senior Nurse made an important observation that there were two types of facilitation: the '*enabling, cultural, development side*' and '*the task-like change-management*'. The Senior Nurse had been involved in both, but with the emphasis on the former.

Facilitation was seen as a multifaceted skill and the following examples illustrate elements of the skill profile of the facilitators in the Programme (the Senior Nurses); firstly from the perspective of the recipients of that facilitation and then by the Senior Nurses themselves.

- Gordon, Charge Nurse Ward C recognised Lucy's ability to '*draw people out*' and that this came, in part, from her *personality* [P1];
- Laura, Charge Nurse in Development Site F appreciated Michael's ability to '*make people think*' by stimulating lots of discussions, which was also bolstered by his *enthusiasm*;
- Sean, Clinical Manager in Development Site H emphasised that one of the key components of Sam's facilitation was his '*inclusiveness and approachability*';
- Tom, Charge Nurse in Development Site E valued the fact that facilitation brought with it '*shades of grey*' rather than being told what to do [P1]. He valued the '*open, partnership*' working that he had with Lucy along with the fact that he had been allowed to take '*one stabilizer off at a time*' when taking on the practice development techniques [P3];
- Laura, Charge Nurse, Development Site F stressed the need for facilitators to be *leaders*, to be able to give direction and focus. She also recognised that '*they have to be able to see the positive in everybody and treat all staff as individuals, same as they would patients*' [P3];
- Martha, Policy Maker emphasised the *role modelling* ability of the facilitators (as opposed to just issuing a tool kit) and recognised that this included '*allaying fears and anxieties through face to face discussions, explanations, understanding, answering questions*' [P3].

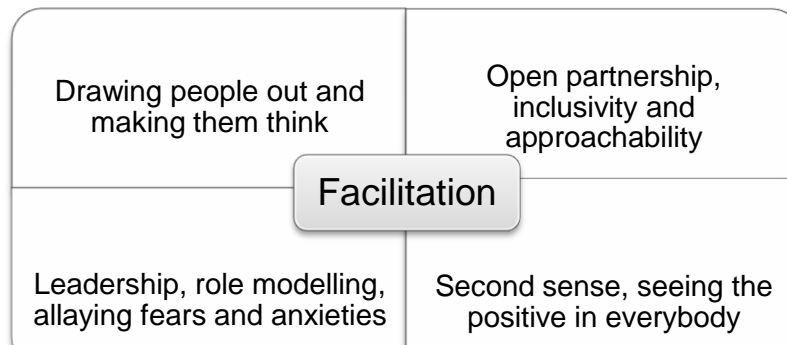
Catriona, Clinical Manager, Development Unit J described in some detail her experience of observing Michael facilitate a challenging meeting with some

relatives who had made a complaint about nursing care in one of her wards. Michael used emotional touchpoints with the family, and whilst Catriona had previous experience of the method, in this case she felt she was observing ‘a second sense’. In stating that Michael had ‘a skill set that are way beyond ours for that sort of thing’, Catriona went on to explain:

*You need a high level of perception, you need to be all that touchy feely stuff around body language, to realise when somebody is not responding the way you want you change tact and go in another way... and I can do all of these things, I’m a good communicator and I think I’m quite insightful as to when to shut up and when not to shut up. Or I’d like to think I was, but [Michael] just seems to have a second sense about it that ... [he] picks up on things that I’m not necessarily sure I would, but then again I probably sit in there with pre-conceived ideas of what I think what should happen but not necessarily what does happen. [P3]*

Figure 22 below illustrates how these facilitation skills were seen to come together to support the ward teams.

**Figure 22: Staff perceptions of the facilitation skills of the LCC Senior Nurses**



When the Senior Nurses reflected on their own facilitation skills they described a number of complementary components. They used phrases such as adaptability; ‘in the moment analysis’ [Michael P3]; ‘using the right tricks’ [Diana P3]; development of relationships and outcomes being centred on the people involved.

Given that by the end of Phase 3 of the LCC Programme each of the Senior Nurses worked in very different clinical settings their reflections on context featured prominently. Lucy emphasised the need for adaptability particularly

when working alongside staff and used the example of moving from a mental health ward to a maternity setting, which included going into women's homes. Ruth had observed the work of one of her Senior Nurse colleagues in Ward G and could see that she had demonstrated great '*insightful skills in adapting to context*' in '*maximising opportunities whilst being respectful of the clinical demands*' of the ward.

The Senior Nurses felt that having the ability to quickly assess and understand an area or group of staff was essential. The more experienced facilitators recognised this skill in themselves, whereas the less experienced knew it was something that they needed to develop. Diana talked about her '*box of tricks*' and the fact of '*knowing what works in your box of tricks*' so that she could really understand how to '*very, very quickly move people towards finding out about change*'. Another consideration Diana emphasised was recognising what wards were ready for:

*I had to go into the bag and have a look and work out what worked for the right places. And there were things that I would have chosen to do but were not the sort of things that the wards were ready for.*  
[P3]

Michael articulated his perspective on how skilled facilitation is manifest when he reflected back on his experience:

*[it] ..is the working in the moment, analysis in the moment, so picking up something that's happened and linking it back and feeding it back and then developing something new.* [P3]

Lucy had been new to the role of facilitator at the beginning of the Programme but by the end of Phase 3 could see the development of her own skill set as having been a major outcome. She placed emphasis on relationships and '*how quickly you can put people at ease*' [P3]. Furthermore Lucy placed an emphasis on the wider outcomes of facilitation for staff, which were based around reflection and moving forwards. For her the outcome '*must be that the people themselves will have a journey in terms of reflecting on their practice ...the outcome has to be a way forward in terms of re-engaging with them, doing something different, or whatever. Or finding from them where they want to go*' [P3]. What Lucy did also acknowledge was that a key skill for a facilitator

was going into an area looking confident, regardless of whether that was how you were feeling.

Despite all these positive endorsements of facilitation there was concern that the benefits achieved and skills developed could be lost at the end of the funded period if the investment was not sustained. However, there was clear acknowledgement by the Policy Makers that facilitation was part of the sustainability plan, albeit a less intense model, and that a compassionate care toolkit alone would not achieve cultural change.

Although the Senior Nurses were recognised for their facilitation skills, Michael felt that perhaps they did not have sufficient 'authority' within the organisation to implement change at both policy and practice level. He argued, therefore, that moving forward there was a need not only to consider having the right people with the right skills but that they should be at the right level within the organisation.

#### **6.4.5 Leadership Programme**

Although my study was focussed on the Beacon Ward Strand it became evident very early on that the Leadership Strand was absolutely fundamental, not only to what went on in the Beacon Wards and Development Sites but to the wider dissemination of the Programme's influence. Ruth, Senior Nurse was the first to articulate this in LCC Phase One of my data collection and recognised that it needed to be raised with the Programme Steering Board as to how the Beacon and Leadership Strands would be taken forward in parallel. Diana felt that even by the end of the first cohort of the Leadership Programme it was possible to see definite outcomes:

*.. they're changed people, they're doing things in a different way. And, ok, they won't necessarily .. at this moment in time they're fledgling practice developers in practice, but there's definite evidence from the way they are that they've changed their way of thinking about how you bring about change. And even if it's just the .. people that came on that ... they're changed people. [P1]*

The Leadership Programme expanded over the course of the Programme with 19 participants in 2008, 32 in 2009 and 55 in 2010 (total 106) and eventually included allied health professionals, education staff and 2 psychiatrists. By the end of the second cohort Michael, Senior Nurse was suggesting that the

Leadership Programme would be *the* route by which the LCC Programme would become embedded in the long term, largely through its focus on the practice development processes rather than simply *'talking about compassionate care for six days'* [P2]. This recognition was substantiated further in Phase 3 (when the Senior Nurses were facilitating the Programme across whole units) when it was much more explicit that the Leadership Programme participants would be the main means by which the Programme would be taken forward in the clinical areas.

The use of the Senses Framework (Nolan et al., 2006) as the thread running through the Leadership Programme had a major influence on participants and was a very visible aspect of the three Celebration Days that I attended. During these events participants presented their action projects to managers and colleagues. A striking feature was the degree to which the focus of action projects had been on meeting the senses of staff, in the recognition that this would in turn have an impact on patients. Ruth, Senior Nurse also noted this amongst the Cohort 3 presentations when she remarked:

*Interestingly a number of the projects are all about staff and staff morale and trying to support them and a bit kind of FISH! Philosophy<sup>65</sup> of 'choosing your attitude' and that kind of thing, is definitely coming through. So it's about compassionate care for staff in amongst the situation, I think that's quite notable.* [P3]

All of the stakeholders I interviewed that had undertaken the Leadership Programme were very positive about the experience, to the degree that Laura, Charge Nurse in Ward F, said that it was *'one of best things I've ever done'* [P3]. She commented that *'It's not sitting at a computer doing audit after audit after audit. It's the interaction with the staff, interaction with the patient'*. Furthermore she particularly valued the networking opportunities and group work and the fact that they were able to test out the LCC methods safely before taking them back to their clinical settings. This latter point was endorsed by Tom, Charge Nurse in Ward E who felt that he was given the confidence to try out the practice development techniques, particularly because he knew he would also get supervision and critical feedback from his

---

<sup>65</sup> The FISH! Philosophy™ is an approach to teamwork and customer service that was developed by John Christensen following observation of the Seattle Pike Place Fish Market which follows four core principles: i) Play ii) Make their Day iii) Be There (for co-workers) and iv) Choose your attitude <http://www.charthouse.com/content.aspx?nodeid=22610>

senior nurse [P3]. Hannah, Charge Nurse in Ward H reflected that it had made her think about the way she (and the ward) did things and in particular the gaps that they had in their relationship with relatives [P2].

There were a number of testimonies about how the Leadership Programme had changed participant's perspectives completely; personally and professionally. Ruth, Senior Nurse described a Charge Nurse [Heather] who had participated in Cohort 1 of the Leadership Programme but who was not linked to the Beacon Wards.

*But clearly for some people, people like [Heather] for example, who's been on the Leadership Programme which is a very good example of somebody, if I mention [Heather]'s name they say 'What a difference in [Heather]!' Everybody says that to me. And interestingly it's a real 360 thing so people that she works with, other people, other managers it's a very consistent message and I use her as an example because I think she's a good one. ... that thing flies up to the top of a manager's agenda because they can see a very real difference in an individual, how they behave and conduct themselves. [P2]*

Similarly Lucy described the impact on two nurses that were in one of her action learning sets:

*And she used to talk about how she was almost burnt out and the leadership course completely invigorated and inspired her again to be a nurse. And I've had that when I was doing the evaluation of the action learning set, there was one person that said how what this has all done for her is enabled her to celebrate being a nurse again. [P3]*

Catrina, Charge Nurse in Development Unit K who became involved in the Programme in Phase 3 also recognised the impact that participation in the Programme had had on herself and her outlook on nursing:

*And it's just changed my whole outlook on everything ... and I just loved everything about it and everything I've learnt and I've used. And I've been teaching as we go, everybody, how to use it. ... It actually taught me to look at nursing in a completely different way. I'm quite easy osey, everybody knows that, but it's made me look at compassion and nursing and patients in a completely different way. [P3]*



One final example, again from Lucy, emphasised the sense of reinvigoration that senior nurses/midwives were experiencing and that it was ‘allowing’ them to reconnect with their patients:

*Let me be absolutely clear about this because I personally think that there are still changes happening, for instance if I look at [Ailsa] the change in her is the enthusiasm that she has, this reconnecting with her profession, this understanding of compassion that she believes in, and that she can articulate.*

[Lucy, Senior Nurse, P3]

Whilst the majority of participants were positive about the Leadership Programme, there were a number of caveats. In the very early days Liam, Clinical Nurse Manager expressed reservation about its length, commenting that his own charge nurse participants (who were not on Beacon Wards) were not very positive about their experience, for example in contrast to the Leading Better Care (LBC) Leadership Programme that was running concurrently<sup>66</sup>. However, they did not have the benefit of the follow up local facilitation that those involved in the Beacon Strand had. Later in my study two of the stakeholders specifically reflected on the need to give more thought as to who participated in the Leadership Programme. This was particularly related to the degree of influence that the individuals would have on return to their clinical setting. This may not have been the case for all areas but certainly in these two (and one of the ‘Other Wards’ who also had had a participant in Cohort 1) it was felt that relatively inexperienced staff nurses at Band 5 (or even Band 6) or those that were ‘sent’ did not really make much impression when they returned to the ward. This was then seen as a potential lost opportunity. Monica, Nurse Manager in Development Unit J requested that there was a more evidence-based approach to selection criteria rather than ‘*Oh she’s really good, she’s enthusiastic*’ which had been the case in one of her wards and had ultimately led to problems 3 – 4 months into the Programme.

With reference to the contrast between the LCC Leadership Programme and Leading Better Care (or Senior Charge Nurse Review) Programme, Tom was in a position to reflect on what he had taken from each when he stated ‘*the Senior Charge Nurse Review’s given me a heads up on what’s going on,*

---

<sup>66</sup> The Leading Better Care Programme was described in Section 2.4.5.

*whereas the compassionate care is actually educating me, and you're learning how to take care forwards' [P3]*

#### **6.4.5 Working without an agenda**

Many of the stakeholders valued the iterative nature of the Programme, the interaction and relationships between people, the exploration of emotions and creative thoughts about compassion in ways that they had not previously considered. Lucy, one of the Senior Nurses perhaps summarised effectively a number of dimensions of the Programme as well as the concept of compassion itself when she concluded her final interview saying:

*.. embrace people, enjoy what you're doing, work with them without agenda, don't go in there with your own assumptions of what something would look like, or should look like and drive that forward, work with the people that you've got. Whether you're confident or not, go in feeling confident, looking confident. [P3]*

She did go on, however, to give a note of caution to the participating organisations, whilst on the one hand being very congratulatory to both for taking this programme on in the way that they did.

*And for an organisation, well done for doing all this, for allowing it to happen, and for working so well between the two organisations, but actually put your neck above the parapet and sign up to it now if it means that much to you. And realise that if you want to change culture, you have to invest in it. It ain't gonna be done cheaply, it just won't ... won't be done so you choose whether you do it or not. That's it ...*

[Lucy, Senior Nurse, P3]

#### **6.5 Synthesis of findings within the realistic evaluation framework**

This section will synthesise the findings from the eight case studies within the realistic evaluation framework (Pawson & Tilley 1997) in such a way to map the essential learning from this study. Its emphasis is on the addressing third aim of the study which was to 'examine the interplay of context and mechanisms that are seen to influence the process and outcomes in order to understand 'why the LCC Programme works, for whom and in what circumstances?'. Its purpose is to prepare for the discussion in Chapter Seven and to point towards recommendations for wider implementation of ways to understand and embed compassionate care in practice. This includes a wider organisational perspective on the impact of this distinctive Programme

to some of those already published (Smith et al., 2010; Dewar & Mackay, 2011; Dewar 2012; Edinburgh Napier University & NHS Lothian, 2012; Dewar & Nolan, 2013) involving a deeper understanding of mechanisms that foster the delivery of compassionate care within complex healthcare environments. In particular it addresses the interplay between macro and micro forces that have implications for care delivery in the ‘real world’ of the NHS.

### 6.5.1 Realistic Evaluation: Conjectured and Refined CMO Configurations

An important aspect of the realistic evaluation framework is the consideration of conjectured context-mechanism-outcome configurations (CMOs), based on the underpinning ‘folk theories’ that the researcher brings to the study. The ‘folk theories’ pertinent to this study were outlined in Section 4.5.3 and included impact of workplace demands, organisational culture, work environment, leadership style, complexity of healthcare systems, implementation of evidence into practice. These, along with my knowledge of the organisation at that point in time, influenced the conjectured CMOs that I formulated in Section 4.7 (Rule 6) and are illustrated again in Table 27 below.

**Table 27: Conjectured CMO configurations for the LCC Programme**

<b>Context</b>	<b>Mechanisms</b>	<b>Outcomes</b>
<p>Macro:</p> <ul style="list-style-type: none"> <li>• leadership,</li> <li>• financial position,</li> <li>• targets</li> </ul> <p>Meso:</p> <ul style="list-style-type: none"> <li>• management support</li> </ul> <p>Micro:</p> <ul style="list-style-type: none"> <li>• leadership of Senior Charge Nurse,</li> <li>• facilitation style of Senior Nurses,</li> <li>• acceptance/engagement of staff</li> </ul>	<ul style="list-style-type: none"> <li>• Underpinning Culture</li> <li>• Inter-professional relationships</li> <li>• Make up of practice development processes</li> <li>• Establishing trust with ward staff</li> </ul>	<ul style="list-style-type: none"> <li>• Understanding of compassionate care</li> <li>• Increase focus on compassion at macro and micro levels</li> <li>• Specific outcomes at organisational and individual levels for staff, patients and relatives.</li> <li>• Discrete practice development initiatives with potential to share best practice</li> </ul>

With the realistic evaluation framework the process of data collection and analysis is intended to lead to the generation of 'refined' CMOs, which Pawson and Tilley (1997) suggest should form the basis of hypothesis making. They argue that such hypotheses should permit the social programme to be broken down so that it is possible to identify:

1. what it is about the programme that might produce change (what worked?)
2. which individuals/subgroups and locations might benefit most readily from the programme (for whom?)
3. which cultural and social resources are necessary to sustain the change (in what context?). ( p.85)

The refined CMOs I have developed for the LCC Programme (which are presented in Table 28 in Section 6.5.5) are based around the concept of 'level of adoption' that I defined as 'the degree to which participating settings engaged with and adopted the LCC mechanisms and sustained them'. The criteria against which each of the clinical settings was evaluated to determine their 'level of adoption' were outlined in Section 6.2.1. Furthermore it has been possible to generate the refined CMOs from cross-analysis of the realistic evaluation summary diagrams presented at the end of each ward case study in Figures 12-19. In order to address the over-riding question of 'what worked, for whom and in what context?', this section focuses primarily on the attributes of the 'high adopter' wards (A, B, E, F, H).

### **6.5.2. Contextual factors**

There were six main contextual factors that were seen to promote high adoption of the LCC Programme. These were:

1. The establishment of a local infrastructure to raise and maintain the profile of Programme within the directorate: examples include the establishment of a directorate-wide LCC Programme Group and/or the Programme being a standing agenda item at directorate meetings with an expectation of regular reporting on processes and outcomes.
2. Support from the immediate clinical nurse manager for the staff team to engage in the LCC activities.
3. The leadership skills of charge nurse.

4. Stability of leadership at meso (directorate) and micro (ward) level.
5. Committed leadership at macro (Board) level.
6. The facilitation skills of the LCC Senior Nurse.

Several factors that did not seem to influence the level of adoption included: the specialty of the ward; the location (i.e. whether the ward was embedded within a major service or isolated/self contained); and the length of experience of the charge nurse.

In addition it was possible to identify contextual factors that *may* have influenced the level of adoption and had some impact on wards outside the high adopter group. These included the size of the staff team (for example Ward G which had 140 staff) and the pressures of 'patient flow' and the 4-hour waiting time targets (which particularly affected Wards D and G, although to a lesser extent Ward A which was a high adopter).

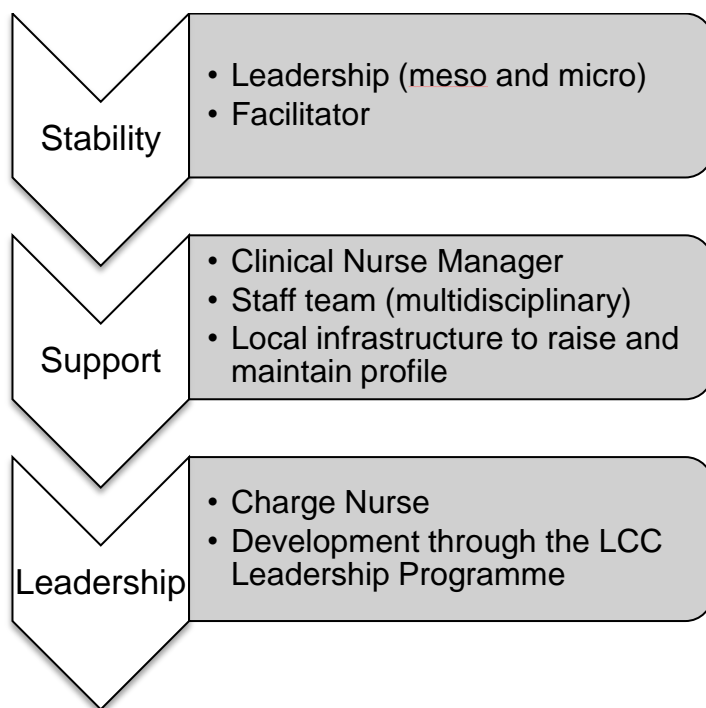
Four factors that were seen to hinder the level of adoption and primarily affected Wards C and D included:

1. Instability or change of leadership at both local (micro) and middle management (meso) level.
2. Lack of interest or support at middle management level.
3. Co-existing pressures such as financial overspend, high sickness levels, unexpected clinical pressures such as the emergence of the H1N1 virus (which led to alternative training demands and a higher level of patient acuity and throughput).
4. Opposition to participation in LCC activities by the leadership figure at local level resulting in a divided staff team, which was a particular issue in Ward D.

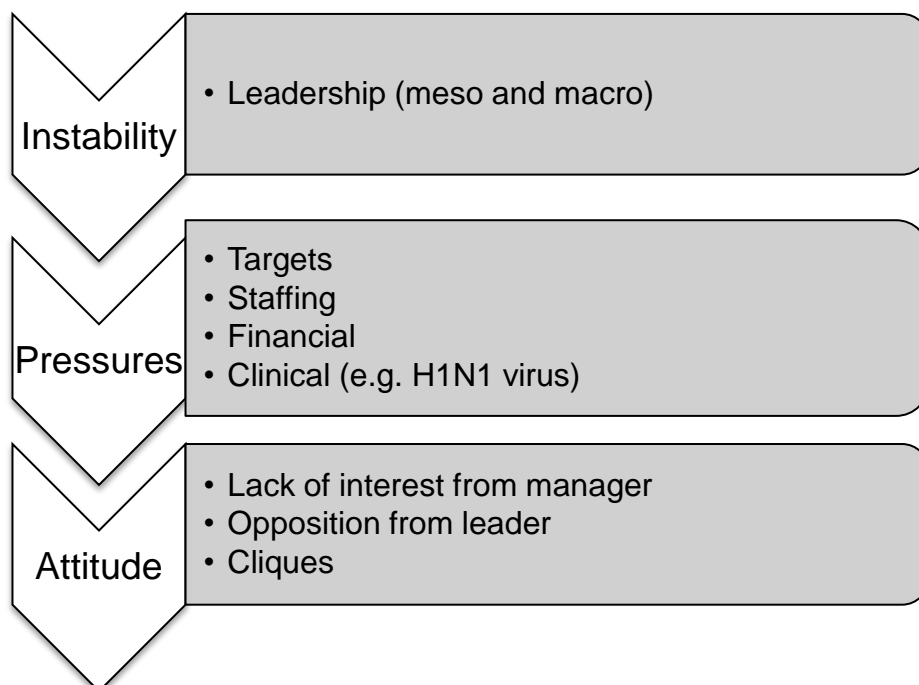
Figure 23 overleaf summarises the contextual promoting and limiting factors that were seen to have the greatest influence on the adoption of the programme or otherwise.

**Figure 23: Promoting and limiting factors within the context that influenced the level of adoption within the Beacon Wards and Development Sites**

**Promoting Factors**



**Limiting Factors**



Stability, support and leadership were important features of the high adopting wards. In some cases, where there was temporary instability this was moderated by effective support and leadership including effective succession

planning. Instability of leadership, particularly and middle management and charge nurse level had the greatest influence on level of adoption of the LCC Programme. Where there were significant external pressures it was difficult for the clinical teams to remain focussed on the LCC Programme unless the strong leadership was in place. Where this was limited or absent it led to a change in attitude towards the Programme which in turn mitigated against its potential impact.

### **6.5.2. Mechanisms**

Critical examination of mechanisms permits response to the 'what works?' question. The LCC Programme involved both of what Pawson and Tilley (1997) described as 'underlying' and 'programme' mechanisms. The former relate to the underpinning theoretical principles: action research, appreciative inquiry and relationship-centred care as well as intrinsic features of the setting such as culture and leadership that influence behaviours and inter-relationships. The programme mechanisms involved the specific practice development activities undertaken by the Senior Nurses within each setting. Again, analysing the 'high adopter' wards it is possible to identify both types of mechanisms that were seen to influence outcomes:

#### **a) Underlying mechanisms**

These were a combination of the:

- skilled facilitation of the Senior Nurses, which centred on building trusting relationships.
- appreciative approach which enhanced the development of relationships and building a sense of esteem.
- flexibility to adapt the Programme approaches based on sensitivity to local context and competing pressures.
- pace of the programme in each setting which permitted ground work with staff, patients and relatives before embarking on implementing change or new developments<sup>67</sup>.

---

<sup>67</sup> This was founded on recognition that the ward teams needed to be given time to achieve cultural change, and stood in contrast to some of the other concurrent initiatives such as Releasing Time to Care™ and the Scottish Patient Safety Programme.

## **b) Programme mechanisms**

Catherine, Charge Nurse in Ward A reflected that the programme had enabled her to 'hear the voice' of patients, relatives and staff. This was one of the defining elements of the Programme and the technique that was most effective in doing this and generating 'stories' was emotional touchpoints. What was also important was that the technique was adopted and tailored to the needs of the individual setting. Emotional touchpoints are now not only used widely in NHS Lothian, but through the wider sharing of the LCC Team are in use in a number of other Scottish Health Boards and affiliated organisations (e.g. Scottish Health Council, 2013).

Whilst the generation of stories was important at a local level for stimulating discussion, reflection and action what was also important was that they were shared more widely in the organisation, including at Board level. This was particularly effective where the stories identified good practice as this supported the appreciative approach of the Programme and was seen to boost both morale within the wards and enhanced their wider reputation. For a period of time a story from the LCC Programme was read at the beginning of each Board meeting, however, it is not known if this was sustained in the long term.

There was a strong emphasis on building internal relationships within the individual settings, primarily through the use of team discussions to explore and understand the meaning of compassion within that local context. The Programme mechanisms that were most effective in eliciting views were the beliefs and values clarification exercises particularly where they used images to facilitate creative expression. It was acknowledged in many areas that having the space and opportunity to both express their own feelings and gain insight into those of their colleagues led to a reinvigoration of their roles and vision for the ward.

Whilst the concepts of both generating stories and eliciting views were important their success depended largely on achieving real time feedback to keep the Programme live in the minds of participating staff, patients and relatives. Maintaining real time feedback was a major element of the Senior



Nurses' workload and involved important skills of analysis and distilling data into meaningful information.

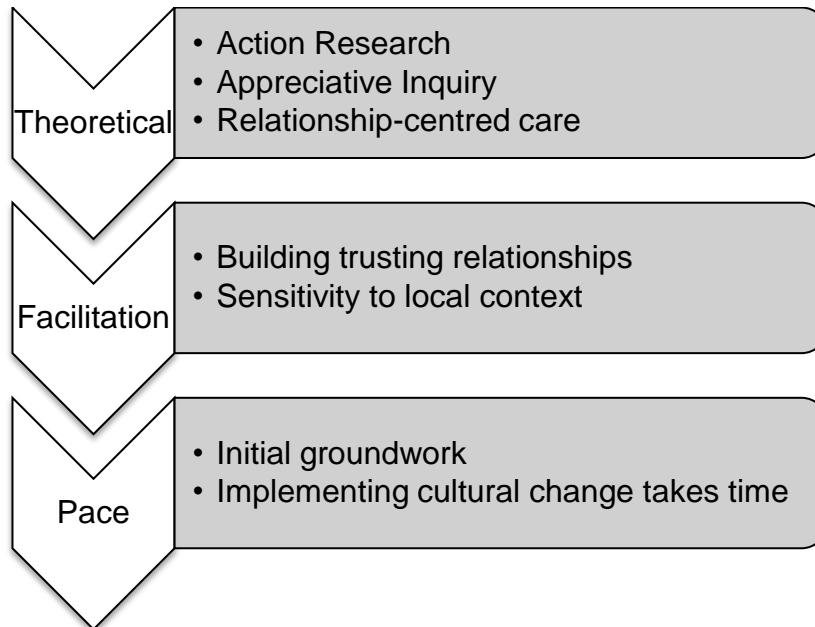
The use of photo elicitation to generate positive care practices was also found to be valuable and in turn stimulated ongoing 'caring conversations' as a routine part of the working day (although these were largely linked to one of the Senior Nurses and only worked in some locations). However, they were time consuming to develop and there were challenges with installing digital photo frames in several of the settings, where they were perhaps seen as presenting an infection or safety risk for patients. In some cases, however, it was more of a practical issue as a consequence of the building being a PFI arrangement and therefore staff did not have the scope to install this type of equipment on the walls.

What was of major importance was introducing and sustaining 'caring conversations' into the work routine and general culture of the ward. These took a variety of formats, for example in some settings this was through the instigation of a daily/twice daily 'hug' meeting to focusing on patient and staff support issues, whilst in others it was simply a way of communicating and ensuring that care issues were fore grounded alongside patient flow, breaching or more task-based work. An important component of generating true caring conversations and delivering person-centred care were the introduction of effective tools to understand the patient as a person. These included the 'All About Me' tool that was particularly suited in the older people and mental health settings.

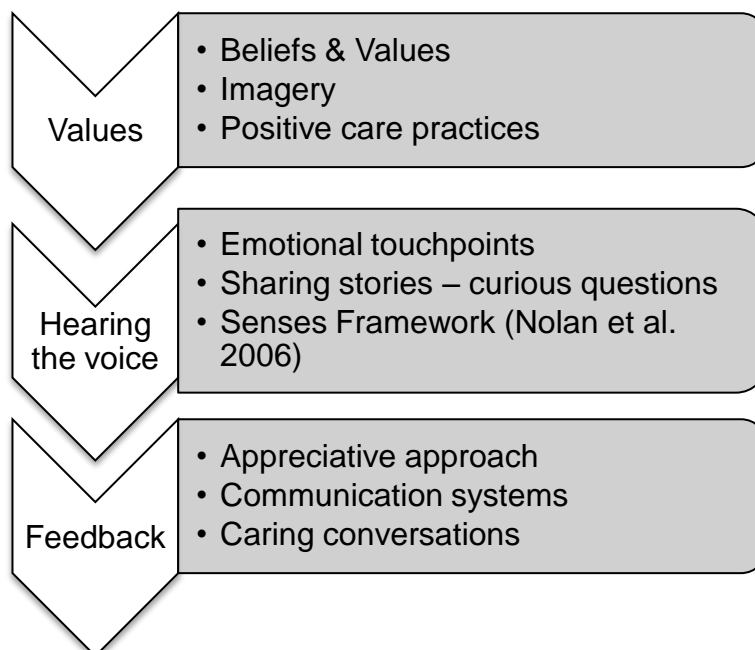
Figure 24 overleaf summarises the key underlying and programme mechanisms that were seen to influence the level of adoption. The three main underlying mechanisms were the underpinning theoretical model adopted in the LCC Programme, facilitation and the pace of the programme. The three programme mechanisms that were most influential in terms of understanding and embedding compassionate care were articulating and demonstrating the underpinning values within the clinical setting, adopting mechanisms that would give patients, relatives and staff a voice to express their experiences, feelings and emotions and instituting effective mechanisms for feedback.

**Figure 24: Underlying and programme mechanisms impacting on the level of adoption of the LCC Programme**

**Underlying Mechanisms**



**Programme Mechanisms**



The theoretical underpinning of the LCC Programme involving combining action research, appreciative inquiry (Cooperrider et al. 2008) was a novel and effective underpinning mechanism. Each component fulfilled an important role with the action research being directed to developing the evidence based on

understanding compassionate care as well as systematically evaluating the practice development techniques. Appreciative inquiry offered a fresh approach to examining care practices and giving real time feedback, which gave staff confidence in their care. The adoption of the Senses Framework (Nolan et al. 2006) to introduce the concept of relationship-centred care in such a way that staff could see its application to patients, relatives and themselves left a lasting impression on many of those involved. The facilitation skills of those implementing the Programme were vital as was recognition that embedding cultural change of this nature takes time and investment given the pace and complexity of the clinical environments.

It was evident that the most important starting point with the Programme mechanisms were techniques that permitted staff to explore and express their values and understanding of the meaning of compassionate care. Following on from this where staff were enabled to 'hear the voice' of key stakeholders (patients, relatives, colleagues and students) they were able to focus directly on developments in practice including strengthening communication and relationships. Finally, receiving real time feedback through a variety of mechanisms served to embed understanding of compassionate care and to reflect on real examples of practice that had made a difference.

#### **6.5.4 Outcomes**

Examining the outcomes of the LCC Programme across the eight settings addresses the 'what worked, for who?' question. Again focussing on the high adopter wards there were a number of consistent outcomes that emerged for different stakeholder groups.

##### **a) Patients**

For patients the main outcome was improved personalisation of care as a result of the approaches used to elicit personal information, whether this was within an intermediate/long term or acute setting. Where formal (and perhaps lengthy tools such as 'All About Me') were not suitable staff were encouraged to ask questions to support engagement and plan care. These included 'what matters to you most while you are in hospital?'; 'tell me something that will help

us to care for you here?’ (Dewar & Nolan 2013 p.8). Taking this approach allowed staff to pay attention to the ‘little things that make a big difference’.

In addition many patients had opportunity to express their experience of care and the emotions associated with their situation. This was particularly effective in the mental health settings where there was evidence of a reduction of aggression and an increased in engagement between patients and staff.

### **b) Relatives**

In many of the settings staff became comfortable to admit that they found interaction with relatives difficult, often because they feared criticism. Following discussion and support by the Senior Nurses in most of the participating wards there was an increase in staff proactively engaging with relatives in a variety of ways according to context: for example pre-admission telephone calls, regular relatives’ rounds, weekly relatives’ clinics (this was introduced in Development Unit K). Where relatives did have concerns they were now being offered the opportunity to explore these at an earlier stage rather than a situation progressing to a complaint. Emotional touchpoints were recognised as being particularly influential in achieving this outcome. Most stakeholders reported, therefore, that improved relationships between staff and relatives had been an important outcome.

### **c) Staff (individual)**

An important outcome for individual staff (both registered nurses and support workers) was the opportunity to express their feelings. As previously stated this included acknowledgement of the stress they felt with regard to engaging with relatives, which seemed to be a common experience in all settings. Through engagement in the LCC Programme activities it was evident that there was an overall increase in many individual’s confidence, which manifest in two important spheres: firstly confidence to address relatives’ concerns and secondly increased confidence to discuss issues around care practices with colleagues. This was both in an appreciative way or, where necessary, questioning an aspect of practice.

Individual staff had much more involvement in taking forward ward-based projects. In some cases this involved taking the lead, for example the clinical support workers in Ward B creating personalised bedrooms for all the patients.

In the mental health settings many staff increased their engagement in therapeutic activities with patients, which not only led to more positive outcomes for patients but also for their own job satisfaction and personal development.

#### **d) Team**

Although the Beacon Wards were recognised for their teamwork as part of the selection process, what was evident was that through the work of the LCC Programme this was enhanced. In particular there was greater understanding of roles between the registered and support nursing staff, and to a lesser degree between the multi-disciplinary team<sup>68</sup>. The engagement processes such as beliefs and values clarification promoted valuing of each other's opinions and in turn increased openness to change, particularly where opinions on whether the change was working or not were listened to. There was also an example where, in the face of an incident of poor practice, a ward team demonstrated a strong sense of collective responsibility and desire to move forward. This was recognised as being a departure from 'normal' team behaviour before involvement in the LCC Programme and demonstrated the potential for investing in the engagement processes.

#### **e) Leaders (charge nurses)**

The main outcome for the local leaders, regardless of their length of experience was a general increased confidence in their abilities, which extended both to leadership of the Programme, management of their wards and contribution to the wider organisational objectives<sup>69</sup>. Within the high adopter wards most became recognised internally and externally as ambassadors for compassionate care and presented at numerous formal events, including internationally.

Their main focus, in addition to fulfilling their management and clinical responsibilities, was making compassionate care the core of their work.

---

<sup>68</sup> Although in some settings such as Development Unit E (mental health rehabilitation) the multidisciplinary teamwork improved and this was felt, in part, to be a result of the lead psychiatrist participating in the LCC Leadership Programme.

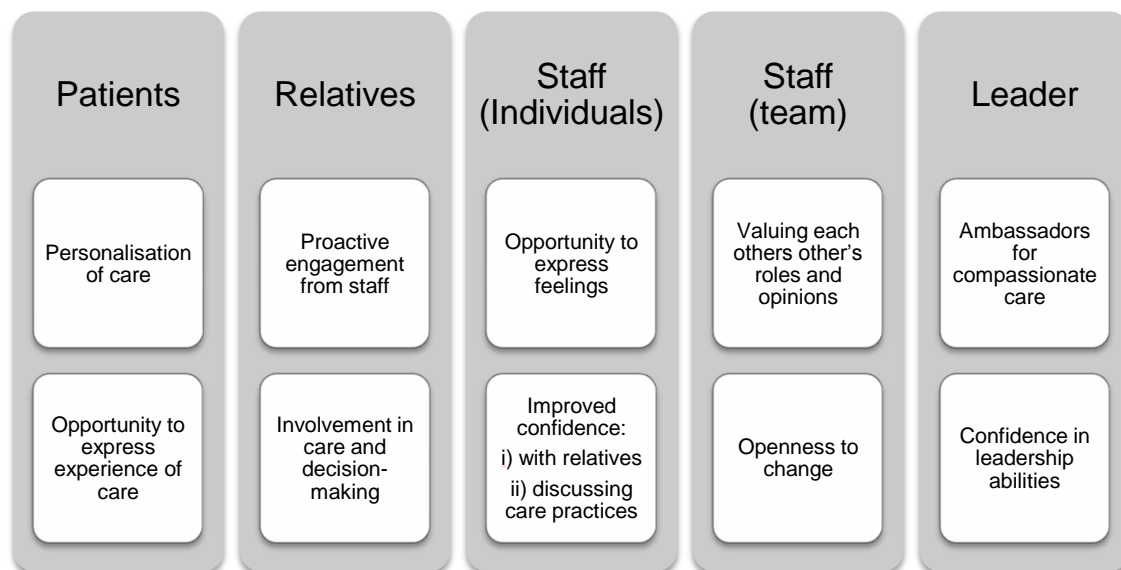
<sup>69</sup> At the end of Phase Three of my data collection I conducted a specific analysis of a focus group with three of the Development Unit Charge Nurses when they had been more than a year without the intensive input of the Senior Nurse. I presented this paper 'Reflections of three leaders of compassionate care: it's about confidence, determination and relationships' at the Second International Leadership in Compassionate Care Conference.

Through their enhanced leadership skills they were able to take forward initiatives that enhance compassionate care for patients, relatives, staff and students. This included facilitating group meetings with staff and students (often using the Senses Framework (Nolan et al., 2006) as a structure) and using emotional touchpoints with all parties.

Through this sense of personal growth most of the charge nurse in the high adopter wards expressed a sense of empowerment to act in the best interests of patients, relatives, staff and students. Furthermore they felt that they had a strong sense of community with the other LCC Programme Charge Nurses that had the potential to be sustained following the end of the formal programme.

Figure 25 overleaf summarises the principal outcomes domains for each stakeholder group. This diagram has the potential to shape an outcomes framework for examining compassionate care across an organisation, rather than solely focussing on the experience of the patient, which has been the main focus to date.

**Figure 25: Principal outcome domains for each stakeholder group following implementation of LCC Programme**



An important feature of this outcome summary is the focus on opportunity express experiences and feelings (for patients and staff) alongside a sense of involvement (for relatives). In addition it emphasises the importance of personalisation of care (for patients) and the ability for staff to discuss care practices in such a way that 'caring conversations' become an accepted part of working practice, whether that is to appreciate good practice or highlight areas where perhaps care has not been optimal. Working in this way is dependent on the whole team valuing each other's role and being open to change. Once again there is a focus on the leadership of the charge nurse, who if effectively supported and developed in the ways previously described and working in a context that is conducive to development will become the ambassador for compassionate care.

### **6.5.5 Refined CMO Configurations**

Having analysed the data I was now in the position to derive the refined CMO configuration for the LCC Programme. This is presented in Table 27 overleaf and serves to conclude this chapter by summarising the important contextual conditions at macro, meso and micro level that were seen to enable embedding of the Programme and supported the achievement of its aims in the participating settings and beyond. Furthermore it articulates key

mechanisms (both underlying and specific to the Programme) that were crucial to achieving a high level of adoption. Finally it proposes a series of outcomes were achieved from the implementation of this specific Programme and which could be used to formulate future outcome measures.

The detail surrounding the refined CMO configurations will now be examined in more detail in Chapter Seven: Discussion and will form an important component of the recommendations that are presented in Chapter Eight.



**Table 28: Refined CMO configurations for the LCC Programme**

Context	Mechanisms	Outcomes
<p>Macro:</p> <ul style="list-style-type: none"> <li>• Strategic support and maintenance of profile at Board level.</li> </ul> <p>Meso:</p> <ul style="list-style-type: none"> <li>• Support from immediate Clinical Nurse Manager</li> <li>• Establishment of Directorate level structures to maintain focus on process and outcomes of Programme</li> <li>• Stable financial position,</li> <li>• Recognition of targets but not dominance by them.</li> </ul> <p>Micro:</p> <ul style="list-style-type: none"> <li>• Stability and leadership of Senior Charge Nurse,</li> <li>• Facilitation skills of Senior Nurses,</li> <li>• Acceptance/engagement of staff</li> </ul>	<ul style="list-style-type: none"> <li>• Pace that permits groundwork and establishment of trust</li> <li>• Appreciative approach and focus on ‘what works around here?’</li> <li>• Well-developed facilitation skills.</li> <li>• ‘Box of tricks’ that can be drawn on according to local context.</li> <li>• Emotional touchpoints to explore experience and emotions with all stakeholder – followed by action.</li> <li>• Real time feedback</li> <li>• Sharing of stories locally and at higher levels</li> <li>• Leadership programme for key ward figures</li> <li>• Succession planning</li> </ul>	<ul style="list-style-type: none"> <li>• Enhanced understanding of compassionate care. Focus not on care that you would want to receive but the care that individual desires.</li> <li>• Increase focus on compassion at macro and micro levels within the organisation</li> <li>• Outcomes at organisational and individual levels for staff, patients, relatives and ward leaders.</li> <li>• Recognition of the needs of staff in order to deliver compassionate care.</li> <li>• Discrete practice development initiatives some of which shared and adopted more widely.</li> </ul>

## **Chapter Seven: Discussion**

### **7.1 Introduction**

This chapter will draw on the findings presented in Chapters Five and Six in order to put forward a model of organisational capacity for understanding and embedding compassionate care in practice. I have chosen to present this model sequentially in order to incrementally focus on the key issues that have been derived from my investigation and analysis. The model commences with an articulation of what were identified as the core elements of compassionate care, followed by an exploration of the role of 'relational work' and 'relational inquiry' in constantly reinforcing its delivery. I then go on to examine the three essential components of organisational infrastructure that were demonstrated to be highly influential in embedding and sustaining a focus on compassionate care in my study: strategy, practice development and leadership.

The chapter will overview the importance of this study in the current healthcare context, particularly in light of the Francis Inquiry (2013) and highlight the relevance of Pawson and Tilley's (1997) realistic evaluation framework as the underpinning methodology. It will then go on to initially present the key messages I have formulated from my findings in brief. Before moving on to the gradual construction of my model, I will critically examine the more recent literature on compassionate care building on the analysis presented in Chapter Three. The model itself will be revealed in five stages, followed by an analysis of its potential to inform both policy and practice. Before concluding my work I will reflect on the strengths and weaknesses of my study and suggest areas for future research.

### **7.2 Importance of this study**

The importance of my study is that it has taken a longitudinal perspective on a complex practice development and action research study that aimed to examine compassionate care and has studied in detail eight contrasting clinical settings as they have moved along their journey. The research has profited from the fact that it commenced at the outset of the LCC Programme itself, which permitted critical examination of process in a way that has built both a narrative and analytical perspective. By taking this approach, and being

in the position of insider-outsider researcher, I have been able to gain insight and demonstrate what did and did not support a sustained focus on compassionate care within those settings and within the broader organisation.

My research has also benefitted from being positioned within the theoretical context of realistic evaluation (Pawson and Tilley, 1997), which is increasingly being recognised as holding currency within international health service evaluation studies (for example Wand, White & Patching, 2010; Rycroft Malone et al., 2011; Williams, Burton & Rycroft-Malone, 2013). Viewing the LCC Programme as a 'social programme' in the way that Pawson and Tilley (1997) described recognises the emphasis on the interplay between individual (staff, patient, relative) and institution (system, processes, culture) and the place of social interactions that Pawson and Tilley (1997) suggested create interdependencies which develop custom and practice. My methodological approach has permitted examination of Pawson and Tilley's (1997) focus on 'context' and 'mechanisms' (both 'underlying' and 'programme'<sup>70</sup>) and points not simply to the range of outcomes achieved, but focuses on the essential questions of 'what worked?', 'why did it work?' and 'for whom?'. Such questions are crucial if initiatives like the LCC Programme are to be understood, sustained and replicated elsewhere. By examining the key messages that have come out of my work I intend to present a dynamic model for enhancing organisational capacity for compassionate care that will be gradually revealed throughout this chapter.

There has been considerable focus on compassionate care in the intervening years since the LCC Programme was conceived in 2007, however as will be discussed in Section 6.3 of this chapter this largely remains theoretical and opinion pieces rather than research. My work is, therefore, a substantial contribution to the small body of empirical work on the success or otherwise of focussed initiatives to enhance its delivery. Publications from the LCC Programme itself have provided insights into the approaches and techniques

---

<sup>70</sup> Pawson and Tilley (1997) suggest that 'underlying' mechanisms are those that explain how things work beneath the surface, whilst 'programme' mechanisms are more specifically linked to the 'interventions' under investigation.

adopted to illuminate and enhance compassionate care in both practice and education (Smith et al., 2010; Adamson, Dewar & Tocher, 2011; Dewar, 2011; Dewar & MacKay, 2011; Dewar, 2012; Horsburgh & Ross, 2013) and a conceptual model for compassionate relationship-centred care (Dewar & Nolan, 2013).

However, what has not been evidenced to date is a systematic organisational analysis of the outcomes of the Programme that shed light on enabling and limiting factors that have lessons for sustainability. The findings from my analysis presented in Chapter Six have demonstrated important outcomes relating to the delivering of compassionate care in three areas: relationships, care delivery and developments in practice. Where enabling factors were in place these outcomes were demonstrated for patients, relatives, individual staff, staff teams and local leaders.

### **7.3 Key messages**

This chapter, therefore, draws together the key messages of my study in order to make recommendations that will be presented in Chapter Eight. I have identified five substantive elements from the data which I will examine in turn as I build and explain my conceptual model of ways to strengthen organisational capacity to deliver and embed compassionate care in local NHS practice. These five elements are: compassionate care; relationships; strategy; practice development; and leadership. My rationale for identifying them is that they emerged as the core and consistent features within the high adopting wards and were seen as important enablers or lessons learned by the different stakeholders who participated in the study.

#### **7.3.1 Compassionate care**

- a) The delivery of compassionate care is centred upon the interplay of shared values which focus on identifying and meeting the needs of the patient as an individual. This demands proactive assessment and engagement resulting in meaningful responses.

#### **7.3.2 Relationships**

- a) The sustained delivery of compassionate care involves understanding and meeting a series of core needs of patients, relatives *and* staff.

- b) Relational work and relational inquiry are fundamental to both the delivery of compassionate care and the achievement of the type of cultural change needed to embed it in healthcare settings.
- c) Supporting nursing staff to examine and acknowledge uncertainties about their relational practices, particularly with relatives, provides the opportunity to take a proactive approach to address these.

### **7.3.3 Strategy**

- a) Organisational commitment at macro (NHS Board, steering groups), meso (directorate management teams, clinical managers) and micro levels (ward/departments, individual practitioners) are crucially important to ensure a sustained focus on the delivery of compassionate care.
- b) Embedding cultural change takes time, particularly gaining the trust of key participants, and should not be viewed as a 'quick fix'. A long-term vision with ongoing resource and review play an important role.

### **7.3.4 Practice Development**

- a) Practice development that supports the enhancement of compassionate care should be seen as a core enabling function within the NHS, rather than as a luxury.
- b) Facilitation has a crucial role to play in achieving cultural change. The skills involved are an important organisational asset, which benefit from investment and long term security.
- c) Adopting an appreciative rather than problem-based approach is a powerful tool to underpin critical inquiry and cultural change.
- d) The delivery of compassionate care can be enhanced through the use of key practice development techniques that bring the examination of emotions to the fore. This type of work permits 'hearing the voice' of patients, relatives and staff, and can result in meaningful actions and outcomes.
- e) Having a critical mass of healthcare professionals who have the skills and ability to use creative techniques to hear the stories of patients, relatives and staff accelerates the process of embedding culture change and working practices.
- f) Focussed leadership programmes that encompass reflective processes such as action learning have an important role to play in building a critical mass, particularly where they recognise the emotional dimensions of health and illness, as well as those relating to giving and receiving care.
- g) The exploration of personal and team values are fundamental to creating a vision for compassionate care within their own setting.

- h) Practice development and change techniques that are sensitive to local context are more likely to be embraced by staff that are facing competing demands.

### **7.3.5 Leadership**

- a) Strategic leadership that embodies and role models compassionate values are essential.
- b) The role of the charge nurse is crucial to the delivery of compassionate care in terms of leadership and role modelling behaviours and values.
- c) Stability of the charge nurse role or the smooth and planned transition to a successor who has the support and authority to act has a strong influence on the sustained delivery of compassionate care.
- d) Recognising the support required for charge nurses (and their successors) to realise their leadership potential has an important impact on the enablement of others within their teams to develop and contribute to this agenda.

From my research it is apparent, therefore, that there are four essential elements necessary to embed compassionate care in local NHS practice are illustrated in Figure 26 overleaf.

**Figure 26: Four essential elements for embedding compassionate care in NHS practice**



The placement of relationships at the centre of the pyramid is deliberate in recognition of the cohesive position they play in stabilising the other elements. The meaning of relationships in this context is both in terms of communicative practices between patients, relatives and staff; but also importantly relational practices that influence local culture. This will be explained in more detail in Section 7.5.2.

#### **7.4 Literature on compassionate care**

Aside from the LCC Programme itself, the main other UK initiative to address specific interventions related to compassionate care has been the work of The King's Fund *Point of Care* Programme, in particular evaluation of the implementation of Schwartz Centre Rounds<sup>®</sup> in two English trusts (Goodrich, 2012). This study involved 1,250 staff and the first year evaluation reported that the Rounds were perceived as a source of support for individuals and that their benefit may translate into benefits for patients and team working (however there was no detail on how this might be expressed or what the outcomes might be). In addition Goodrich (2012) argued that Rounds<sup>®</sup> have the potential to effect change in the hospital culture, including the

demonstration of compassion, however agreed that further research was needed. Whilst another of The King's Fund's work programmes (the Patient-centred Care Project) did achieve some positive outcomes in terms of establishing patient groups for breast and lung cancer patients and improved team working and communication, the project team found that it was difficult to engage with senior managers and so broader strategic issues were not addressed (The King's Fund, 2011). The King's Fund *Point of Care* Programme has recently emphasised the importance of creating 'the right culture of care' as a means of addressing some of the shortfalls in care highlighted by the Francis Report (2013). It has identified eight factors to support this: i) developing a clear vision for culture; ii) supporting staff to deliver the best care; iii) boards developing the right culture; iv) using data well to drive quality and safety; v) responsiveness to patients' needs and preferences; vi) an open and just environment; vii) adopting the right leadership styles; and viii) thinking and acting long term (The King's Fund, 2013).

Patterson et al. (2010) undertook a mixed methods longitudinal study to investigate culture change and the quality of acute hospital care for older people in 65 wards in 4 NHS Trusts in England. Their report *Metrics to Meaning: Culture Change and Quality of Acute Hospital Care for Older People* presents findings that also have strong parallel with this study, particularly where they stress the importance of good leadership, the significance of a shared philosophy and staff supporting each other.

Although not based on a research study, in her exploration of compassion for contemporary nursing, Straughair (2012b) presented an adaptation of Youngson's (2008) 'action plan for compassion', which included declaring compassion as a core value; honing communication and relationship skills; providing staff time and space to discuss difficult issues; and declaring compassion as a management and leadership competence.

There are relatively few recent international research studies on compassionate care in nursing. In a meta-ethnography of acute care nurses' experiences of the nurse-patient relationship, Bridges et al. (2013) argue that



whilst it is clear that good practice does exist, there is little understanding of the conditions in which high quality, compassionate in-patient care is delivered. They go on to state that insight into nurses' experience as they engage with patients is critical to understanding how best to support existing good practice and focus service improvement initiatives.

Van der Cingel (2011) undertook a qualitative study of 30 nurses and 31 older people with a chronic condition in The Netherlands in order to understand the benefit of compassion for nursing within the context of long term care. Her analysis led to the identification of seven dimensions to compassion. These were: attentiveness; listening; confronting; involvement; helping; presence; and understanding. She went on to propose a theoretical framework for compassion which drew resonance with the structure of my own literature review on compassion presented in Chapter Three when she delineated suffering relating to compassion; compassion and identification; the emotion compassion; motives: compassion and pity; and the moral significance of compassion.

Curtis, Horton and Smith (2012) carried out a grounded theory study in England examining student nurses' socialisation in compassionate practice. Their main findings pointed to a dissonance between the professional ideals of delivering compassionate care and practice reality, particularly when the students looked ahead at the role of the registered nurse. The practice reality was, they felt, heavily influenced by having time to empathise and communicate effectively, something which the students saw as diminishing following qualification, due to the pace and complexity of the environment. Curtis, Horton and Smith (2012) argue, therefore for the need for increased collaborative working between university and practice settings that involve recognition of this uncertainty and sense of dissonance. Whilst this was not the focus on my own study the third and fourth strands of the LCC Programme (the undergraduate curricula and supporting newly qualified nurses) examined approaches to overcome such potential dissonance (Adamson & Dewar, 2011; Horsburgh & Ross, 2013).

Most other research has focussed on educational programmes designed to develop communication skills that enhance compassionate interactions with patients: for example scenario-based role play in a hospital in the USA for patients in palliative care (Betcher, 2010); simulated inter-disciplinary education for care of older people in the UK (Ross et al. 2012); an innovative curriculum for communication skills for US medical students that included Schwartz Rounds® (Sheild et al., 2011); and another education programme for medical students in the USA involving videotaped patient consultations and annotated reflection from both tutors and patients (Kalish et al., 2011). All of these studies have demonstrated positive impact on attitude and practice of the intended professional groups, but give little illustration on the longer term outcomes for patients.

Aside from these few recent research studies the literature on compassion in healthcare remains largely dominated by opinion pieces, theoretical and conceptual work (Goetz, Keltner & Simon-Thomas, 2010; Burnell, 2010; Maben, Cornwell & Sweeney, 2010; Halifax, 2011; Spandler & Stickley, 2011; Struaghair, 2012a & b), which tend to respond to the ongoing calls for improvement by politicians, regulators, professional bodies, patients, relatives, nurses, doctors and journalists (Clwyd, 2012; Nursing and Midwifery Council, 2012; Department of Health, 2012; Royal College of Nursing, 2012; Reed, 2012; Holmes, 2013). Many of these papers identify a lack of research in this area. The publication of the Francis Report (2013) *The Mid Staffordshire NHS Foundation Trust Public Inquiry* on February 6th 2013 brought the issues into sharp focus once again and has made the need for applied research all the more necessary. On 4<sup>th</sup> April 2013 the National Institute for Health Research (NIHR) put out a commissioned call for proposals 'After Francis: Research to strengthen organisational capacity to deliver compassionate care in the NHS' (NIHR, 2013). The findings from this study are, therefore, timely with important implications for policy, practice and future research.

Responding to this agenda in a meaningful and effective manner necessitates approaches that take account of the complexity of the NHS, particularly where maintenance of 'patient flow' and the achievement of targets largely drive operational priorities. Crawford (2013) has used the term 'compassion

depletion' (acting with coldness, cruelty or disinterest to the suffering of others) and argues that simply positioning the 'problem' at the door of nursing, whilst perhaps easy, is quite wrong. He emphasises the fact that compassion should be at the very heart of the design of the healthcare system, arguing that it 'should be fundamental to place, process and person alike and a focus for all the professionals who work in the NHS – and, just as importantly, all those who manage its services' (n.p.). In a similar vein and following a review of national and international evidence on core professional values Flynn and Mercer (2013) conclude that politics, policy and organisational culture can and does exert a damaging influence on professional nursing values. They discuss this in the context which they describe as one in which 'the social welfare ideals on which the NHS is built are being systematically dismantled' (p.14). Their pessimistic forecast is based on a vision of the NHS (in England at least) becoming more market orientated, which they argue is at odds with compassionate values.

The findings from my study emphasise the factors that can promote the enhancement of compassionate care alongside essential technical healthcare and operational processes in the 'real world' healthcare environment. It goes beyond consideration of what individual healthcare professionals should do. Furthermore, it recognises the multi-faceted elements that can be influential in achieving the kind of cultural change that recent deficiencies have highlighted in such a way that compassionate care is embedded at all levels of the organisation. As Patterson et al. (2010) stress, policy tends to promote aspirational visions without fully considering the complex processes that need to be in place if such visions are to become a reality.

### **7.5 Embedding compassionate care**

This section will examine the key messages of my study and in doing so will construct an emergent model that has the potential to become the type of 'middle range theory' put forward by Pawson and Tilley (1997) as an output of the realistic evaluation framework. My study has promise in this sphere in that it did involve the two-stage process that Byng, Norman and Redfern (2005) discussed as being essential to the development of middle-range theories:

coding individual cases (each of the eight Beacon Wards or Development Sites) and then generalising across the cases. Each element of my model will be presented stage-by-stage, along with examination of implications for implementation.

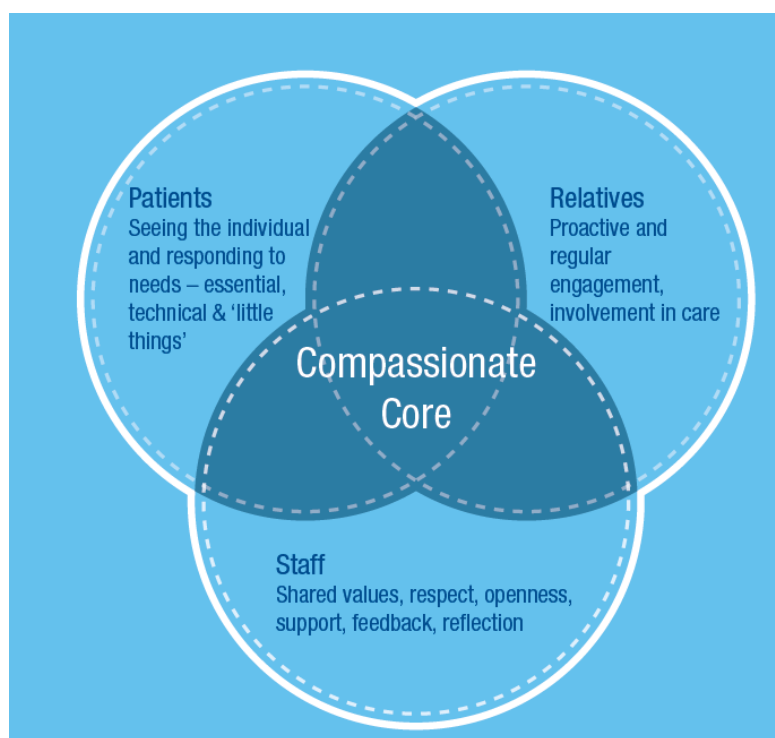
### 7.5.1 Compassionate care

*'You really understand the whole situation, the whole context you're working in. What it means to you, the person, the family'*

[Sam, Senior Nurse]

A key finding from this study was that in order to sustain and embed the focus on compassionate care the needs of patients, relatives<sup>71</sup> and (crucially) staff needed to be addressed. Figure 27 below highlights the key outcomes within the 'high adopter' wards that emerged from the work the LCC and ward teams engaged in. Sustained focus on the delivery of compassionate care was more likely at the point of convergence (the 'compassionate core') where all these needs were being addressed simultaneously.

**Figure 27: Key elements of compassionate care for patients, relatives and staff – the 'Compassionate Core'**



<sup>71</sup> The term 'relatives' is used to denote the individuals that the patient has identifies as being important to them during their care, whether or not they are actually a relative as such.

## 7.5.2 Relationships: Relational Work and Relational Inquiry

*'Relationships with everyone you come into contact with'*

[Laura, Charge Nurse]

Within all the participating settings of the LCC Programme relationships were seen as an important component of context, mechanisms and outcomes: as demonstrated in the outcome matrices (Tables 19-26) and the realistic evaluation summaries (Figures 11–18). One of the three underpinning theoretical principles of the LCC Programme was relationship-centred care (Tresolini, 1994) with emphasis on the Senses Framework (Nolan et al., 2006). Whilst relationship-centred care was explicit within the LCC Programme what my study has added is the value of locating this underpinning philosophy within the concepts of 'relational work' and 'relational inquiry'.

Parker (2002) views 'relational work' as those activities necessary to develop and sustain interpersonal relationships based on an understanding of individual circumstances and their contexts and has argued for greater recognition of it within healthcare. She uses the terminology 'care provider' and 'care seeker' and suggests that relational work occurs when the care provider uses activities such as open-ended questions, reflective listening, and empathy to establish rapport and develop an understanding of the care seeker's perspective on a particular episode of illness. This stance is strongly supported by Patterson et al. (2010) in their *Metrics to Meaning* study. They acknowledge that there has been an increased focus on the need to transform the status of relationships between all parties in healthcare systems. This includes consideration of the context of care and taking the focus away from tasks. Their own literature review in this area points to relationships and what they call 'relational practices' as being key factors in creating and sustaining culture change designed to promote dignity or compassionate care. This position is something that is borne out strongly within the structure of the LCC Programme and the findings of this study.

The importance of relationships is similarly endorsed in the recently produced 'Model for Change' for the English NHS where Land, Hex and Bartlett (2013) introduce their concept of 'Energy for Change' as a way of focussing on the

intrinsic factors within organisations that need to be harnessed to promote sustained cultural change. The first of the five domains within this model is 'social' where the emphasis is on personal engagement, relationships, connections between people and a 'sense of us' (p.13)<sup>72</sup>.

Doane and Varcoe (2007, p.200) argue that where there is a focus on individual nurse-patient relationships (which has often been the level of debate in the literature on compassionate care), there may be little consideration of the personal and contextual factors that can make fostering trusting, fruitful and therapeutic relationships challenging (examples they suggest include workload, acuity and supportive (or unsupportive) collegiate relationships). They use the term 'relational inquiry' as a mechanism which integrates responsive, compassionate, therapeutic relationships and ethical competent nursing by foregrounding the ways in which the personal and contextual factors shape both patients and nurses capacities for relational connection. They go on to describe 'creating relational spaces' for patients to tell their stories, which was a strong feature of the LCC Programme. However, Doane and Varcoe (2007) acknowledge that such relational opportunities are affected by personal and contextual elements, such as the nurse's sense of responsibility, the competing demands of caring for other patients and the normative values of the local healthcare culture. Relational inquiry they argue requires moving beyond surface(s) of people, situations and relationships, something that they term 'the iceberg pattern of relationships' (with smiling being a good example (p.199)<sup>73</sup>). They argue that contexts can contribute to iceberg patterns of relationships and relational inquiry demands looking beyond the tip of the iceberg at both the contextual and personal elements. Within the LCC Programme the mechanisms and facilitation by the Senior Nurses supported this type of relational inquiry as a way of examining beliefs and values and gaining trust. In the high adopting settings these were sustained through ongoing use of techniques such as emotional touchpoints, tools such as 'All About Me', the integration of the Senses Framework into a range of activities (with staff and students in particular) and sustained

---

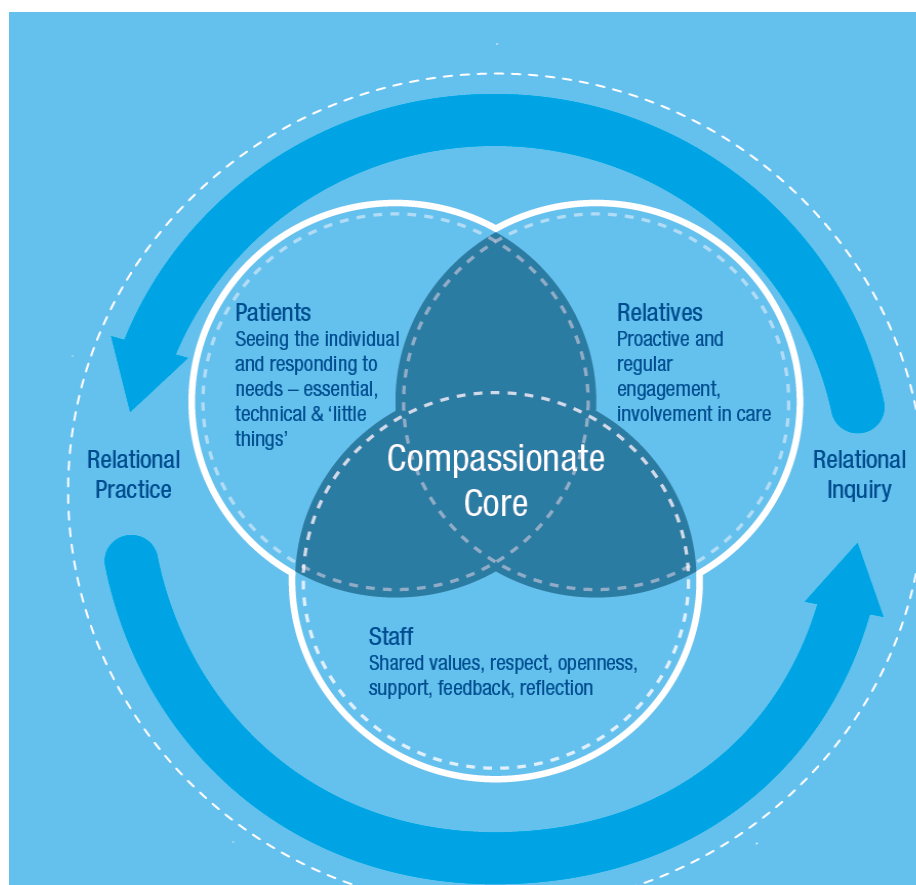
<sup>72</sup> The other four domains are spiritual, psychological, physical and intellectual (Land, Hex and Bartlett 2013, p13).

<sup>73</sup> This carries resonance with Alan Johnson's (Former Labour Health Minister) call for nurses to be told to smile to show compassion (Clout 2008).

commitment from the charge nurse and more senior managers to embed such activities in practice.

Building on Figure 27 with its emphasis on compassionate care centring on the interplay between the needs of patients, relatives and staff, relational practice and relational inquiry create the dynamic that supports ongoing focus and reflection on these issues. Within the LCC Programme some of the key relational work that was addressed included: fostering relationships with patients with regard to the local context (i.e. whether it was acute, medium or long term); becoming more proactive rather than reactive with relatives; and recognising the importance of team relationships by making them more open and reflective with regular appreciative feedback. Figure 28 overleaf illustrates how surrounding the three key components of compassionate care with a focus on relational practice and ensuring critical reflection through the lens of relational inquiry is an essential element of the embedding process.

**Figure 28: Relational practice and relational inquiry as the dynamic influencing the compassionate core.**



What became clear as the study progressed was that many nurses felt uneasy and challenged by their relations with relatives, in some cases acknowledging a degree of avoidance as a defence mechanism. Using the type of relational inquiry described (through beliefs and values clarification, stories and emotional touchpoints) led not only to open acknowledgement of this situation but a commitment to change and to take a more proactive approach with information seeking and sharing with relatives.

### **7.5.3 Strategic Factors**

*‘Taking that aspiration into reality’*

[Tom, Charge Nurse]

One of the defining features of the LCC Programme was that, right from the outset, it had strong strategic leadership through an effective Steering Group and that this was sustained even when there were changes of key individuals.



Furthermore the implementation of the Programme was included as a NHS Board objective and was reported on within the annual review process. At the end of the first Phase of my study these factors were seen by the main stakeholders as one of the key promoting features, particularly while the concept of 'compassion' was still controversial and needed to be championed at a high level. The importance of strong, committed senior leadership has been recognised as a critical factor in changing and sustaining a more patient-centred approach within healthcare organisations (Luxford, Safran & Delbanco, 2011). The strategic level partnership between the NHS and higher education institution was similarly supported and sustained.

At the meso level, sustained interest at middle management level was absolutely vital to the success or otherwise of the Programme. Where this was limited or indeed absent (which was the case in one of the Development Units) the staff and LCC Team had little success in effectively engaging in the Programme activities or sustaining any meaningful change. These stakeholders became quickly demoralised and, for the staff teams, their focus quickly shifted to the issues that were more 'pressing' for their managers, which in the main were target and patient flow oriented. By contrast in one of the most successful Development Sites the Chief Nurse had established her own local Compassionate Care Steering Group that involved staff from wards beyond the participating ward. This accelerated dissemination of the work, uptake of the Leadership Programme and built capacity that meant when succession planning became an issue there was a relatively seamless transition of action projects and ongoing commitment to engagement with patients, families and staff.

Powell, Rushmer and Davies (2009) undertook a systematic narrative review of quality improvement models in health care (such as Total Quality Management, Lean Thinking, Six Sigma) and identified sustained managerial focus and attention as one of the 'necessary but not sufficient' conditions necessary for successful implementation<sup>74</sup> (p.7). Their analysis of this domain

---

<sup>74</sup> Other conditions that also carry resonance with my study include the provision of practical and human resources; active engagement with healthcare professionals (especially doctors); use of multifaceted interventions; co-ordinated action at all levels; substantial investment in

concluded that managers need to be actively involved for both symbolic and practical purposes. This is particularly important in terms of ensuring alignment with strategic objectives and ensuring that the activities are organised and resourced effectively. Furthermore, Powell and colleagues argued that it is managers who are instrumental in addressing barriers to change.

The influence of leadership styles on workforce and work environment, job satisfaction and patient outcomes has been reported widely in the literature. In a systematic review of leadership styles Cummings et al. (2010) found that leadership that focussed on task completion alone was not sufficient to achieve optimum outcomes for the nursing workforce. As previously stated, within this study task orientation and the achievement of targets remained the main focus for the middle manager in some settings and this was seen to negatively impact on the ability of the ward teams to engage in the LCC Team's activities. Wong and Cummings (2007) undertook a systematic review to examine the relationship between nurse leadership and patient outcomes and determined that an emphasis on developing transformational nursing leadership was an important organisational strategy to improve patient outcomes. Whilst transformational leadership is most often associated with bottom-up approaches to change, in their discussion of approaches to transforming care comparing three programmes (Transforming Care at the Bedside, Releasing Time to Care™ and the work of the Struder Group®) Burston et al. (2011) found that a hybrid of approaches to change involving a blend of top-down and bottom-up leadership strategy may offer more sustainably behavioural change. The model of the local Compassionate Care Steering Group previously described possibly provided the greatest success because it did combine both bottom-up and top-down focus.

At micro level it was the leadership of the charge nurse, the experience of the LCC Senior Nurse, in particular their ability to adapt the LCC Programme to local context and circumstances that were instrumental within the high adopting wards. In their study of culture change Patterson et al. (2010) argued

---

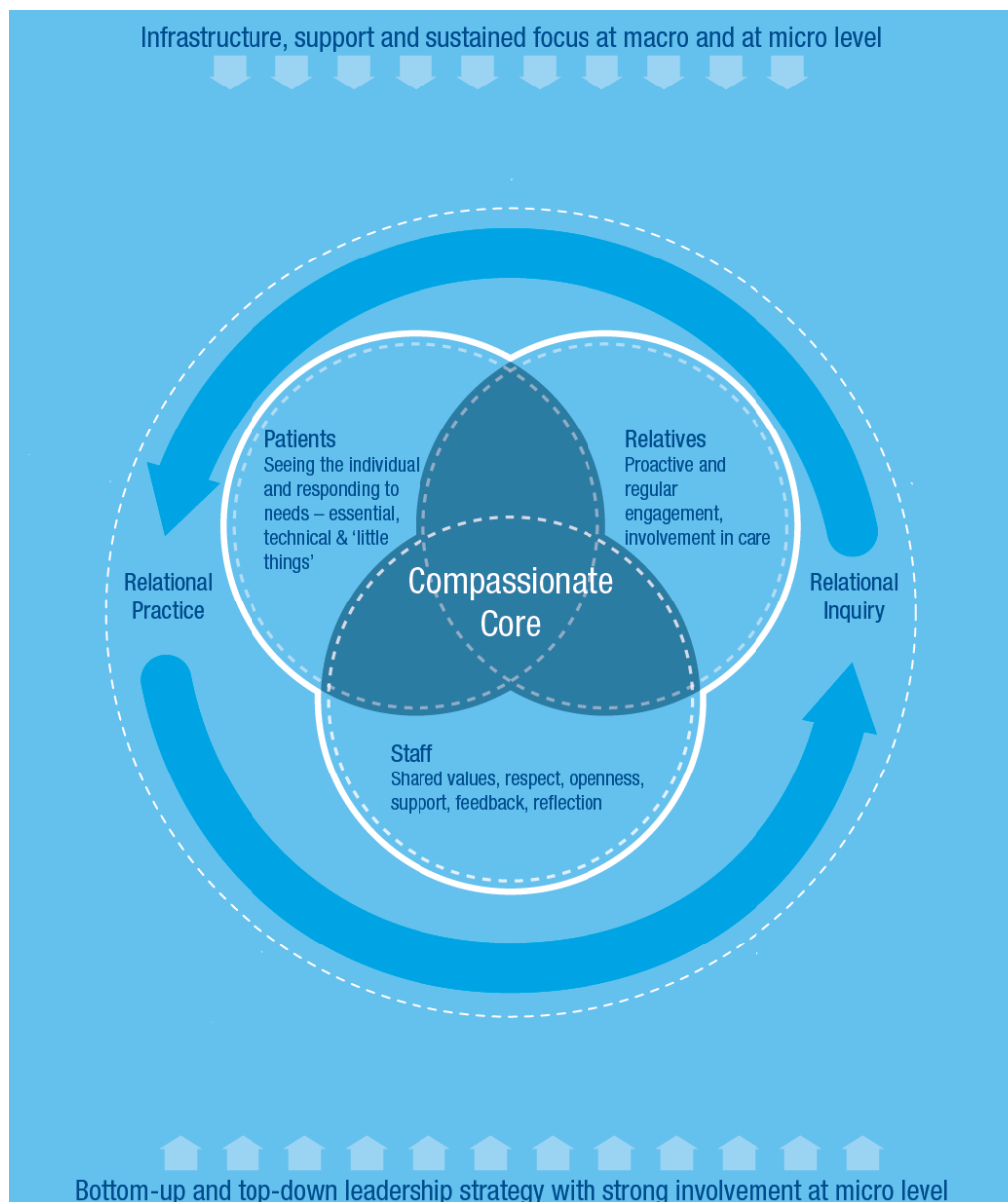
training and development; and availability of timely data through supported IT systems (Powell, Rushmer & Davies 2009, p.7).

that although 'support from the top' was important to the overall strategic direction of the initiatives they studied the real focus for organisational culture was a positive team culture that was shaped by the immediate team environment. Whilst effective teamwork is essential for the delivering of clinical care, what was unique about the LCC Programme was that there was investment to support opportunities for engagement in exploratory and reflective techniques on a multi-disciplinary basis that led to the creation of shared values around compassionate care at a local level.

The other dimension to the strategic vision for embedding a culture of compassionate care was recognition that this would take time, requires ongoing engagement and should not be viewed as a 'quick fix'. This position was similarly supported by Patterson et al. (2010 p.178) who felt that achieving sustained culture change was problematic because the NHS in general is 'too driven by a 'pace' agenda that looks for quick fix solutions and tends to overlook the 'complexity' of the issue involved and the amount of time it takes for real and enduring change to occur'.

Figure 29 overleaf adds two essential strategic features to the emerging model: the first being the need for high level strategic support and interest, along with investment in an infrastructure that will foreground compassionate values and practice in the organisation. Underpinning the ongoing process of relational practice and relational inquiry there is a need for both bottom up and top down influence at the middle management level, with an expectation for local dissemination and ongoing review of outcomes.

**Figure 29: Strategic factors influencing the delivery of compassionate care**



#### 7.5.4 Practice Development

*‘Hearing the patient’s voice, hearing the staff’s voice’*

[Catherine, Charge Nurse]

Manley, McCormack and Wilson (2008) present practice development as a systematic process of transformative action towards developing person-centred cultures that focuses on changing people and practice rather than just systems and processes. The key elements involve engaging with individuals and teams and embedding processes and outcomes in corporate strategy. Reflecting back to Patterson et al.’s (2010) observation that policy promotes

aspirational visions without always fully considering the complex processes that are needed, my study supports Manley, McCormack and Walsh's (2008) assertion that it is practice development that has the potential to translate complex organisation and strategic agendas into practice reality carries important resonance. Practice development is founded on the input of facilitators who have the skills and ability to address culture change.

In the case of the LCC Programme the investment of the benefactor permitted the employment of a number of skilled practice development facilitators, whilst others were given the opportunity to develop. Their skills were deployed not only to work with the individuals and teams but to undertake the critical analysis associated with the action research, something that was recognised by one of the strategic leaders as a previously unrecognised aspect and benefit to the Programme. The practice development and outcomes of this study continue to echo strongly with the Promoting Action on Research Implementation in Health Services (PARIHS) Framework developed by Kitson, Harvey and McCormack (1998) which was highlighted in Chapter One, whereby the interplay and interdependence of the following three key factors are seen to influence person-centred care:

- *Evidence* (research evidence, clinical experience and patient preferences)
- *Context* (culture, leadership and measurement)
- *Facilitation* (characteristics, role and style)

The LCC Programme had much to contribute towards the evidence on compassionate care (which had been the 'missing' component at the outset) and the facilitation, whilst fulfilling the same function, had its own characteristics reflecting the individual Senior Nurse and style depending on the context. What my study has illustrated was, that whilst most of the eight sites sustained a context that was seen as being conducive to the delivery of compassionate care, two in particular did not. This was largely affected by unstable leadership (at macro and meso level), which in turn affected the ward culture and focus on the Programme aims.

What was important in the LCC Programme was the adoption of an appreciative rather than problem-based approach to the practice development

and action research. In a methodological review of appreciative inquiry, Trajkovski et al. (2013) describe it as an emerging research methodology and worldview that builds on action research, organisational learning and organisational change<sup>75</sup>. Their review of nine qualitative studies determined that appreciative inquiry generated participant enthusiasm and commitment, something which was evidenced in the LCC Programme. They suggested that the key strengths of appreciative inquiry is the engaging, inclusive and collaborative nature of inquiry that acknowledges participant's experiences, skills and enthusiasm. Within the LCC Programme, whilst overall AI was seen as beneficial, adopting an appreciative stance was not, however, something that came easily to either the Senior Nurses or the staff in the participating settings. Many nurses were embarrassed to have their work praised or were waiting for the Senior Nurses to 'catch them out' and identify problems, as this was something they were more used to. Trajkovski et al. (2013) similarly found reports of staff wanting to focus on problems, or researchers being accused of 'glossing over' problems in their review.

Having identified that the delivery of compassionate care involves shared values and meeting the needs of patients, relatives and staff means that it is important to adopt practice development techniques that permit the safe examination of emotions alongside experience of care and its delivery. This type of work permits 'hearing the voice' of patients, relatives and staff, and can result in meaningful actions and outcomes. Given the move towards 'Experience-based Design' and other methodologies that can augment the large-scale patient experience surveys in the NHS, the techniques developed, adopted and adapted in the LCC Programme have the potential to be used in a wide variety of settings. Whilst some elements, such as emotional touchpoints have been publicised (Dewar et al., 2010; Knowledge Network, n.d.), the wider resources and methods that were developed in the LCC Programme have not been translated into the kind of toolkit or product that many stakeholders had envisaged as an outcome of the Programme. The Final Report (Edinburgh Napier University & NHS Lothian, 2012 p.159-172) does, however, detail a 'final analytic framework for Compassionate Care'

---

<sup>75</sup> The application of the four phases of the 4D cycle (Discovery, Dream, Design and Destiny) in the LCC Programme was discussed in Section 1.3.1.2.

including a breakdown of the six compassionate care themes they developed as a result of the action research. This framework does have the potential to be shared and used as the basis for practice development focus in other settings, however, further research would be needed to determine its transferability and the generalisability of the approach. My study focuses on the important issue of organisational capacity for implementation of this type of framework.

In the three years of the externally funded LCC Programme 33 clinical settings directly participated and 106 individuals took part in the Leadership Programme. Whilst the uptake of the Programme was deliberately staged in this way, what is evident from my study is the importance of building a critical mass of healthcare professionals who have the skills and ability to take this type of work forward and in particular to use creative techniques to hear the stories of patients, relatives and staff. The LCC Leadership Programme was probably the most instrumental factor in building this critical mass and building the potential for sustainability. Whilst the focussed facilitation model in the Beacon Wards, Development Sites and even that progressed in the Development Units (where the facilitator was 'spread' over 4-5 wards) was not going to be sustained beyond the funded period, the Leadership Programme is to continue on an annual basis. It will continue to encompass reflective processes such as action learning.

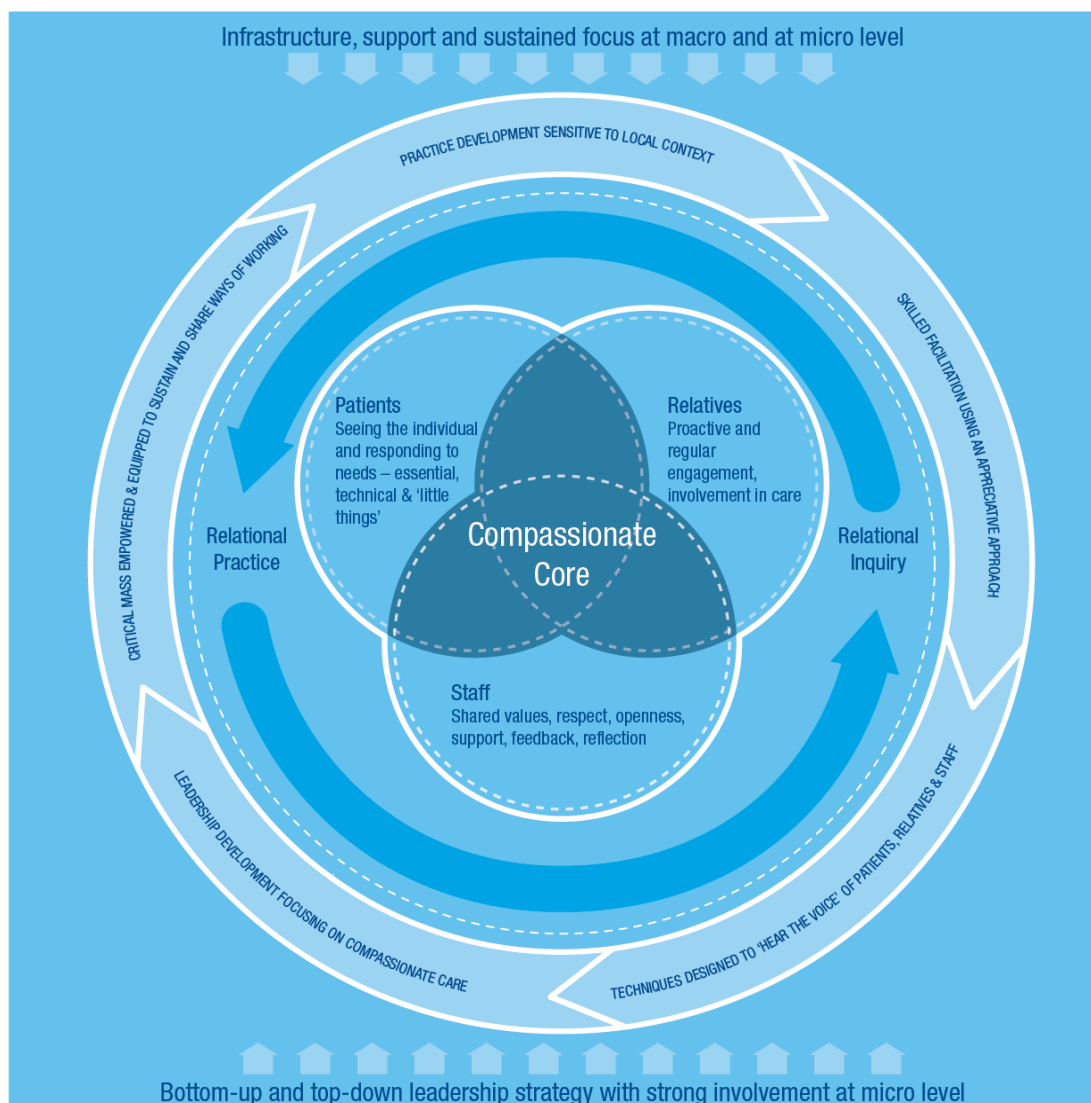
My study demonstrates that one of the most important aspects of the LCC Programme that influenced the success of the LCC Team's input was the focus on equipping and empowering staff to examine their personal and team values in order to create a vision for compassionate care within their own setting. Each healthcare context is unique in terms of patient group, type of care, make-up of the staff team, culture and goals and therefore the expression of compassionate care had to be context-specific. This was perhaps one of the reasons why the LCC Team made a deliberate decision not to define compassionate care, rather to present an analytic model which would encourage staff to reflect on their personal and team values and goals. Given, therefore, the unique nature of most healthcare settings it is vital that the practice development and change techniques are sensitive to local context and

facilitators have the skills to adapt in the moment so as to make the most effective use of time with staff, patients and relatives.

Figure 30 overleaf continues to build my model of the organisational capacity to embed compassionate care by surrounding relational practice and inquiry with the key practice development components of the LCC Programme that were seen to be beneficial. The ongoing movement through the practice development processes continues to emphasise that a programme that is seeking to build organisational capacity needs to be continuous and that as the critical mass develops there will be more practitioners equipped to move again through the cycle.



**Figure 30: Practice development components within the model of building organisational capacity to embed compassionate care.**



#### 7.5.4 Leadership and succession planning

*'The drive to deliver compassionate care'*

[Molly, Policy Maker]

The need for strong leadership at macro and meso level has already been acknowledged. What was most evident, however, and what has been borne out in the nursing literature for many years is the crucial role charge nurses have in determining the quality of patient care (RCN, 2009). In a critical examination of the ward sister/charge nurse role in the past and present Bradshaw (2010) argues that as a result of professional, educational and managerial changes, the traditional authority of the ward sister for nursing

standards, ward services and ward facilities has diminished. This situation has been recognised within the UK and in both Scotland and Wales there have been strategies *Leading Better Care* (Scottish Government, 2008a) and *Free to Lead, Free to Care* (Welsh Assembly Government, 2008) to re-orientate the charge nurse role to have a stronger emphasis on patient experience as well as meeting organisational objectives. Both initiatives have had associated development programmes, which in the case of *Leading Better Care* was being run in parallel to the LCC Programme. What was evident, however, from the charge nurses interviewed for this study and from the internal evaluation undertaken of the first four cohorts of *Leading Better Care* in NHS Lothian (MacArthur et al. 2010) that whilst that type of leadership development improved their knowledge of organisational issues and expectations of their role, the charge nurses did not feel well equipped to approach ways of investigating or improving the patient experience. In contrast, the LCC Leadership Programme was seen as giving opportunity to examine a range of approaches in detail and test them out in practice with both experienced facilitator and peer support. For the charge nurses involved in this study that experienced both leadership experiences they were clear that this was what had been influential in giving them the confidence to embed ways of exploring patient, relative and staff experience in to the routine work of the ward.

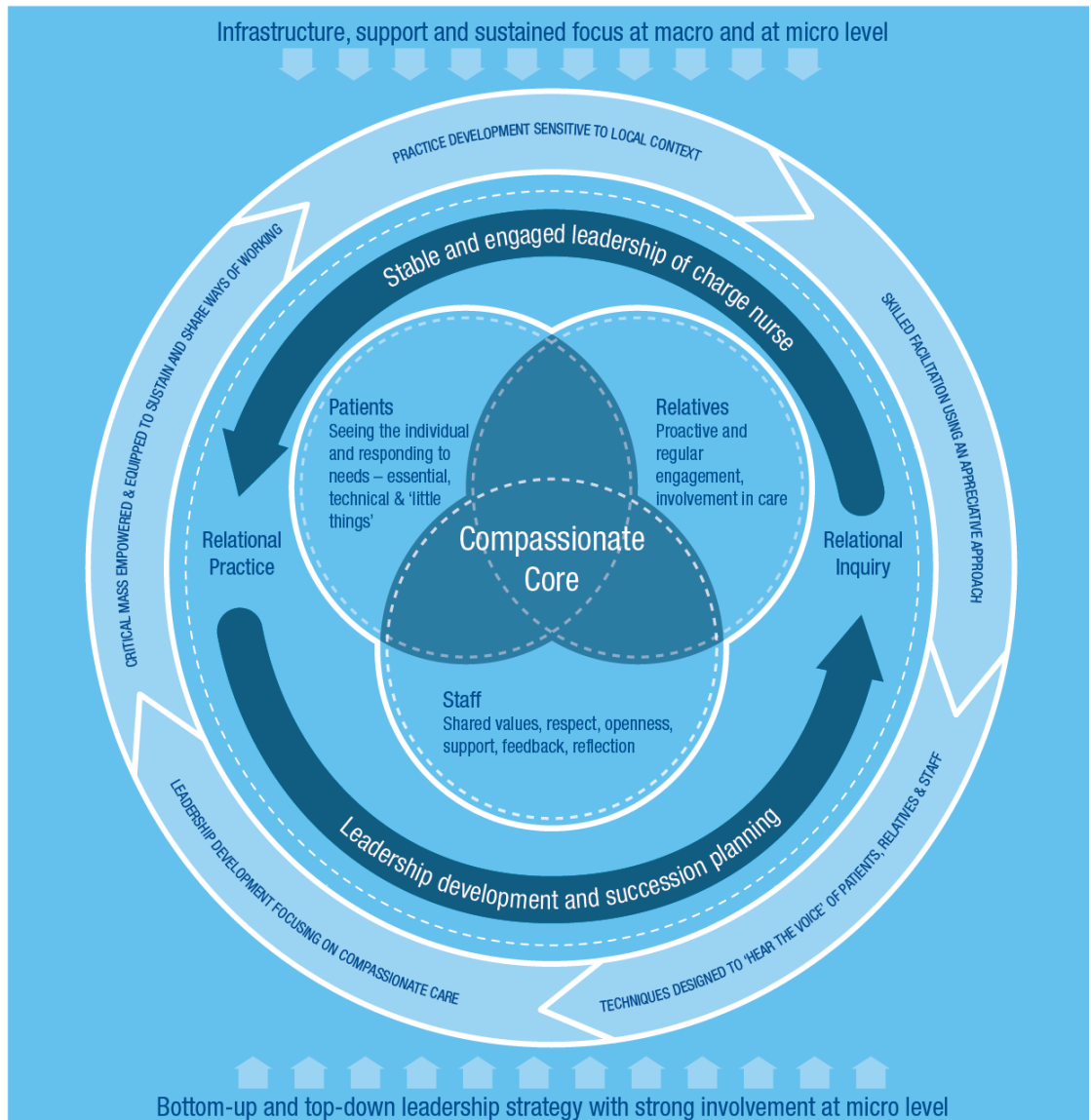
The recommendations from the Francis Inquiry (2013) include that ward managers / charge nurses should operate in a supervisory capacity, and not be office-bound or counted as part of the ward numbers. This is a position that was put forward by the RCN in 2010, in which they emphasise that a supervisory role is distinct from supernumerary, which implies being extra to the establishment numbers within a clinical team. The key elements of the RCN's definition of the supervisory role charge nurse role include: being visible and accessible in the clinical area; working alongside the team to support junior colleagues and facilitate learning; monitoring and evaluating standards of care; providing regular feedback to the clinical team; and creating a culture for learning and development that will sustain person-centred, safe and effective care (RCN, 2010b). Whilst the charge nurses participating in this study were not defined as supervisory during their involvement in the LCC

Programme, the nature of the work they undertook, particularly with the support of the Senior Nurse mirrored this definition.

Given the importance of the charge nurse role, what was evident in my study was that where this became unstable (as a result of secondments, maternity leave and organisational restructuring) it was difficult to sustain the focus on the Programme. This was exacerbated when the appointment of a successor, or as was often the case, an 'acting' charge nurse who perhaps did not have the support and authority to take work forward. Where senior staff nurses had been involved in the Leadership Programme at an early stage the issue of succession planning was much more straightforward with a smooth transition for achieving the goals of the work already initiated. It is essential, therefore, that healthcare organisations recognise the support that charge nurses (and their successors) need to realise their leadership potential and enable others within their teams to do so.

Figure 31 overleaf finally draws together all the elements of the key messages drawn from my research into a conceptual model that illustrates the components that can enhance organisational capacity to deliver compassionate care. In this final model the leadership role of the charge nurse is positioned to surround the importance of relational practice and relational inquiry and is in itself supported by the practice development components including facilitation, appreciative inquiry and leadership development.

**Figure 31: Conceptual model of enabling factors to enhance organisational capacity to deliver compassionate care.**



## 7.6 Summary

What this model represents is a dynamic articulation of the enabling factors that were demonstrated in my study of the implementation of the LCC Programme to enhance organisational capacity to deliver compassionate care within a complex healthcare environment. At the core is an expression of the elements of practice that will foster compassionate care by focusing on the needs of the three key parties within a healthcare encounter: the patient, their relatives and the staff caring for them. Delivering compassionate care necessitates meeting all these needs: for example, it was evident in the high

adopting wards that staff were working in an environment where they had agreed shared values, respected each other's contribution, were open in their exploration of ways to enhance care, supported each other and were in turn supported by their managers and were both reflective and not afraid to give feedback (either positive or pointing out practices that did not accord with the agreed values). Conversely where some or all of these elements were lacking, implementation of the Programme, regardless of the input of the Senior Nurse progress was limited.

Supporting the 'compassionate core' of this model are four essential layered, but interconnected elements that together were shown to strengthen organisational capacity for the delivering of compassionate care. Working from the outside of the model inwards the four are a strategic vision and infrastructure, investment in practice development, leadership at all levels and a sustained focus on relational practices.

My model has the potential at both policy and practice level to clarify requirements to enhance the understanding and delivery of compassionate care. This is examined in some depth in Chapter Eight: Recommendations.

Before concluding my thesis I will examine the strengths and limitations of my study, discuss areas for future research that it points towards and reflect on the experience of being an insider-outsider researcher.

## **7.7 Strengths and limitations**

### **7.7.1 Strengths**

The main strengths of this research are that it was conducted concurrently to the implementation of the LCC Programme itself, and through its longitudinal design permitted ongoing detailed inquiry using a variety of participative methods and semi-structured interviews. Furthermore, the adoption of Pawson and Tilley's (1997) realistic evaluation framework proved to be ideal as an underpinning methodology as the grounds for and structure of the LCC Programme resonated strongly with Pawson and Tilley's (1997) conceptualisation of a 'social programme' that was the basis of their rationale

for a realist inquiry<sup>76</sup>. Through repeatedly reasserting Pawson and Tilley's core question of 'what works, for whom in what circumstances?' I was able to focus my thinking and design the research methods accordingly, particularly with regards to the identification of the key stakeholders for my study sample and formulation of my interview schedules. In addition the fact that realistic evaluation is a theory led approach, I was able to draw both on my own experience of organisational change, practice development and implementation of evidence in practice and bring such 'folk theories' into the study design. The resultant data obtained over three years from 33 key informants involving 46 semi-structured interviews and 3 focus groups were very rich and through the systematic process of thematic analysis I adopted a clear series of conceptual propositions emerged. These propositions, which centred on the notion of 'level of adoption' of the LCC Programme became useful in generating the conceptual model of enabling factors to enhance organisational capacity to deliver compassionate care.

A further strength of this study, which was predetermined by the LCC Programme itself, was that although it was conducted in a single Health Board the case study sites were extremely diverse in terms of specialty, management structures, acuity of patients, average length of stay, experience of both ward leader and LCC Senior Nurse, size of staff group and environmental factors. The detailed analysis both within and across the case study sites both recognised this heterogeneity but also revealed which of these factors both enabled or limited the embeddedness of the Programme. What was ultimately evident, however, was that none of these factors in themselves influenced the 'compassionate core' that was at the heart of the model illustrated in Figure 27.

### **7.7.2 Limitations**

The main limitation of this study is that it did not include any primary data collection involving patients or relatives. It could be rightly argued that representatives of these two stakeholder groups should have been involved. This had been considered as part of the original quasi-experimental design outlined in Section 4.3, however, once the realistic evaluation framework

---

<sup>76</sup> Pawson and Tilley's (1997) essential features of a 'social programme' were described in Section 4.8.1 along with the mapping of these features to the rationale for the LCC Programme.

(Pawson & Tilley 1997) had been adopted my research design was fundamentally altered. The identification of the stakeholder groups that Pawson and Tilley (1997) articulated (Policy Maker, Practitioner and Subject) led to my focus being on the charge nurses of the participating sites as representing the 'Subject' group. Given that I was using semi-structured interviews as my principal data collection method I consciously decided not to attempt to include patients or relatives. This was for two main reasons: the first was a capacity issue in terms of scope to undertake interviews and manage the additional volume of data; and secondly a sampling issue in relation to how I would sample one or two representative patients and relatives who would be able to give a perspective on the implementation and impact of the LCC Programme. Linked to this latter reason was the issue of whether patients or relatives would be in a position to discern such impact unless they were regular attenders and I could interview them in the same time frames as the other participants. I took the decision, therefore, to draw on the perspective of patients and families from the secondary data that was available to me. This was two-fold: firstly the perspectives of the Senior Nurses and Charge Nurses when they talked about patients and relatives' stories and experiences; and secondly elements of the action research findings that the LCC Team undertook and published internally.

As already stated the LCC Programme was conducted in a single Health Board in Scotland and therefore my study could only explore in depth what was working in terms of embedding compassionate care in the participating settings. These could have been influenced by an overarching organisational culture which makes it difficult to generalise the findings at this stage beyond NHS Lothian.

Pawson and Tilley's (1997) realistic evaluation framework proved to be appropriate to address the research aims and to provide a theoretical underpinning to a study that was grounded in the 'real world' of everyday NHS practice. However, unlike many other studies using realistic evaluation, my study was purely qualitative and therefore there was no 'measurable' data to examine the impact of the LCC Programme in the participating areas. At the time of developing the methodology this was considered but, other than tools

on caring and work environment, no proxy measures for compassion existed. It was anticipated that an outcome of LCC Programme might be the generation of a measurement / assessment scale which could be proposed for future testing. Although some work has progressed from the LCC Programme none has been formally tested. There are, however, other tools available that measure patient and carer assessments of quality that could be considered. This includes the Consultation and Relational Empathy (CARE) measure developed at the Departments of General Practice in Glasgow University and University of Edinburgh (Mercer et al., 2005) that was used by Patterson et al. (2010) in their study on organisational culture. This measure has been named in the NHS Scotland Quality Strategy as the measure of choice for healthcare staff in NHS Scotland for patient feedback.

### **7.8 Reflections on role as insider-outsider researcher**

In Section 1.8 I acknowledged my position as insider-outsider researcher in the organisation. Throughout my research planning, data collection, analysis and discussions within supervision I have been very mindful of this relationship and the benefits and potential limitations that it carries. My duty has been to remain faithful to the ethical principles, research governance processes and research design whilst simultaneously recognising opportunities to utilise my insider position to enhance my understanding of the Programme implementation. In particular I feel that I have benefited from developing the contextual understanding that is so important to a realistic evaluation (Pawson & Tilley, 1997) approach. My relationship with the LCC Team became more distant as the Programme was implemented and by Phase Three was largely limited to that of researcher rather than the more collegiate relationship that was in place at the outset. I feel that this was an appropriate position to hold whilst I was analysing my data and developing my theoretical framework and has contributed to the trustworthiness of the findings.

### **7.9 Ethical considerations**

In Section 4.10 I outlined the key ethical considerations raised by this study. My chief concern was the protection of anonymity of the research participants, given that the LCC Programme in itself was high profile and that several of the key stakeholders were within the public domain including the nursing and wider academic press. In the information sheet given at recruitment (Appendix



3) I acknowledged that for some participants it would be difficult to fully protect their identity but that I would take measures as far as possible to do so. I did not name the specific wards in the organisation (although they would be known to many internally) and all participants were given pseudonyms which may have involved (or not) change of gender. During discussions with my supervisors it was apparent that they were not always able to identify directly attributed quotes even though they knew they key many of the stakeholders and when elements of the work were presented at the LCC Conferences it was fairly clear to me that only those who were participants could identify themselves or others directly involved. The latter was largely due to the way I described the ward characteristics. I feel that, as far as is possible, that I have honoured my commitment but remain mindful that this is an area that I need to consider moving forward to future publications. As stated in my information sheet I will consult, where necessary, with research participants if I feel their contribution could be identifiable in any potential publications and seek their consent to attribute direct quotes.

#### **7.10 Areas for future research**

The principal findings of my work are based on implementation of the LCC Programme within a single ward/department. In Phase 3 of the LCC Programme the model of implementation was spread over 4-5 wards at a time. Due to time constraints of my period of study I was not able to fully evaluate the impact of this method of implementation to the same degree as the Beacon Wards and Development Sites and therefore it would be important to investigate the outcomes of this way of working in those sites and examine whether they match the findings of the characteristics of 'level of adoption'.

The issue of long term sustainability of this type of investment is important. The role of the Senior Nurse was seen to be vital to the process and yet it would not be possible to maintain such a level of involvement at a local level in the long term. Further work should be undertaken with the existing eight wards, particularly the five that were identified as 'high adopters' to examine the degree they have embedded the focus on compassionate care and, if so, the ways in which this has been achieved. This research would be needed to identify whether there was sustained attitudinal change and how this impacted on actual care delivery on a long-term basis.

Given that I have acknowledged that a potential limitation of this study is the fact that the LCC Programme was implemented in one Health Board in Scotland further work should be done to test my findings in different health organisations. This would demand the implementation of the LCC Programme (or elements of it) and to replicate the methodology and data analysis. What would be of particular interest in this process would be the role of alternative contextual factors in influencing Programme outcomes

In the broader sense research on the delivery of compassionate care should extend to community based settings. In addition it is important that the future inquiry places more emphasis on inter-professional care delivery and sustained compassion across care transitions.

### **7.11 Conclusion**

At the time of writing the outline proposal for this PhD study in 2007 I could not have foreseen the degree to which its findings and recommendations would hold such currency at the time of its completion. Although concerns about the care of older people in hospital settings were at the heart of the inception and funding of the Leadership in Compassionate Care Programme, the national focus on such issues did not overtly link the term 'compassion' with the fundamental place of caring within the NHS in the United Kingdom. Indeed, the choice of the term compassion was at times controversial both locally and in the wider arena. There was, to some degree, a prevailing belief that compassion was intrinsic to the motivation to become a healthcare professional. To suggest therefore that there were perhaps deficits in a real understanding of compassion and its delivery was almost perceived as a threat to professional integrity.

It has been possible to trace a clear trajectory of interest and attention towards compassionate care in healthcare practice during the course of my study. My initial question posed in Chapter Two - 'why worry about compassion?' - has been demonstrated to be both relevant and complex, perhaps even more so at the present time. The elements of my study that examined the need for the LCC Programme strongly mirrored the literature and policies during the period 2007 – 2009. This included recognition of key changes in the organisation of care in hospitals, the increased acuity of patients, and a change in the role of

nurses in response to these factors as well as important adjustments to the role and training of junior doctors. In some quarters there was a suggestion that it was the move to higher education that was at the root of the 'problem' in nursing, making the newer generation of nurses more focussed on technical skills rather than essential care. This suggestion has not been vindicated either in my own study or formal inquiries such as that undertaken by Lord Willis (RCN, 2012). What was evident was that the root of the 'problem' and therefore the solutions of the perceived problem were located in the practice environment itself.

What was also clear from my study was that, despite the challenges faced by the contemporary NHS, the delivery of compassionate care can and does thrive in many wards and departments. My analysis of the characteristics of the Beacon Wards illustrated that compassionate care was essentially a function of the attitude and behaviour of staff working in an environment that emphasised relationship-centred care. Compassionate care itself involves caring and confident actions on the part of healthcare professionals in response to a real understanding of individual needs. It is dependent on a relationship of trust between healthcare professionals, patients and relatives and involves addressing 'the little things' as well as meeting specific healthcare needs. The main factors that were shown to influence the sustained delivery of compassionate care at a local level were the leadership of the charge nurse, a positive culture, team work and professional respect, and the organisation of care itself.

Now in 2013 the notion of compassionate care is absolutely central to debates about the 'state' and future of the NHS. Compassion (or the perceived lack of it) is at the centre of damning reports such as the Francis Inquiry (2010 and 2013) and views, opinions and experiences of compassionate care in the health service are almost a weekly, if not daily, feature of professional, political, public and media outputs. There are loud calls for professional and leadership development of existing staff and for innovative methods for the selection and preparation of future generations. What is perhaps less clear is the organisational infrastructure that is needed to embed and sustain a focus on compassionate care alongside all the other health service priorities.

This study has, therefore, an important contribution to make. The LCC Programme was one of the earliest focussed 'interventions' that took a systematic approach to investigating this complex issue and through this developed an evidence-based approach to practice development that could be implemented across a range of specialties. It was, in part, the heterogeneity of the practice settings involved in the Programme that enhances the potential impact of my findings. Through adopting Pawson and Tilley's (1997) realistic evaluation framework I have been able to generate a dynamic, practice based model for strengthening organisational capacity for compassionate care.

Given the fact that the debate surrounding enhancing compassionate care is still very much live at both policy and practice level within the UK there is a need for evidence-based recommendations that offer real insight into enabling cultural and practice changes at macro, meso and micro levels of the NHS. Discussions of compassionate care have rightly centred on the experiences of patients and relatives. What my study has demonstrated is that focussing on the needs of staff and supporting them to develop and work within a shared culture of compassion is instrumental to the sustained delivery of compassionate care. This finding has been echoed by Anna Dixon (2013) from The King's Fund in her blog 'Building a culture of compassion in the NHS'. She argues that unless staff work in a culture where they feel empowered and able to care for patients with the empathy and compassion with which they wish to be treated themselves, then even if many of Lord Francis' (2013) recommendations are implemented the situation will not improve. Dixon argues that this 'is the real test for the NHS' (2013, n.p.). The need for support and recognition of the role of front line workers (particularly junior nurses and doctors) was similarly highlighted by Sir Bruce Keogh in his more recent review of 14 Trusts in England in the wake of the Mid Staffordshire Inquiries (Keogh 2013). He argued that 'their constant interaction with patients and their natural innovative tendencies means they are likely to be the best champions for patients and their energy must be tapped not sapped' (2013, p.5).

Chapter Eight presents my recommendations at policy and practice level. These will be of relevance to politicians, healthcare professionals and managers. I am in no doubt that compassion should be at the heart of the

NHS and that by far the majority of healthcare professionals support this view. To sustain this focus in a very challenging environment staff need to be supported by a strategic vision for compassionate care that recognises and values the role of relationships and that invests in practice development and leadership at all levels of local organisations.

## Chapter Eight: Recommendations

This final chapter draws on the model for enhancing organisational capacity to embed the delivery of compassionate care in NHS practice that I constructed in Chapter Six. In doing so, I will make recommendations that have important implications for policy and practice. These recommendations are not purely for the nursing profession and, whilst not specified directly, relate to the multidisciplinary team particularly at local level. After outlining the full range of recommendations I will conclude this chapter by highlighting those that emerged from the data as being the key priorities.

### 8.1 Policy Recommendations

Policy recommendations are directed at both national and local levels. At the present moment they are likely to reflect some of the responses the recommendations from the Francis Inquiry (2013). What is unique about this study and therefore these recommendations, however, are that they are grounded in evidence in response to the question of ‘what worked, for whom and in what circumstances?’ (Pawson & Tilley 1997), rather than from a perspective of deficits in practice.

#### 8.1.1 National commitment to compassionate care

National health and quality strategies should continue to articulate a commitment to the delivery of person-centred compassionate care. There should be clear a message from Government health leaders that ***NHS organisations will be required to evidence their delivery of compassionate care at annual reviews, alongside clinical and financial monitoring.*** Such reporting should go beyond patient and staff experience surveys and include patient, relative and staff stories and exemplars of best practice that can be shared and implemented more widely.

#### 8.1.2 Organisational commitment to compassionate care

***NHS organisations should give prominence to the delivery of compassionate care in their individual vision and value statements.***

These should be clear that compassionate care is everybody’s business and that it extends to patients, relatives and staff. Such statements should form the basis of a long-term vision and a range of strategic activities directed

towards elevating the focus on compassionate care in order that it is embedded throughout the organisation. ***Compassionate values should be role-modelled at all levels alongside a culture of feedback, support and reflection.*** Adopting an appreciative rather than problem-focussed approach to improving care delivery should be viewed as a powerful tool to underpin critical inquiry and cultural change in this area. Where possible, executive leads and senior managers should be exposed to appreciative inquiry as an improvement/research methodology.

In the same way that organisational policies and business plans are required to address issues such as risk and impact on equality and diversity there should be a requirement to articulate the way in which person-centred compassionate care will be enhanced, impacted upon and evidenced.

### **8.1.3 Achievement of cultural change**

There should be recognition at policy level that ***achieving the type of cultural change that will embed compassionate caring practices takes time and strategic and operational objectives in this area should not be viewed as a 'quick fix'.*** This includes recognition that investment in infrastructure to enhance organisational capacity to embed and sustain the delivery of compassionate care may be necessary.

This ***infrastructure should include a practice development function that is seen as a core enabling function rather than as a luxury.*** Investment should include the employment of skilled facilitators who have sufficient organisational authority and resource to work with clinical and managerial staff to enable change. It also requires ***investment in specific leadership development opportunities/programmes that focus on individual, team and organisational capacity to deliver compassionate care through the use of practice development techniques.*** There should be the ambition to build a critical mass of staff with these skills at all levels of the organisation that can lead and support work at a local level.

### **8.1.4 Recognition of front line pressures**

There should be ***acknowledgement at policy level of the clinical and organisational pressures that front-line staff are under*** alongside clear expectation and understanding that upholding compassionate values can

support the maintenance of patient flow, improve relationships between staff, patients and relatives and reduce the potential for expressions of concern and/or complaints.

## **8.2 Practice Recommendations**

Practice recommendations are presented for all levels of the organisation and reflect what were seen in my study as the key enablers within the high adopting wards and in their managerial environments.

### **8.2.1. Operational**

#### **8.2.1.1 Macro level requirements**

At a macro level in individual NHS **organisations the operation of committees should reflect the organisational vision and value statements that embrace compassionate care** and take active steps to integrate examples of practice (from patient, relative and staff stories) to maintain focus on ongoing experiences.

NHS organisations should **acknowledge the importance of the Charge Nurse/Ward Manager role in the delivery of compassionate care in terms of leadership and role modelling behaviours and values**. In line with Recommendation 1.188 of the Francis Inquiry that NHS organisations should secure investment that will **allow Charge Nurses/Ward Managers to work in a supervisory capacity**<sup>77</sup> and be involved in and aware of the plans of care for all their patients (Francis 2013 p.76).

#### **8.2.1.2 Meso level requirements**

**Support for front line staff to deliver compassionate care is vital at middle management (meso) level.** Clinical Nurse Managers themselves need support and development in this area to ensure that they are familiar with specific initiatives and techniques that are underway within their sphere of responsibility. Where possible, this should include participation in elements of the locally developed leadership programmes. There **should be an expectation that activities directed at enhancing compassionate care are reported regularly at meetings, linked to related initiatives and that examples of achievement are celebrated and shared.**

---

<sup>77</sup> The components of the supervisory charge nurse role were detailed in Section 6.6.4 'Leadership and Succession Planning'.



The focus on compassionate care should be integrated into existing directorate level quality structures, where they exist. Where they do not the possibility of establishing directorate level committees to create a local vision and plan for measures to enhance compassionate care should be considered. These should be led by senior figures but extend to all members and levels of the multidisciplinary team.

Where the Supervisory Charge Nurse role has been implemented there ***should be a clear emphasis on enhancing and evidencing the delivery of compassionate care*** in order that this is given prominence alongside other metrics such as reduction in complaints, patient falls, medication errors and length of stay.

### **8.2.1.3 Micro level requirements**

Focussing on ways to enhance the delivery of compassionate care should be extended to all members of the multidisciplinary team, including medical staff. ***The exploration of personal and team values should be seen as fundamental to creating a vision for compassionate care within individual settings.***

Stability within local clinical teams is an important pre-requisite for the delivery of compassionate care. This is particularly important in terms of the Charge Nurse/Ward Manager but extends to ensuring, as far as is possible, that staffing establishments are maintained. Given the inevitability of staff turnover ***it is vital that priority is given to succession and manpower planning in order to avoid over-reliance on secondments or protracted use of temporary staff.***

Individual wards and departments should ensure that their ***induction process for new appointments, students and temporary staff emphasise compassionate care and incorporate feedback mechanisms that focus on their own experience of compassion within the setting.***

### **8.2.2 Compassionate Care**

There should be recognition that the ***sustained delivery of compassionate care involves understanding and meeting a series of core needs of patients, relatives and staff.*** These needs are both inter-related and at the

same time specific to each group. Patients value care that responds to them as an individual, paying attention to the essential and technical components whilst at the same time responding to 'little things' that enhance their individual experience. Relatives seek proactive and regular engagement with healthcare professionals and the opportunity, where appropriate, to be involved in care either in a broad or very direct sense. Staff can be best supported to deliver compassionate care where they work in an environment with shared values, mutual respect, openness, support, regular feedback and opportunities for reflection.

There should be ***investment in opportunities for reflective discussion about compassionate care practice ('caring conversations'<sup>78</sup>) at micro and meso level.*** The nature of these opportunities should be determined locally but should be valued as a core element of management and clinical practice.

### **8.2.3 Relationships**

There should be recognition at all levels of practice that relational work and relational inquiry are fundamental to both the delivery of compassionate care and the achievement of the type of cultural change needed to embed it in healthcare settings. Relational work within multidisciplinary teams and their link to local and higher management structures within the organisation are an important foundation for the delivery of compassionate care. ***Communication mechanisms and team development opportunities should be seen as important elements of organisational infrastructure and should be subject to ongoing review and investment.***

There should be ***opportunities for staff to examine and acknowledge uncertainties that they may have about their relational practices.*** Where they do exist (for example with relatives) staff should be supported and developed in order that they can take a proactive approach to address these. Examples of best practice in this sphere should be shared and adapted according to local circumstances. There should be ongoing evaluation of

---

<sup>78</sup> 'Caring conversations' is the term developed in the LCC Programme as one of the six themes within their compassionate care model. This was described as 'discussing, sharing, debating and learning how care is provided, amongst staff, patients and relatives and the ways in which we talk about caring practice.' (Edinburgh Napier University & NHS Lothian 2012, p.59).

relationships as part of the review of delivery of compassionate care at local and organisational level.

#### **8.2.4 Practice Development**

Investment in a practice development function within individual organisations is needed to support staff to review and reflect on practice and take forward focussed initiatives to enhance compassionate care (and other related work). Skilled facilitation is vital for practice development to be successful and the ***investment and development of facilitation staff that can be embedded in practice should be viewed as an important organisational asset.***

The ***focus of practice development activities should be on 'hearing the voice' of patients, relatives and staff through approaches that focus on the experience of receiving and delivering care and working in the organisation.*** It is vital that there is an emphasis on feedback of findings and an expectation of meaningful action and outcomes associated with this work. It is vital that practice development facilitators are sensitive to local context and circumstances and have the ability to gain trust and adapt their working practices to reflect competing clinical demands.

Organisations should work towards having a ***critical mass of healthcare professionals over and above a practice development function who have the skills and ability to use creative techniques to hear the stories of patients, relatives and staff.*** This should accelerate the process of embedding culture change and working practices.

#### **8.3 Priority recommendations**

The priorities outlined above are all embedded within the conceptual model of enabling factors to enhance organisational capacity to deliver compassionate care and, therefore, should not be seen in isolation. However, there are a number which stood out from the data as priorities for building and sustaining compassionate care in local NHS practice.

Although this study had focussed on the Beacon Ward strand of the LCC Programme it became clear that the Leadership Programme was the mechanism through which the embedding the theoretical underpinning of the LCC Programme along with the development of a critical mass of practitioners

equipped with the practice development skills was achieved. Skilled facilitators (the Senior Nurses) were absolutely essential to the whole process, both in terms of delivering the Leadership Programme and supporting clinical staff in practice.

Moving forwards, therefore, my priority recommendations would be that NHS organisations recognise and value the role of practice development and invest in it as essential infrastructure. This practice development function should be embedded within existing quality, education and governance functions in order to ensure sharing of learning. Skilled facilitators should be employed with a key focus on delivering a multi-professional leadership programme focussed on compassionate care. This type of programme should be championed at strategic level and involved middle managers both as sponsors and participants. There should be an expectation that the outputs and outcomes of this leadership investment is reported and shared widely throughout the organisation.

## References

Adamson, E., Dewar, B., 2011. Compassion in the nursing curriculum: making it more explicit. *Journal of Holistic Healthcare* **8**(3) pp.42-45.

Adamson, L., Dewar, B., Tocher, R. 2011. Teaching and assessing compassionate care in pre-registration nursing education. JORUM. Accessed online from <http://vm-jorum.ds.man.ac.uk/xmlui/handle/10949/15178> on 6th April 2013.

Agnew, T., 2007. Dignity in care: a genuine commitment? *Nursing Older People* **18**(12) pp.17-18.

Aiken, L.H., & Patrician, P.A., 2000. Measuring organisational traits of hospitals: the Revised Nursing Work Index *Nursing Research* **49**(3) pp.146-153.

Aiken, L.H., Buchan, J., Ball, J., Rafferty, A.M., 2008a. Transformative impact of Magnet designation: England care study. *Journal of Clinical Nursing* **17**(24) pp.3330-3337.

Aiken, L.H., Clarke, S.P, Sloane, D.M., Lake, E.T., Cheney, T., 2008b. Effects of Hospital Care Environment on Patient Mortality and Nurse Outcomes *Journal of Nursing Administration* **38**(5) p223-229.

Aiken, L. H., Sermeus, W., Van der Heed, K., Sloane, D. M., Busse, R., McKee, M. et al. 2012. Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. *British Medical Journal* **1136** pp.344.

Alimo-Metcalfe, B., Alban-Metcalfe, J., Samele, C., Bradley, M., Mariathasan, J., 2007. *The impact of leadership factors in implementing change in complex health and social care environments*. Department of Health, NHS SDO P22/2002. Accessed online [http://www.netscc.ac.uk/hsdr/files/project/SDO\\_FR\\_08-1201-022\\_V01.pdf](http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1201-022_V01.pdf) on May 31st 2008.

Anderson, R., 2008. New MRC Guidance on evaluating complex interventions (Editorial) *British Medical Journal* **337a** p.1937.

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) pp.356-359.

Aristotle, 1959. Ross, W.D., (Eds) *Ars Rhetorica* Oxford: Clarendon Press. Cited in Crisp, R., 2008. Compassion and beyond. *Ethical Theory and Moral Practice* **11** pp.233-246.

Baillie, L., Gallagher, A. & Wainright, P., 2008. *Defending Dignity – Challenges and opportunities for nursing*. Accessed online from [http://www.rcn.org.uk/newsevents/campaigns/dignity/the\\_rcns\\_dignity\\_survey](http://www.rcn.org.uk/newsevents/campaigns/dignity/the_rcns_dignity_survey) on 22nd December 2010.

Baillie, L., Gallagher, A., 2010, Evaluation of the Royal College of Nursing's 'Dignity: at the heart of everything we do' campaign: exploring challenges and enablers *Journal of Research in Nursing* **15**(1) pp.15–28.

Bate, P., Robert, G., 2006. Experience-based design: from redesigning the system around the patient to co-designing services with the patient. *Quality and Safety in Health Care* **15**(5) pp.307-310.

BBC News, 1999. *Health Campaign to improve elderly care*. 18 January. Accessed online from <http://news.bbc.co.uk/1/hi/health/256137.stm> on 28th January 2009.

BBC News, 2007. *Older patients' rights 'abused'* 14 August. Accessed online from <http://news.bbc.co.uk/1/hi/health/6944699.stm> on 15th August 2008.

Beach, M.C., & Inui, T., 2006. Relationship-centred Care: A constructive reframing. *Journal of General Internal Medicine* **21**: SPP.3-8.

Beauchamp, T. L., Childress, J. F., 2009. *Principles of Biomedical Ethics*. 6<sup>th</sup> Edition Oxford: Oxford University Press.

Benner, P. & Wrubel, J., 1989. *The Primacy of Caring: Stress and Coping in Health and Illness*. Menlo Park, California: Addison-Wesley. Cited in Sabo, B.M. (2006) Compassion fatigue and nursing work: can we accurately capture the consequences of caring work? *International Journal of Nursing Practice* **12** (3) p.137.

Betcher, D.K., 2010. Elephant in the Room Project: Improving caring efficacy through effective and compassionate communication with palliative care patients. *MedSurg Nursing* **19**(2) pp.101-105.

Bick, D.E., Rycroft-Malone, J., Fontenla, M., 2009. A case study evaluation of a care pathway to support normal birth in one English birth centre: anticipated benefits and unintended consequences. *Pregnancy and Childbirth* **9**:47.

Blamey, A. & Mackenzie, M., 2010. Theories of change and realistic evaluation: peas in a pod or apples and oranges? *Evaluation* **13**(4) pp.439-455.

Blum, L., 1980. *Compassion*. In Rorty, A.M. (ed.) *Explaining Emotions* Berkley, CA: University of California Press, pp.507-517. Cited in Sabo, B.M., 2006. Compassion fatigue and nursing work: can we accurately capture the consequences of caring work? *International Journal of Nursing Practice* **12** (3) pp.136-142.

Boyzatis, R.E., 1998. *Transforming Qualitative Information: Thematic Analysis and Code Development* California: Sage Publications.

Bradshaw, A., 2009. Measuring nursing care and compassion: the McDonaldised nurse? *Journal of Medical Ethics*. **35** pp.465-468.

Bradshaw, A., Is the ward sister role still relevant to the quality of patient care? A critical examination of the ward sister role past and present. *Journal of Clinical Nursing* **19**(23-24) pp.3555-3563.

- Brand, G. & McMurray, A., 2009. Reflection on Photographs: Exploring first year nursing students' perceptions of older adults. *Journal of Gerontological Nursing* **35**(11) pp.30-35.
- Bridges, J., Nicholson, C., Maben, J., Pope, C., Flatley, M., Wilkinson, C., Meyer, J., Tziggili, M. 2013. Capacity for care: meta-ethnography of acute care nurses' experiences of the nurse-patient relationship. *Journal of Advanced Nursing* **69**(4) pp.760-722.
- Brown, J., Nolan, M., Davies, S., Nolan, J. and Keady, J., 2008. 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) pp.1214-1232.
- Burdett Trust for Nursing, 2006. *Who Cares, Wins: Leadership and the business of caring*. Accessed online from [http://www.burdettnursingtrust.org.uk/docs/5719\\_burdett\\_trust\\_who\\_cares\\_wins\\_031006.pdf](http://www.burdettnursingtrust.org.uk/docs/5719_burdett_trust_who_cares_wins_031006.pdf) on 20th September 2007.
- Burnell, L., 2010. Exploring the compassionate care connection. *Journal of Christian Nursing*. **27**(4) pp.306-3011.
- Burston, P.L., & Stitchler, J.F., 2010. Nursing work environment and nurse caring: relationship among motivational factors. *Journal of Advanced Nursing* **66**(8) pp.1819-1831.
- Burston, S., Chaboyer, W., Wallis, M., Stanfield, J., 2011. A discussion of approaches to transforming care: contemporary strategies to improve patient safety. *Journal of Advanced Nursing* **67**(11) pp.2488-2495.
- Byng, R., Norman, I., Redfern, S., 2005. Using realistic evaluation to evaluate a practice-level intervention to improve primary healthcare for patients with long term mental-illness. *Evaluation* **11**(1) pp.69-93.
- Byng, R., 2011. What makes a realistic evaluation? *Family Medicine* **43**(2) pp.112-113.
- Campbell, D., 2011. Elderly NHS patients' harrowing plight is revealed in report. *The Guardian* February 15. Accessed online from <http://www.guardian.co.uk/society/2011/feb/15/nhs-report-elderly?INTCMP=ILCNETTXT3487> on 20<sup>th</sup> February 2011.
- Campbell, D., 2013. Nurses must spend a year on basic care: Jeremy Hunt to announce measure aimed at improving levels of compassion after Mid Staffordshire scandal. *The Guardian* 26 March. Accessed online from <http://www.guardian.co.uk/society/2013/mar/26/nurses-basic-care-training> on 20th May 2013.
- Care Quality Commission, 2010. *National NHS patient survey programme: Survey of adult inpatients 2010. Full national results with historical comparisons*. Accessed online from <http://www.cqc.org.uk/node/1667> on 23rd November 2011.
- Care Quality Commission, 2011. *Dignity and nutrition inspection programme: National overview*. Accessed online from <http://www.cqc.org.uk/public/reports->

[surveys-and-reviews/reviews-and-studies/dignity-and-nutrition-older-people](#) on 27th December 2011.

Care Quality Commission, 2012. *National summary of the results for the 2011 Inpatients survey*. Accessed online from [http://www.cqc.org.uk/sites/default/files/media/documents/ip11\\_national\\_summary\\_final.pdf](http://www.cqc.org.uk/sites/default/files/media/documents/ip11_national_summary_final.pdf) on 5th September 2012.

Caruana, E., 2008. Comprehensive systematic review of evidence on developing and sustaining nursing leadership that fosters a healthy work environment in health care. *Journal of Advanced Nursing* **62**(6) pp.653-654.

Carvel, J., 2008. Nurses to be rated on how compassionate and smiley they are. *The Guardian*. 18 June. Accessed online <http://www.guardian.co.uk/society/2008/jun/18/nhs60.nhs1> on 19th September 2008.

Cash, K., 2007. Compassionate strangers. *Nursing Philosophy* **8** pp.71-72.

Cass, E., 2008. Delivering dignity in care. *Working with Older People* **12**(1) pp.12-15.

Catholic Herald (1964) As the patient sees it: review of Cohen, G.L. 1964, *What's Wrong with British Hospitals?* Penguin Books Ltd. Accessed online from <http://archive.catholicherald.co.uk/article/17th-july-1964/6/as-a-patient-sees-it> on 12th December 2013.

Clinical Standards Board for Scotland, 2002. *Clinical Standards for Older People in Acute Care*. Accessed online from [http://www.healthcareimprovementscotland.org/previous\\_resources/standards/older\\_people\\_acute\\_standards.aspx](http://www.healthcareimprovementscotland.org/previous_resources/standards/older_people_acute_standards.aspx) on 10th December 2011.

Clout, L., 2008. *NHS nurses told to smile and show compassion*. Telegraph 11 November. Accessed online from <http://www.telegraph.co.uk/health/2148140/NHS-nurses-told-to-smile-and-show-compassion.html> on 28th January 2009.

Clwyd, A. 2012. Ann Clwyd MP: A plea for compassion in nursing. *BBC News*. 9 December. Accessed online <http://www.bbc.co.uk/news/uk-politics-20657319> on 24th February 2013.

Coetzee, S. K. and Klopper, H. C., 2010. Compassion fatigue within nursing practice: A concept analysis. *Nursing & Health Sciences* **12**(2) pp.235–243.

Cohen, G.L. 1964, *What's Wrong with British Hospitals?* Penguin Books Ltd. Cited in MacFarlane, J.K. 1974, *The Proper Study of the Nurse*. The Study of Nursing Care Project Reports Series 1, Number 6. London: Royal College of Nursing and National Council of Nurses of the United Kingdom. p.28 Accessed online from [http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0016/235420/Series\\_1\\_Introduction.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0016/235420/Series_1_Introduction.pdf) on 12th December 2013.

Connect in Care, 2008. <http://www.connect-in-care.net/>



Cooperrider, D.L., Whitney, D., Stavros, J.M (2008) *Appreciative Inquiry Handbook*. Bedford, OH: Lakeshore Communications Inc & San Francisco: Berrett-Koehler Publishers Inc.

Corbin, J., 2008 Is caring a lost art in nursing? *International Journal of Nursing* **45**(2) pp.163-165.

Corbin-Dwyer, S., Buckle, J.L., 2009. The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal of Qualitative Methods*. **8**(1) pp.54-63.

Cornwell, J., 2011. Care and compassion in the NHS. *The Health Foundation* Accessed online from <http://www.health.org.uk/blog/care-and-compassion-in-the-nhs/> on 10<sup>th</sup> September 2011.

Cornwell, J. & Goodrich, J., 2010. Supporting staff to deliver compassionate care using Schwartz Center rounds – a UK pilot. *Nursing Times* **106**(5) pp.10-12.

Coryn, C. L.S., Noakes, L.A., Westine, C.D., Schroter, D.C., 2011. A Systematic Review of Theory-Driven Evaluation Practice From 1990 to 2009 *American Journal of Evaluation* **32**(2) 199-226

Cossette, S., Pepin, J., Côté J.K, Poulin de Courval, F., 2008. The multidimensionality of caring: a confirmatory factor analysis of the Caring Nurse-Patient Interaction Short Scale. *Journal of Advanced Nursing* **61**(6) pp.669-710.

Coulter, A., 2005. *Trends in Patients' Experiences of the NHS* Oxford: Picker Institute.

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**(4) pp.450-459.

Crawford, P., 2013. The NHS and the true meaning of compassion. *Health and Social Care Reform*. 8<sup>th</sup> February. Accessed online <http://www.hscreformseries.co.uk/leadership/14747-the-nhs-and-the-true-meaning-of-compassion> on 10<sup>th</sup> March 2012.

Crisp, R., 2008. Compassion and beyond. *Ethical Theory and Moral Practice* **11**(3) pp.233-246.

Cummings, G.G., Hayduk, L. & Estabrooks, C.A., 2006. Is the Nursing Work Index measuring up?: moving beyond estimating reliability to testing validity. *Nursing Research* **55**(2) pp.82-93.

Cummings, G.G., MacGregor, T., Davey, M., Lee, H., Wong, C., Lo, E., Muise, M., Stafford, E., 2010. Leadership styles and outcome patterns for the nursing workforce and work environment: A systematic review *International Journal of Nursing Studies* **47**(3) pp.363-385.

Curtis, K., Horton, K., Smith, P., 2012. Student nurse socialisation in compassionate practice: A Grounded Theory Study *Nurse Education Today* **32**(7) pp.790-795.

Darbyshire, P. 2009. Reader response to Evans, R., 2009. RCN defends nurses against Patients Association report on poor NHS care. *NursingTimes.net* 27 August. Posted 22-Oct-2009 12:19 pm. Accessed online from <http://www.nursingtimes.net/whats-new-in-nursing/acute-care/rcn-defends-nurses-against-patients-association-report-on-poor-nhs-care/5005657.article> on 10th December 2009.

Darzi A., 2008. *High quality care for all: NHS next stage review final report* Department of Health. Accessed online from [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_085825](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825) on 10th June 2012.

Davies, P., 2000. Contributions from qualitative research. In Davies, H., Nutley, S., Smith, P (Eds) *What Works? Evidence-based Policy and Practice in Public Services*, pp. 291-316. Bristol: The Policy Press. Cited in Dickinson, H., 2006. The evaluation of health and social care partnerships: an analysis of approaches and synthesis for the future. *Health and Social Care in the Community* **14**(5) p.378.

Davis, K., Schoen, C., Stremikis, K., 2010. *Mirror, mirror on the wall: how the performance of the U.S. health care system compares internationally*, Update Commonwealth Fund. Accessed online from <http://www.commonwealthfund.org/Publications/Fund-Reports/2010/Jun/Mirror-Mirror-Update.aspx?page=all> on 23<sup>rd</sup> November 2011.

Dean, R., Proudfoot, R., Lindsay, J., 1993. The Quality of Interactions Schedule (QUIS): Development, Reliability and Use in the Evaluation of Two Domus Units. *International Journal of Geriatric Psychiatry* **8**(10) pp.819-826.

Delamonte, T., 2011. We need to talk about nursing. *BMJ* **342** p.3416.

Department of Health, 2001. *National Service Framework for Older People*. Accessed online from [http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationpolicyandguidance/DH\\_4003066](http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationpolicyandguidance/DH_4003066) on 14th February 2009.

Department of Health, 2003. *Essence of Care Patient-focused benchmarks for clinical governance*. Accessed online from [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4005475](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005475) on 16th February 2009.

Department of Health, 2005. *Now I Feel Tall: What a patient-led NHS feels like*. London: Department of Health. Accessed online from [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4124475](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4124475) on 14th February 2009.

Department of Health, 2007. *About Dignity in Care*. Accessed on line from [http://www.dh.gov.uk/en/SocialCare/Socialcarereform/Dignityincare/DH\\_4134922](http://www.dh.gov.uk/en/SocialCare/Socialcarereform/Dignityincare/DH_4134922) on 15<sup>th</sup> August 2007.

Department of Health, 2008a. *High quality care for all: NHS Next Stage Review final report*. Accessed online from [http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationpolicyandguidance/DH\\_085825](http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationpolicyandguidance/DH_085825) on 12th January 2011.

Department of Health, 2008b. *Confidence in Caring*. London: Department of Health. Accessed online from [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_086387](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086387) on 19th January 2009.

Department of Health, 2009. *The NHS Constitution for England: The NHS Belongs to Us All*. Accessed online from <http://www.dh.gov.uk/en/Healthcare/NHSConstitution/index.htm> on 14th February 2009.

Department of Health, 2012. *Compassion in Practice: Nursing, Midwifery and Care Staff. Our Vision and Strategy*. Accessed online at <http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf> on 24th January 2013.

De Vignemont & Singer, T., 2006. The empathic brain: how, when and why? *Trends in Cognitive Science* 10, pp.435-41. Cited in Loggia, M.L., Mogil, J.S., Bushnell, M.C., 2008. Empathy hurts: compassion for another increases both sensory and affective components of pain perception. *Pain* 136 p.168.

Dewar, B., & Mackay, R., 2010 Appreciating compassionate care in acute care setting caring for older people *International Journal of Older People Nursing* 5 pp.299-308.

Dewar, B., MacKay, R., Smith, S., Pullin, S., Tocher, R., 2011. Use of emotional touchpoints as a method of tapping into the experience of receiving compassionate care in a hospital setting. *Journal of Research in Nursing* 15 (1) pp.29-41.

Dewar, B., Pullin, S., Tocher, R., 2011. Compassion: can it be defined and measured? *Nursing Management* 17(9) pp.30-35.

Dewar, B., 2012. Using creative methods in practice development to develop and understand compassionate care. *International Practice Development Journal* 2(1) pp.1-11.

Dewar, B. & Nolan, M., 2013. Caring about caring: developing a model to implement compassionate relationship-centred care in an older person care setting. *International Journal of Nursing Studies*. 50(9) pp.1247-1258.

Dewing, J., 2004. Concerns relating to the application of frameworks to promote person-centredness in nursing with older people. *Journal of Clinical Nursing* 13 Issue Supplement s1 pp.39–44.

Dickinson, H., 2006. The evaluation of health and social care partnerships: an analysis of approaches and synthesis for the future. *Health and Social Care in the Community* 14(5) pp.375-383.

Dickson, N., 2008. cited in Dreaper, J., 2008a. *NHS 'fast losing its compassion'*. BBC News. 30<sup>th</sup> December. Accessed online from <http://news.bbc.co.uk/1/hi/health/7797868.stm> on 27th January 2009.

Dietze, E. von & Orb, A., 2000. Compassionate care: a moral dimension of nursing. *Nursing Inquiry* 7 pp.166-174.

- Diggins, K., 2007. Compassion or pity? *Journal of Christian Nursing* **24**(2) p.81.
- Dignity in Care Project, 2010. *Everybody Matters: Sustaining Dignity in Care Resources*. Accessed online from <http://www.staff.city.ac.uk/~jacky/dignity/resources.htm> on 21st October 2010.
- Dignity in Care Network, 2010. Accessed online from <http://www.dignityincare.org.uk/> on 21<sup>st</sup> December 2010.
- Dixon, A., 2013. Building a culture of compassion in the NHS. *The Kings Fund Blog*. Accessed online from <http://www.kingsfund.org.uk/blog/2013/02/building-culture-compassionate-care-nhs> on 30th July 2013.
- Doane, G.H., Varcoe, C., 2007. Relational practice and nursing obligations. *Advances in Nursing Science* **30**(3) pp.192-205.
- Doris, J., 2002. *Lack of character: Personality and moral behaviour*. Cambridge: Cambridge University Press. Cited in Miller, C.B., 2009. Empathy, social psychology, and global helping traits. *Philosophical Studies* **142** (2) pp.247-275
- Dreaper, J., 2008a. NHS 'fast losing its compassion'. BBC News 30<sup>th</sup> December. Accessed online from <http://news.bbc.co.uk/1/hi/health/7797868.stm> on 27th January 2009.
- Dreaper J., 2008b. *Compassion 'key to good healthcare'*. BBC News 30<sup>th</sup> December. Accessed online from <http://news.bbc.co.uk/1/hi/health/7797548.stm> on 27th January 2009.
- Duffy, J., 1992. The impact of nurse caring on patient outcomes. In Gaunt D. (Ed.) *The Presence of Caring in Nursing* pp.113-116 cited in Watson, J., 2002. *Assessing and Measuring Caring in Nursing and Health Science* New York: Springer Publishing Company pp.125-150.
- Edinburgh Napier University & NHS Lothian, 2011. Leadership in Compassionate Care: *Enhancing patient care by promoting compassionate practice* 2<sup>nd</sup> International Conference on Compassionate Care 23-24<sup>th</sup> June 2011. Accessed online <http://www.napier.ac.uk/fhlss/NMSC/compassionatecare/Documents/Conference/2011/Handbook%20CCC%20june%202011.pdf> on 17<sup>th</sup> October 2012.
- Edinburgh Napier University & NHS Lothian, 2012. *Leadership in Compassionate Care Programme: Final Report*. Accessed online <http://www.napier.ac.uk/fhlss/NMSC/compassionatecare/Documents/Compassionate%20Care%20Final%20Report%20Report2.pdf> on 18<sup>th</sup> August 2012.
- Emslie, L., & Chen, Y., 2007. *Defining and implementing the Lothian Way*. Lothian Way Steering Group. Unpublished Paper. NHS Lothian.
- Erickson, R.J., & Grove, W.J.C, (2007) Why emotions matter: age, agitation and burnout among registered nurses. *Online Journal of Issues in Nursing*. **13**(1)

Evans, R., 2009. RCN defends nurses against Patients Association report on poor NHS care. *NursingTimes.net* 27 August. Accessed online from <http://www.nursingtimes.net/whats-new-in-nursing/acute-care/rcn-defends-nurses-against-patients-association-report-on-poor-nhs-care/5005657.article> on 10th December 2009.

Express & Star, 2011. Stafford Hospital Chairman hits out at the nursing profession. *Express & Star* 4 August. Accessed online from <http://www.expressandstar.com/news/2011/08/04/stafford-hospital-chairman-hits-out-at-nursing-profession/> on 9<sup>th</sup> December 2011.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*. **5**(1) pp. 1-11. Accessed on line [http://www.ualberta.ca/~iiqm/backissues/5\\_1/pdf/fereday.pdf](http://www.ualberta.ca/~iiqm/backissues/5_1/pdf/fereday.pdf) on March 24th 2010.

Fields, S.K., Hojat, M., Gonnella, J.S., Mangione, S., Kane, G., Magee. 2004. Comparisons of Nurses and Physicians on an Operational Measure of Empathy. *Evaluation and the Health Professions*. **27**(1) pp.80-94.

Finfgeld-Connett, D., 2008. Meta-synthesis of caring in nursing. *Journal of Clinical Nursing* **17**(2) pp.196-204.

Firth-Cozens, J., & Cornwell, J., 2009. *The Point of Care: Enabling Compassionate Care in Acute Hospital Settings*. London The Kings Fund.

Fitzimmons, B., Bartley, A., Cornwell, J., 2011. Intentional rounding: its role in supporting essential care. *Nursing Times* **107**(27) pp.18-21.

Flynn, M., Mercer, D., 2013. Is compassion possible in a market-led NHS? *Nursing Times* **109**(7) pp.12-14.

Ford, S., 2009. No sign of an indicator for nurse compassion. *Nursing Times.Net* 1 September. Accessed from <http://www.nursingtimes.net/whats-new-in-nursing/acute-care/no-sign-of-indicator-for-nurse-compassion/5005725.article> on 11th September 2012.

Ford, P. & Waddington, E., 2004. *Caring in Partnership: Older People and Nursing Staff Working Towards the Future*. Royal College of Nursing, London.

Francis, R., 2010. *The Mid Staffordshire NHS Foundation Trust Inquiry Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 Volume I* London: The Stationary Office.

Francis, R., 2013 *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive Summary* London: The Stationary Office.

Fullbright-Anderson, K. Kubisch, A. & Connell, J., (Eds) 1998. *New Approaches to Evaluating Community Initiatives*, Vol. 2, *Theory, Measurement, and Analysis*. Washington, DC: Aspen Institute.

Gibson, L., 2008. Why spending five years as a NHS patient made me sick at heart. *Daily Mail* 5<sup>th</sup> February. Accessed online from

<http://www.dailymail.co.uk/health/article-512374/Why-spending-years-NHS-patient-sick-heart.html> on 1th February 2008.

Gilgun, J.F., 2010. Reflexivity and qualitative research. *Current Issues in Qualitative Research* 1(2) pp.1-8.

Goetz, J.L., Keltner, D., & Simon-Thomas, E., 2010. Compassion: an evolutionary and empirical review. *Psychological Bulletin*. 136(3) pp.351-374.

Goodrich, J. & Cornwell, J., 2008. *Seeing the person in the patient: The Point of Care review paper*. London: King's Fund.

Goodrich, J., 2012. Supporting hospital staff to provide compassionate care: Do Schwartz Center Rounds work in English hospitals? *Journal of the Royal Society of Medicine* 105(3) pp.117-122.

Graber, D.R. & Mitcham, M.D., 2004. Compassionate clinicians: take patient care beyond the ordinary. *Holistic Nursing Practice* 18(2) pp.87-94.

Gray, B., 2008. The emotional labour of nursing – Defining and managing emotions in nursing work. *Nurse Education Today*. 29(2) pp.168-175.

Gray, D. E., 2009. *Doing Research in the Real World* 2<sup>nd</sup> Edition. London: Sage Publications Ltd.

Green, J., Thorogood, N., 2009. *Qualitative Methods for Health Research* 2nd Edition. London: Sage Publications.

Guardian, 2008. Nurses to be rated on how compassionate and smiley they are. Accessed online from <http://www.guardian.co.uk/society/2008/jun/18/nhs60.nhs1> on 4th August 2008.

Guba, E. G. and Lincoln, Y. S., 1989. *Fourth Generation Evaluation*. Newbury Park: Sage.

Grypdonck, M., 2008. Ethics of care, asymmetry, recognition and pity in nursing care. *Nursing Ethics* 15 (2) pp.274-275.

Halifax, J., 2011. The precious necessity of compassion. *Journal of Pain and Symptom Management*, 41(1) pp.146-153.

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) pp.577-588.

Healthcare Commission 2007a *Caring for dignity: A national report on dignity in care for older people while in hospital*. Commission for Healthcare Audit and Inspection. Accessed online from [http://www.healthcarecommission.org.uk/db/documents/Caring\\_for\\_dignity.pdf](http://www.healthcarecommission.org.uk/db/documents/Caring_for_dignity.pdf). on 29th December 2007.

Healthcare Commission, 2007b. *Investigation of outbreak of Clostridium Difficile at Maidstone and Tunbridge Wells NHS Trust*. Accessed online from <http://news.bbc.co.uk/1/hi/health/7037657.stm> on 23rd November 2011.

Healthcare Commission, 2009. *Investigation into Mid Staffordshire NHS Foundation Trust*. Accessed online from [www.cqc.org.uk/.../Investigation into Mid Staffordshire NHS Foundation Trust.pdf](http://www.cqc.org.uk/.../Investigation_into_Mid_Staffordshire_NHS_Foundation_Trust.pdf) on 21st December 2010.

Help the Aged, 1999. *The views of older people on hospital care: A survey* London: Help the Aged.

Help the Aged, 2007. *The Challenge of Dignity in Care: upholding the rights of the individual* Accessed online from [http://www.helptheaged.org.uk/NR/rdonlyres/30C24F74-6C35-4DF7-95D1-C996142CEFE9/0/dignity\\_in\\_care\\_300708.pdf](http://www.helptheaged.org.uk/NR/rdonlyres/30C24F74-6C35-4DF7-95D1-C996142CEFE9/0/dignity_in_care_300708.pdf) on 14th February 2009.

Help the Aged, 2008. *On our Own Terms: The challenge of assessing dignity in care*. Picker Institute Europe. Accessed online from [http://policy.helptheaged.org.uk/NR/rdonlyres/EFD769F8-930A-412E-B079-FD058EE6AA69/0/on\\_our\\_own\\_terms\\_021208.pdf](http://policy.helptheaged.org.uk/NR/rdonlyres/EFD769F8-930A-412E-B079-FD058EE6AA69/0/on_our_own_terms_021208.pdf) on 20<sup>th</sup> January 2009.

Hentz, P., 2007. Ethical decision-making: blending the voice of reason and the voice of compassion. *Pennsylvania Nurse* **62**(1) pp.14-15.

Heyes, A., 2004. The economics of vocation or 'why is a badly paid nurse a good nurse'? *Journal of Health Economics* **24**(3) pp.561-569.

Hochschild, A. (1983) *The Managed Heart*. Berkley Ca: University of California Press.

Hochschild, A. (2003) *The Managed Heart: Commercialisation of Human Feeling*. 20<sup>th</sup> Anniversary Edition. Berkley Ca: University of California Press.

Hojat, M., Mangione, S., Nasca, T.J., Cohen, M.J.M., Gonnella, J.S., Erdmann, J.B., Veloski, J., Magee, M., 2001. The Jefferson Scale of Physician Empathy: Development and Preliminary Psychometric Data. *Educational and Psychological Measurement* **61**(2) pp.349-365.

Hollins, S., Hope, P. & Sturton, E., 2008. Today Programme 30 September. Audio Accessed online from <http://news.bbc.co.uk/1/hi/health/7797868.stm> on 27th January 2009.

Holland, J., Thomson, R., Henderson, S., 2006. *Qualitative Longitudinal Research: A Discussion Paper* Families & Social Capital ESRC Research Group Working Paper No. 21 London South Bank University. Accessed online from [www.lsbu.ac.uk/families/workingpapers/familieswp21.pdf](http://www.lsbu.ac.uk/families/workingpapers/familieswp21.pdf) on 22nd September 2011.

Holmes, D., 2013. Mid Staffordshire scandal highlights NHS cultural crisis *The Lancet*, **381**(9866) pp. 521-522.

Hooper, C., Craig, J., Janvrin, D.R., Reimels, E., 2010. Compassion satisfaction, burnout, and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialties. *Journal of Emergency Nursing* **36**(5) pp.420-427.

Horsburgh, D., Ross, C., 2013. Care and compassion: the experiences of newly qualified staff nurses. *Journal of Clinical Nursing*. **22**(7-8) pp.1124-32.

House of Lords, House of Commons Joint Committee on Human Rights, 2007. *The Human Rights of Older People in Healthcare Eighteenth Report of Session 2006-2007*. Accessed online from <http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/jtrights.htm> on 19th April 2008.

Howitt, D., Cramer, D., 2008. *Introduction to Research Methods in Psychology*. Harlow: Pearson Education Limited.

Hunter, B., & Smith, P., 2007 Emotional labour: Just another buzz word? *International Journal of Nursing Studies* **44** pp.859–861.

Huynh, T., Alderson, M., Thompson, M., 2008 Emotional labour underlying caring: an evolutionary concept analysis. *Journal of Advanced Nursing* **64**(2) pp.195-208.

Hwan, J.Y. 2008. The Development of the Santa Clara Brief Compassion Scale: An Abbreviation of Sprecher and Fehr's Compassionate Love Scale. *Pastoral Psychology* DOI 10.1007/s11089-008-0117-2.

Jacobson, J.M., 2006, Compassion fatigue, compassion satisfaction and burnout: reactions among employee assistance professionals providing workplace crisis interventions and disaster management services. *Journal of Workplace Behavioural Health* **21**(3-4) pp.133-152.

Jenkins, B., Warren, N., 2012. Concept analysis: compassion fatigue and effects on critical care nurses. *Critical Care Nursing Quarterly* **35**(4) pp.388-35.

Johnson, M., 2008. Can compassion be taught? *Nursing Standard* **23**(11) pp.19-21.

Johnston, B., Smith, L.N., 2006. Nurses' and patients' perceptions of expert palliative care. *Journal of Advance Nursing* **54**(6), pp.700-709.

Joint Improvement Team, 2008. *The User Defined Service Evaluation Toolkit (UDSET): Support Pack for Staff Focusing on the outcomes important to users and carers*. Accessed online from <http://www.jitscotland.org.uk/downloads/1226937855-UDSETsupportpack0908%5B1%5D.doc> on 16<sup>th</sup> February 2009.

Kalish, R., Dawiskiba, M., Sung, Y., Blanco, M., 2011. Raising medical student awareness of compassionate care through reflection of annotated videotapes of clinical encounters. *Education for Health*. **24**(3) p.490.

Kelly, T.B., Tolson, D., Schofield, I., Booth, J., 2005. Describing Gerontological Nursing: An academic exercise of prerequisite for progress. *International Journal of Older People Nursing, in association with Journal of Clinical Nursing* **14**(3A) pp.13-23.

Kenneth B. Schwartz Centre, 2007. *Programs: You have the right to compassionate care*. Accessed online from [http://www.theschwartzcentre.org/programs/compassionatehealthcare\\_tips.html](http://www.theschwartzcentre.org/programs/compassionatehealthcare_tips.html) on 20th June 2008.

Keogh, B., 2013. Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. Accessed online from



<http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf> on 15th July 2013.

Kirkley, C., Bamford, C., Poole, M., Arksey, H., Hughes, J., Bond, J., 2011. The impact of organisational culture on the delivery of person-centred care in services providing respite care and short breaks for people with dementia *Health & Social Care in the Community* **19**(4) pp.438-448.

Kitson, A., Harvey, G., & McCormack, B., 1998. Enabling the implementation of evidence-based practice: a conceptual framework *Quality in Health Care* **7**(3) pp.149-158

Kitson, A., 2008. The need for systems change: reflections on knowledge translation and organisational change. *Journal of Advanced Nursing* **65**(1) pp.217-228.

Kitson, A., Rycroft-Malone, J., Harvey, G., McCormack, B., Seers, K., Titchen, A., 2008. Evaluating the successful implementation of evidence into practice using the PARIHS framework: theoretical and practical challenges *Implementation Science* **3**(1) pp.1-12.

Kitwood, T., 1997. *Dementia reconsidered: the person comes first*. Buckingham: Open University Press.

Koch, T., 2006. Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing* **53**(1) pp.91–103.

Knowledge Network (n.d.) *Emotional Touchpoints Starter Kit*. Accessed online from <https://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/1008113/Emotional%20Touch%20Points%20Starter%20Kit.pdf> on 1<sup>st</sup> May 2013.

Kunyk, D., & Olson, J., 2000. Clarification of conceptualizations of empathy. *Journal of Advanced Nursing*, **35**(3) pp.317–325.

La Monica, E. L., 2001. Construct validity of an empathy instrument. *Research in Nursing and Health* **4**(4) pp.389-400.

Lancet, 2007. Can caring for patients be taught? *The Lancet* (Editorial) **370**(9588) p.630.

Land, M., Hex, N., Bartlett, C., 2013. Building and aligning energy for change: A review of published and grey literature, initial concept testing and development. York Health Economics Consortium & Landmark Health Consulting. Accessed online from [http://www.changemodel.nhs.uk/pg/cv\\_content/content/view/44699/network?index=53](http://www.changemodel.nhs.uk/pg/cv_content/content/view/44699/network?index=53) on 14<sup>th</sup> April 2013.

Larson, E.B., Yoa, X., 2005. Clinical empathy as emotional labour in the patient-physician relationship. *Journal of American Medical Association* **293**(9) pp. 1100-1106.

Laurance, J., 2011. Hospital patients 'left so thirsty doctors had to prescribe water' Shortage of money is not the problem, but a failure to look beyond a patient's clinical needs, says the NHS Ombudsman *The Independent* 26 May. Accessed online from <http://www.independent.co.uk/life-style/health-and->

[families/health-news/hospital-patients-left-so-thirsty-doctors-had-to-prescribe-water-2289098.html?origin=internalSearch](http://www.nhs.uk/news/2012/06/families/health-news/hospital-patients-left-so-thirsty-doctors-had-to-prescribe-water-2289098.html?origin=internalSearch) on 10<sup>th</sup> June 2012.

Lilius, J.M., Worline, J.E., Dutton, J.E., Kanov, J., Frost, P.J., Maitlis, S., 2003. *What good is compassion at work?* Paper presented at National Academy of Management Meetings in Seattle, Washington (August, 2003). Accessed online from <http://www.compassionlab.com/docs/whatgoodiscompassion.pdf> on 9th February 2008.

Local Government Association, NHS Confederation, Age UK, 2012a. *Delivering Dignity: Securing dignity in care for older people in hospitals and care homes. A report for consultation.* Accessed on line from <http://www.nhsconfed.org/priorities/Quality/Partnership-on-dignity/Pages/Draftreportrecommendations.aspx> on 7th March 2012.

Local Government Association, NHS Confederation, Age UK, 2012b. *Delivering Dignity: Securing dignity in care for older people in hospitals and care homes.* Accessed on line from [http://www.nhsconfed.org/.../Delivering\\_Dignity\\_final\\_report150612.pdf](http://www.nhsconfed.org/.../Delivering_Dignity_final_report150612.pdf) on 17th August 2012.

Lorenz, L.S., 2011. A way into empathy: A 'case' of photo-elicitation in illness research. *Health* **15**(3) pp.59-67.

Loggia, M.L., Mogil, J.S., Bushnell, M.C., 2008. Empathy hurts: compassion for another increases both sensory and affective components of pain perception. *Pain* **136**, pp.167-176.

London Network, 2007. *Perceptions of care: Strategies for improving the patient experience.* London Network of nurses and midwives NHS London. Accessed online from <http://www.lnm.co.uk/publications/index.htm> on 20th September 2007.

*Longman's Dictionary of Contemporary English*, 2008. Harlow: Longman.

Luxford, K., Safran, D.G, Delbanco, T., 2011. Promoting patient-centered care: a qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving the patient experience *International Journal of Quality in Health Care.* **23**(5) pp.510-515.

Maben, J. & Griffiths, P., 2008. *Nurses in society: starting the debate.* National Nursing Research Unit, Kings College London, University of London. Accessed online from [www.kcl.ac.uk/content/1/c6/04/32/.../NursesinsocietyFinalreport.pdf](http://www.kcl.ac.uk/content/1/c6/04/32/.../NursesinsocietyFinalreport.pdf) on 10th June 2012.

Maben, J., Cornwell, J., Sweeney, K. 2010. In praise of compassion. *Journal of Research in Nursing* **15** (1) pp.9-13.

MacArthur, J., Sloan, S., Conway, L., Bonnar, F., 2010. *Impact of Leading Better Care Programme – The Managers' Perspective.* NHS Lothian. Unpublished report.

Macduff, C. & West, B.J., 2005. An evaluation of the first year of family health nursing practice in Scotland. *International Journal of Nursing Studies* **42**(1) pp.47-59.

MacFarlane, J.K. 1974, *The Proper Study of the Nurse*. The Study of Nursing Care Project Reports Series 1, Number 6. London: Royal College of Nursing and National Council of Nurses of the United Kingdom. p.28 Accessed online from [http://www.rcn.org.uk/data/assets/pdf\\_file/0016/235420/Series\\_1\\_Introduction.pdf](http://www.rcn.org.uk/data/assets/pdf_file/0016/235420/Series_1_Introduction.pdf) on 12th December 2013.

MacKay, R. & Dewar, B., 2009a. Using Emotional Touchpoints to learn about the experience of receiving care. *Improving Experience Briefing* 4. January. Accessed online from <http://www.napier.ac.uk/fhlss/NMSC/compassionatecare/practicemethods/Pages/EmotionalTouchpoints.aspx> on 27th September 2011.

MacKay, R. & Dewar, B. (2009b) Using digital photo frame as a method of disseminating key messages about compassionate caring to staff. *Improving Experience Briefing* 9. Accessed online from <http://www.napier.ac.uk/fhlss/NMSC/compassionatecare/practicemethods/Pages/PhotoFrame.aspx> on 27th September 2011.

Magee, H., Parsons, S. & Askham, J., 2008. *Measuring Dignity in Care for Older People: A research report for Help the Aged* London: Picker Institute Europe. Accessed online from <http://policy.helptheaged.org.uk/NR/rdonlyres/4EEDFA38-D850-4C53-81DE-C0D2664B50FE/0/MeasuringDignityinCareID8041.pdf> on 20th January 2009.

Manley, K., McCormack, B., Wilson, V., 2008. *International Practice Development in Nursing and Healthcare*. Oxford: Blackwell Publishing Ltd.

Mann, S., 2005 A health-care model of emotional labour: An evaluation of the literature and development of a model *Journal of Health Organization and Management* **19**(4/5) pp.304 – 317.

Manzano-Santaella, A., 2011. A realistic evaluation of fines for hospital discharges: Incorporating the history of programme evaluations in the analysis. *Evaluation* **17**(1) pp.21-36.

Marchionni, C. & Ritchie, J., 2008. Organizational factors that support the implementation of a nursing Best Practice Guideline *Journal of Nursing Management* **16**(3) pp.266-274.

McCance, T.V., 2003. Caring in nursing practice: the development of a conceptual framework. *Research and Theory for Nursing Practice: An International Journal* **17**, pp.101–116.

McCance, T., Slater, P. and McCormack, B., 2009. Using the caring dimensions inventory as an indicator of person-centred nursing. *Journal of Clinical Nursing* **18** pp.409–417.

McCance, T., McCormack, B., Dewing, J., 2011. An exploration of person-centredness in practice. *Online Journal of Issues in Nursing* **16**(2) Manuscript 1. Accessed online from

<http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-16-2011/No2-May-2011/Person-Centredness-in-Practice.html?css=print#Synergies> on 28<sup>th</sup> November 2011.

McCance, T., Telford, L., Wilson, J. & Macleod, O., 2012. Identifying key performance indicators for nursing and midwifery care using a consensus approach. *Journal of Clinical Nursing* **21** (7&8) pp-1145-1154.

McCormack, B., 2003. A conceptual framework for person-centred practice with older people. *International Journal of Nursing Practice* **9**(3) pp.202–209.

McCormack, B., 2004. Person-centredness in gerontological nursing: an overview of the literature *Journal of Clinical Nursing* **13**(3A) pp.31–38

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. & Garbett, R., 2003. The characteristics, qualities and skills of practice developers. *Journal of Clinical Nursing* **12**(3) pp.317-325

McCormack, B. and McCance, T. V., 2006. Development of a framework for person-centred nursing. *Journal of Advanced Nursing* **56**(5) pp.472–479

McCormack, B., Dewar, B., Wright, J., Garbett, R., Harvey, G., Ballantine, K., 2006. *A Realist Synthesis of Evidence Relating to Practice Development: Executive Summary* Accessed online from <http://www.nes.scot.nhs.uk/documents/publications/classa/ExecutiveSummaryPublishedVersion0606.pdf> on 16th February 2009.

McCormack, B., Wright, J., Dewar, B., Harvey, G., Ballantine, K., 2007. A realist synthesis of evidence relating to practice development: methodology and methods. *Practice Development in Health Care* **6**(1) pp.5–24.

McCormack, B., Mitchell, E.A., Reed, J., Childs, S., 2008. Older persons' experiences of whole systems: the impact of health and social care organisational structures. *Journal of Nursing Management* **16**(2) pp.105-114.

McCormack, B., Henderson, E., Wilson, V. and Wright, J., 2009. Making practice visible: The Workplace Culture Critical Analysis Tool (WCCAT). *Practice Development in Health Care* **8** pp.28–43.

McCormack, B. & McCance, T., 2010. *Person-centred Nursing: Theory and Practice*. Oxford: Wiley Blackwell.

McGill, L., & Brockbank, A., 2004. *The Action Learning Handbook*. London: Routledge, Falmer

McHolm, F., 2006. Rx for compassion. *Journal of Christian Nursing* **23**(4) pp.12-19.

McLellan, A. 2008. NHS60: Five days that shook the NHS *Health Service Journal* 30 April. Accessed online <http://www.hsj.co.uk/resource-centre/nhs60-five-days-that-shook-the-nhs/1330881.article#.UqowlbRFBIY> on 12<sup>th</sup> December 2013.

Meade, C.M., Bursell, A.L., Ketelsen, L., 2006. Effects of Nursing Rounds on Patients' Call Light Use, Satisfaction, and Safety *American Journal of Nursing* **106**(9) pp.58-70.

Medical Research Council, 2008. Developing and evaluating complex interventions: new guidance. Accessed online from [www.mrc.ac.uk/complexinterventionsguidance](http://www.mrc.ac.uk/complexinterventionsguidance) on 31st August 2011.

Mental Welfare Commission, 2011. *Starved of Care: Summary investigation report into the care and treatment of Mrs V*. Accessed online from [mwc.mrsv.summaryreport.pdf](http://mwc.mrsv.summaryreport.pdf) on 10<sup>th</sup> December 2011.

Mercer, S.W., McConnachie, A., Maxwell, M., Heaney, D., Watt, G.M.C, 2005. Relevance and practical use of the Consultation and Relational Empathy (CARE) Measure in general practice *Family Practice* **22**(3) pp.328-334

Meterko, M., Mohr, D.C., Young, G. J., 2004. Teamwork Culture and Patient Satisfaction in Hospitals. *Medical Care* **42**(5) pp. 492-498.

Meyer, S., 2007. Care with compassion: the case for palliative care. *Trustee* **60**(5) pp.20-24.

Meyer, J., 2000. Qualitative research in healthcare: Using qualitative methods in health related action research. *British Medical Journal* **320** (7228) pp.178-181.

Miller, C.B., 2009. Empathy, social psychology, and global helping traits. *Philosophical Studies* **142**(2) pp.247-275

Mitchell, M., 2011. Poor treatment of older people in the NHS is an attitude problem. *The Guardian* February 15. Accessed online from <http://www.guardian.co.uk/society/joepublic/2011/feb/15/poor-treatment-older-people-nhs> on 20th February 2011.

Mooney, H. 2009. Can you measure compassion? *NursingTimes Net* 21 April. Accessed online from <http://www.nursingtimes.net/whats-new-in-nursing/management/can-you-measure-compassion/5000543.article> on 14th January 2011.

Morse, J. M., Bottorff, J., Anderson, G., O'Brien, B., Solberg, S.,1992. Beyond empathy: expanding expressions of caring. *Journal of Advanced Nursing*. **17**(7) pp.809-21.

National Health Service (1968) Findings and recommendations following enquiries into allegations concerning the care of elderly patients in certain hospitals. London: HSMO. 3697. Accessed online <http://www.sochealth.co.uk/national-health-service/democracy-involvement-and-accountability-in-health/complaints-regulation-and-enquiries/allegations-concerning-the-care-of-elderly-patients-in-certain-hospitals/> on 12<sup>th</sup> December 2013.

National Institute for Health Research, 2013. Commissioning Brief: 13/07 - *After Francis: Research to strengthen organisational capacity to deliver compassionate care in the NHS*. Accessed online from

[http://www.netscc.ac.uk/hsdr/files/adhoc/commissioning-brief-13\\_07.pdf](http://www.netscc.ac.uk/hsdr/files/adhoc/commissioning-brief-13_07.pdf) on 10th April 2013.

National Nursing Research Unit (2012) *Intentional Rounding: What's the evidence?* Issue 35. Accessed online from <http://www.kcl.ac.uk/nursing/research/nuru/policy/By-Issue-Number/Policy--Issue-35final.pdf> on May 31st 2012.

National Research Ethics Service (2011) *Information sheets and consent forms guidance*. Accessed online from [http://www.nres.nhs.uk/applications/guidance/consent-guidance-and-forms/?1311929\\_entryid62=67013](http://www.nres.nhs.uk/applications/guidance/consent-guidance-and-forms/?1311929_entryid62=67013) on 17<sup>th</sup> October 2012.

Neale, B., 2010. What is qualitative longitudinal research? Accessed online from [www.timescapes.leeds.ac.uk/assets/files/brennealewhatisqlresearch.ppt](http://www.timescapes.leeds.ac.uk/assets/files/brennealewhatisqlresearch.ppt) on 22nd November 2011.

New Zealand Centre for Compassion in Healthcare, 2008. *Compassion in Healthcare* Accessed online from [http://www.clanz.org.nz/compassion\\_in\\_healthcare/](http://www.clanz.org.nz/compassion_in_healthcare/) on 20<sup>th</sup> June 2008.

NHS Confederation, 2008. *Futures debate: compassion in healthcare – the missing dimension of healthcare reform?* Futures Debate Series May: Paper 2. Accessed online from <http://www.debatepapers.org.uk> on 20<sup>th</sup> June 2008.

NHS Confederation, 2010. *Feeling better? Improving patient experience in hospital*. Accessed online from [www.nhsconfed.org.uk/Feeling\\_better\\_in\\_hospital\\_report.pdf](http://www.nhsconfed.org.uk/Feeling_better_in_hospital_report.pdf) on 10<sup>th</sup> June 2012.

NHS Education for Scotland, 2007. *The 10 Essential Shared Capabilities for Mental Health Practice Learning Materials (Scotland)*. Accessed online from <http://www.nes.scot.nhs.uk/mentalhealth/work/#values> on 16<sup>th</sup> January 2008.

NHS Education for Scotland, 2012. *People at the Centre of Health and Care*. Accessed online <http://www.nes.scot.nhs.uk/about-us/whats-new/people-at-the-centre-of-health-and-care.aspx> on 24th February 2013.

NHS Leadership Academy, 2013. *NHS Leadership Academy to launch largest ever development programme: leading with compassion*. Accessed online <http://www.leadershipacademy.nhs.uk/about/media/news/programmes/nhs-leadership-academy-to-launch-largest-ever-development-programme-leading-with-compassion/?repeat=w3tc> on 24<sup>th</sup> February 2013.

NHS Lothian, 2006. *The External Reference Group for Older People's Service*. Unpublished report.

NHS National Institute for Innovation and Improvement. 2006-2012 *The Productive Ward: Releasing Time to Care*. Accessed online [http://www.institute.nhs.uk/quality\\_and\\_value/productivity\\_series/productive\\_ward.html](http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html) on 2nd October 2012.

NHS Scotland, 2010. A Joint Declaration on NMAHP Leadership from Scotland's Chief Nursing Officer, Chief Health Professions' Officer and Nursing, Midwifery and Allied Health Professions Leaders. Accessed online

from <http://www.knowledge.scot.nhs.uk/qualitycouncils.aspx> on 10th December 2011.

NHS Scotland, 2012. *Scottish Patient Safety Programme*. Accessed online from [http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programme\\_on\\_2nd\\_October\\_2012](http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programme_on_2nd_October_2012).

Nicholson, C., Flatley, M., Wilkinson, C., Meyer, J., Dale, P., Wessel, L., 2010a. Everybody matters. 1: How getting to know your patients helps to promote dignified care. *Nursing Times* **106**(20) pp.12-14.

Nicholson, C., Flatley, M., Wilkinson, C., Meyer, J., Dale, P., Wessel, L. 2010b. Everybody matters 2: promoting dignity in acute care through effective communication. *Nursing Times* **106**(21) pp.12-14.

Nicholson, C., Flatley, M., Wilkinson, C., 2010c. Everybody matters 3: engaging patients and relatives in decision making to promote dignity. *Nursing Times* **106**(22) pp.10-12.

NIHR, 2013 13/07 Commissioning Brief 'After Francis: Research to strengthen organisational capacity to deliver compassionate care in the NHS' Health Services and Delivery Research Programme. Accessed online from [http://www.netccc.ac.uk/hsdr/commissionedcalls.html?src=call\\_alert\\_March\\_13\\_after\\_francis\\_01](http://www.netccc.ac.uk/hsdr/commissionedcalls.html?src=call_alert_March_13_after_francis_01) on 1<sup>st</sup> May 2013.

NMAHP Research Unit, 2013. *The Scottish Person Centred Interventions Collaboration*. Accessed online from <http://www.g-apframework.scot.nhs.uk/SCOPIC/Studies/IPECHome.aspx> on 20th May 2013.

Nolan, M.R., 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* in association with *Journal of Clinical Nursing* **13**(3a) pp.45–53.

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. Accessed online from [www.shura.shu.ac.uk/280/1/PDF\\_Senses\\_Framework\\_Report.pdf](http://www.shura.shu.ac.uk/280/1/PDF_Senses_Framework_Report.pdf) on 10th June 2012.

Noravian, A., 2008. Compassion, empathy and being a humanist. *The Humanist* March-April, pp.33-35. Accessed online from <http://thehumanist.org/march-april-2008/compassion-empathy-and-being-a-humanist/> on 10<sup>th</sup> June 2012.

Nouwen, H.J.M., McNeil, D.P., Morrison, D.A., 1982. *Compassion: A reflection on the Christian Life*. Doubleday Ltd.

Nursing and Midwifery Council, 2010. *Guidance for the Care of Older People*. Accessed online from [www.nmc-uk.org/.../Guidance/Guidance-for-the-care-of-older-people.pdf](http://www.nmc-uk.org/.../Guidance/Guidance-for-the-care-of-older-people.pdf) on 20th December 2012.

Nursing and Midwifery Council, 2012. *NMC and GMC release joint statement on professional values*. Accessed online from <http://www.nmc-uk.org/Press->

[and-media/Latest-news/NMC-and-GMC-release-joint-statement-on-professional-values/](#) on 24<sup>th</sup> February 2013.

Nursing Standard, 2011. What causes poor care. Transcript of meeting held by Nursing Standard and Patients Association 21 October 2011. Accessed online <http://nursingstandard.rcnpublishing.co.uk/campaigns/care-campaign/what-causes-poor-care/transcript> on 9th December.

Nussbaum, M.C., 2003. *Upheavals of Thought: The Intelligence of Emotions*. Cambridge: Cambridge University Press.

Oakely, J., 1992. *Morality and Emotions* London: Routledge. Cited in Sabo, B.M., 2006. Compassion fatigue and nursing work: can we accurately capture the consequences of caring work? *International Journal of Nursing Practice* **12** (3) p.137.

Olsen, D.P., 2007. Ethical cautions for nurses. *American Journal of Nursing* **107**(7), p.75

Oroviogicoechea, C. & Watson, R., 2009. A quantitative analysis of the impact of a computerised information system on nurses' clinical practice using a realistic evaluation framework. *International Journal of Medical Informatics* **78**(12) pp.839-849.

Oxford English Dictionary Online, 2008 *Compassion*. Accessed online from <http://dictionary.oed.com> on 19<sup>th</sup> August 2008.

Paice, E., Heard, S.R. & Moss, F., 2002. How important are role models in making good doctors? *British Medical Journal* **325**(7366) pp.707-101.

Parker, V.A., 2002. Connecting relational work and workgroup context in caregiving organizations. *Journal of Applied Behavioural Science* **38** (3) pp.276-297.

Parkinson, M., 2010. *My Year as National Dignity Ambassador* Dignity in Care Network. Accessed online from <http://www.dignityincare.org.uk/Ambassador/12345/> on 21<sup>st</sup> December 2010.

Parliamentary Health Service Ombudsman, 2011. *Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people*. Accessed online from <http://www.ombudsman.org.uk/care-and-compassion/home> on 27th October 2011.

Patients Association, 2009. *Patients ... not numbers, People ... not statistics*. Accessed online from <http://www.patients-association.org.uk/DBIMGS/file/Patients%20not%20numbers,%20people%20not%20statistics.pdf> on 4<sup>th</sup> September 2009.

Patients Association, 2010. *Listen to Patients, Speak Up for Change*. Accessed online from [http://www.patients-association.com/dbimgs/Listen\\_to\\_patients\\_Speak\\_up\\_for\\_change\(1\).pdf](http://www.patients-association.com/dbimgs/Listen_to_patients_Speak_up_for_change(1).pdf) on 21<sup>st</sup> December 2010.

Patients Association, 2011. *We've been listening, have you been learning?* Accessed online from <http://patients-association.com/default.aspx?tabid=80&Id=23> on 9<sup>th</sup> November 2011.



- Patterson, C., 2011. Christina Patterson: Nasty nurses? Tell me something new. *The Independent* 16 February. Accessed online from <http://www.independent.co.uk/opinion/commentators/christina-patterson/christina-patterson-nasty-nurses-tell-me-something-new-2215918.html> on 27th February 2011.
- Patterson, M., Nolan, M, Rick, J., Brown, J., Adams, R., Musson, G., 2010a. *From Metrics to Meaning: Culture change and quality of acute hospital care for older people*. Report for the National Institute for Health Research Service Delivery and Organisation programme. Accessed online from [www.netscc.ac.uk/hhdr/files/project/SDO\\_FR\\_08-1501-93\\_V01.pdf/](http://www.netscc.ac.uk/hhdr/files/project/SDO_FR_08-1501-93_V01.pdf/) on 20<sup>th</sup> March 2012.
- Patterson, M., Nolan, M, Rick, J., Brown, J., Adams, R., Musson, G., 2010b. *From Metrics to Meaning: Culture change and quality of acute hospital care for older people*. Executive summary for the National Institute for Health Research Service Delivery and Organisation programme. Accessed online from [www.sdo.nihr.ac.uk/files/project/93-exec-summary.pdf](http://www.sdo.nihr.ac.uk/files/project/93-exec-summary.pdf) on 28th November 2011.
- Patton, M. Q., 2002. *Qualitative Research and Evaluation Method 3<sup>rd</sup> Edition*. Sage Publications Ltd: London.
- Pawson R., & Tilley N., 1997. *Realistic Evaluation*. Sage Publications Ltd: London.
- Peate, I., 2011. 'Shame on us nurses' *BBC News* 21 October. Accessed online from <http://www.bbc.co.uk/news/health-15388038> on 27th November 2011.
- Phillips, J.L., Davidson, M., Ollerton, Jackson, D., Kristjanson, L., 2007. A survey of commitment and compassion among nurses in residential aged care. *International Journal of Palliative Nursing* **13**(6) pp.282-290.
- Potter, P., Deshields, T., Berger, J.A., Clarke, M., Olsen, S., Chen, L., 2013. Evaluation of compassion fatigue resilience programme for oncology nurses. *Oncology Nursing Forum* **40**(2) pp.180-187.
- Powell, A.E., Rushmer, R.K., Davies, H.T.O, 2009. *A systematic narrative review of quality improvement models in healthcare*. Social Dimensions of Health Institute of the University of Dundee and St. Andrews: NHS Quality Improvement Scotland. Accessed on line from [http://www.healthcareimprovementscotland.org/previous\\_resources/hta\\_report/a\\_systematic\\_narrative\\_review.aspx](http://www.healthcareimprovementscotland.org/previous_resources/hta_report/a_systematic_narrative_review.aspx) on 10th February 2013.
- Prater, L., 2006. Called to nursing: perceptions of student nurses. *Journal of Holistic Nursing* **24**(1) pp.63-69.
- Proctor, S., 2007. Can nurses show compassion? *Nursing Management* **14**(8) pp. 10-11.
- Pullin, S., 2009. Beliefs and Values: clarification to improve understanding of ward culture *Improving Experience Briefing* 3. Accessed online from <http://www.napier.ac.uk/fhlss/NMSC/compassionatecare/practicemethods/Pages/BeliefsandValues.aspx> on 27<sup>th</sup> September 2011.

Purdon, S., Lessof, C., Woodfield, K., Bryson, C., 2001. *Research Methods for Policy Evaluation: Department for Work and Pensions Research Working Paper No. 2*. London: National Centre for Social Research. Accessed online from <http://www.dwp.gov.uk/asd/asd5/WP2.pdf> on 16th February 2009.

Rafferty, A., Ball, J., Aiken, L.H. 2001 Are teamwork and professional autonomy compatible, and do they result in improved hospital care? *Quality in Health Care*. **10**(2) pp.32–7.

Rafferty, A., 2008. Foreword to Maben, J. & Griffiths, P., 2008. *Nurses in society: starting the debate*. National Nursing Research Unit, Kings College London, University of London. Accessed online from <http://www.kcl.ac.uk/schools/nursing/nuru/reviews/nis.html> on 30th March 2009.

Ramunujam, R., Abrahamson, K., & Anderson, J.G., 2008. Influence of workplace demands on nurses' perception of patient safety *Nursing and Health Sciences* **10**(2) pp.144-150.

Ray, S.I., Wong, C., White, D., Heaslip, K. 2013. Compassion satisfaction, compassion fatigue, work life conditions and burnout amongst frontline mental health care professionals. *Traumatology*. Published online before print January 9, doi: 10.1177/1534765612471144. Accessed online from <http://tmt.sagepub.com/content/early/2013/01/09/1534765612471144.abstract> on 20th May 2013.

Redelmeier, D.A., Molin, J-P., Tibshirani, R.J., 1995. A randomised trial of compassionate care for the homeless in an emergency department. *The Lancet* **345**(8958) pp.1131-1134.

Redfern, S., Christian, S., Norman, I., 2003. Evaluating change in healthcare practice: lessons from three studies. *Journal of Evaluation in Clinical Practice* **9**(2), pp.239-249.

Reed, J. McCormack, B., 2007. Editorial: the importance of dignity. *International Journal of Older People Nursing* **2** (3) p.61.

Reed, J. 2012 Is nursing lacking in compassion? *The Guardian* 4 December. Accessed online from <http://www.guardian.co.uk/commentisfree/2012/dec/04/is-nursing-lacking-in-compassion-on-24th-February-2013>.

Robb, B., 1967 *Sans Everything: a case to answer*. Aid for the Elderly in Government Institutions. Cited in McLellan, A. 2008. NHS60: Five days that shook the NHS *Health Service Journal* 30 April. Accessed online <http://www.hsj.co.uk/resource-centre/nhs60-five-days-that-shook-the-nhs/1330881.article#.UqowlbRFBIY> on 12<sup>th</sup> December 2013.

Rogers, C., 1975. Empathic: An unappreciated way of being. *Counselling Psychologist* **5** pp.2-10. cited in Sabo, B.M., 2006. Compassion fatigue and nursing work: can we accurately capture the consequences of caring work? *International Journal of Nursing Practice* **12** (3) pp.137.

Ross, A.J., Anderson, J.E., Kodate, N., Thomas, L. Thompson, K., Thomas, B., Key, S., Jensen, Schiff, R., Jaye, P., 2012 Simulation training for improving

the quality of care for older people: an independent evaluation of an innovative programme for inter-professional education. *BMJ Quality and Safety*. Accessed online <http://qualitysafety.bmj.com/content/early/2012/12/05/bmjqs-2012-000954.short> on 6th April 2013.

Rossi P.H., Lipsey, M.W., Freeman, H.E., 2004. *Evaluation: a systematic approach* London: Sage Publications.

Royal College of Nursing, 2008a *Dignity: at the heart of everything we do* Accessed online from <http://www.rcn.org.uk/newsevents/campaigns/dignity> on 22nd March 2009.

Royal College of Nursing, 2008b. *Defending dignity – challenges and opportunities for nursing*. Royal College of Nursing, London. Accessed online from [www.rcn.org.uk/data/assets/pdf\\_file/0011/166655/003257.pdf](http://www.rcn.org.uk/data/assets/pdf_file/0011/166655/003257.pdf) on 10th June 2010.

Royal College of Nursing, 2009. Breaking down barriers, driving up standards: The role of the ward sister and charge nurse. Accessed on line from [http://www.rcn.org.uk/data/assets/pdf\\_file/0009/287784/003312.pdf](http://www.rcn.org.uk/data/assets/pdf_file/0009/287784/003312.pdf) on 1st May 2013.

Royal College of Nursing, 2010a. *Dignity Campaign Publications and Resources*. Accessed online from [http://www.rcn.org.uk/newsevents/campaigns/dignity/publications\\_and\\_resources](http://www.rcn.org.uk/newsevents/campaigns/dignity/publications_and_resources) on 16th December 2010.

Royal College of Nursing, 2010b. *Making the business case for ward sisters/team leaders to be supervisory to practice*. Accessed online from [http://www.rcn.org.uk/data/assets/pdf\\_file/0005/414536/004188.pdf](http://www.rcn.org.uk/data/assets/pdf_file/0005/414536/004188.pdf) on 1st May 2013

Royal College of Nursing, 2011. *Informed consent in health and social care: RCN guidance for nurses*. Accessed online from [http://www.rcn.org.uk/data/assets/pdf\\_file/0010/78607/002267.pdf](http://www.rcn.org.uk/data/assets/pdf_file/0010/78607/002267.pdf) on 17th October 2012.

Royal College of Nursing, 2012. *Quality with Compassion: the future of nursing education*. Report of the Willis Commission on Nursing Education.

Ryan, T., Nolan, M., Reid, D., Enderby, P., 2008. Using the Senses Framework to achieve relationship-centred dementia care service. *Dementia* 7(1) pp.71–93.

Ryan-Nicholls, K.D., Will, C.I., 2009. Rigour in qualitative research: mechanisms for control. *Nurse Researcher* 16(3) pp.70-85.

Rycroft-Malone, J., Harvey, G., Seers, K., Kitson, A., McCormack, B., Titchen, A., 2002a. An exploration of the factors that influence the implementation of evidence into practice. *Journal of Clinical Nursing* 13(8) pp.913-924

Rycroft-Malone, J., Kitson, A., Harvey, G., McCormack, B., Seers, K., Titchen, A., Eastbrooks, C., 2002b. Ingredients for change: revisiting a conceptual model. *Quality and Safety in Health Care* 11 pp.174-180.

- Rycroft-Malone, J., Wilkinson, J.E., Burton, C.R., Andrews, G., Ariss., Baker, R., Dopson, S., Graham, I., Harvey, G., Martin, G., McCormack, B.G., 2011. Implementing health research through academic and clinical partnerships: a realistic evaluation of the Collaborations for Leadership in Applied Health Research and Care (CLAHRC). *Implementation Science* **6** pp.74-86
- Sabo, B.M., 2006. Compassion fatigue and nursing work: can we accurately capture the consequences of caring work? *International Journal of Nursing Practice* **12** (3) p.137.
- Sackett, D.L., Rosenberg, W. M., Gray, J. A., Haynes, R. B., Richardson, W. S., 1996. Evidence based medicine: What it is and what it isn't. *British Medical Journal* **312** pp.71-72.
- Sadler, J.J., 2004. Descriptions of caring uncovered in students' baccalaureate program admission essays. *International Journal of Human Caring* **8** pp.37-46
- Saldana, J., 2003. *Longitudinal qualitative research: Analyzing change through time*, Walnut Creek, Lanham, New York, Oxford: Altamira Press. Cited in Holland, J., Thomson, R., Henderson, S., 2006. *Qualitative Longitudinal Research: A Discussion Paper* Families & Social Capital ESRC Research Group Working Paper No. 21 London South Bank University. Accessed online from [www.lsbu.ac.uk/families/workingpapers/familieswp21.pdf](http://www.lsbu.ac.uk/families/workingpapers/familieswp21.pdf) on 22nd September 2011.
- Salvage, J., 2007. 'Too posh to wash' is a common charge. *The Independent* 22<sup>nd</sup> November. Accessed online on <http://www.independent.co.uk/student/career-planning/jane-salvage-too-posh-to-wash-is-a-common-charge-758956.html> on 9th December 2011.
- Sanghavi, D.M., 2006. What Makes for a Compassionate Patient-Caregiver Relationship? *Journal on Quality and Patient Safety* **32**(5) pp.283-292.
- Schantz, M., 2007. Compassion: a concept analysis. *Nursing Forum* **42**(2) pp.48-55.
- Schulz, R., Herbert, R.S., Dew, M.A., Brown, S.L., Scheier, M.F., Beach, S.R., Czaja, S.J., Martire, L.M., Coon, D., Langa, K.M., Gitlin, L.N., Stevens, A.B., Nichols, L., 2007. Patient suffering and caregiver compassion: new opportunities for research, practice and policy. *The Gerontologist* **47**(1) pp.4-13.
- Schwartz, K.B., 1995. A patient's story. *Boston Globe Magazine* July 16, 1995. excerpt accessed online from The Schwartz Centre for Compassionate Care <http://www.theschwartzcenter.org/ViewPage.aspx?pageld=50> on 9<sup>th</sup> November 2011.
- Scottish Executive, 2002. *Adding Life to Years: Report of the Expert Group on Healthcare of Older People*. Accessed online from [www.scotland.gov.uk/Publications/2002/01/10624](http://www.scotland.gov.uk/Publications/2002/01/10624) on 10th June 2012.
- Scottish Executive, 2006. *Research Governance Framework for Health and Community Care*. 2<sup>nd</sup> Edition. Accessed online from <http://www.cso.scot.nhs.uk/publications/ResGov/Framework/RGFEdTwo.pdf> on 17th October 2012.

Scottish Executive, 2006. *Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland*. Accessed online from [www.scotland.gov.uk/Publications/2006/04/18164814](http://www.scotland.gov.uk/Publications/2006/04/18164814) on 10th June 2012.

Scottish Executive Health Department, 2006. *Delivering Care, Enabling Health: Harnessing the Nursing, Midwifery and Allied Health Professions' Contribution to Implementing Delivering for Health in Scotland*. Scottish Executive. Accessed online from [www.scotland.gov.uk/Resource/Doc/152499/0041001.pdf](http://www.scotland.gov.uk/Resource/Doc/152499/0041001.pdf) on 10th June 2012.

Scottish Government, 2007. *Better Health, Better Care: Action Plan*. Accessed online from [www.scotland.gov.uk/Resource/Doc/206458/0054871.pdf](http://www.scotland.gov.uk/Resource/Doc/206458/0054871.pdf) on 21st December 2010.

Scottish Government, 2008a. *Leading Better Care: Report of the Senior Charge Nurse Review and Clinical Quality Indicators Project*. Accessed online from [www.scotland.gov.uk/Publications/2008/05/30104057/4](http://www.scotland.gov.uk/Publications/2008/05/30104057/4) on 10th June 2012.

Scottish Government, 2008b *Adults with Incapacity (Scotland) Act 2000 Part 5 Code of Practice*. Accessed online from [http://www.sehd.scot.nhs.uk/mels/CEL2008\\_11.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2008_11.pdf) on 17th October 2012.

Scottish Government, 2010a. *The Healthcare Quality Strategy for NHSScotland*. Accessed online from [www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf](http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf) on 21st December 2010.

Scottish Government, 2010b. *Better Together: Scotland's Patient Experience Programme*. Accessed online from [http://www.bettertogetherscotland.com/bettertogetherscotland/CCC\\_FirstPage.jsp](http://www.bettertogetherscotland.com/bettertogetherscotland/CCC_FirstPage.jsp) on 21st December 2010.

Scottish Government, 2011a. *Scottish Inpatient Patient Experience Survey 2011 Volume 1: National Results*. Accessed online from <http://www.scotland.gov.uk/Publications/2011/08/25164241/0> on 23rd November 2011.

Scottish Government, 2011b. *Care for older people is top priority* News Release. Accessed online from <http://scotland.gov.uk/News/Releases/2011/06/06101224> on 10th December 2011.

Scottish Government, 2012. *Scottish Inpatient Patient Experience Survey 2012 Volume 1: National Results*. Accessed online from <http://www.scotland.gov.uk/Resource/0040/00400672.pdf> on 5<sup>th</sup> September 2012.

Scottish Government Health Department, 2006a. *Delivering Care, Enabling Health: Harnessing the Nursing, Midwifery and Allied Health Professions' Contribution to Implementing Delivering for Health in Scotland* Scottish Executive. Accessed online from [www.scotland.gov.uk/Resource/Doc/152499/0041001.pdf](http://www.scotland.gov.uk/Resource/Doc/152499/0041001.pdf) on 10th June 2012.

Scottish Health Council (2013) *Emotional Touchpoints* Accessed online [http://www.scottishhealthcouncil.org/patient\\_public\\_participation/participation\\_toolkit/emotional\\_touchpoints.aspx](http://www.scottishhealthcouncil.org/patient_public_participation/participation_toolkit/emotional_touchpoints.aspx) on 30th April 2013.

Sheild, R.R., Tong, I., Tomas, M., Besdine, R.W., 2011. Teaching communication and compassionate care skills: An innovative curriculum for pre-clerkship medical students. *Medical Teacher* **33**(8) pp. 408-416.

Shiell, A., Hawe, P., Gold, S., 2008. Complex interventions or complex systems? Implications for health economic evaluation. *British Medical Journal* **336**(7656) pp.1281–1283.

Siriwardena, A.N., 2007. Experimental methods in health research. In Saks, M. & Allsop, J. (Eds) *Researching Health: Qualitative, Quantitative and Mixed Methods* London: Sage Publications Ltd pp.246-264.

Smith, P., 1992. *The Emotional Labour of Nursing: How Nurses Care*. Basingstoke: Palgrave Macmillan.

Smith, P., Lorentzon, M., 2005. Is emotional labour ethical? *Nursing Ethics* **12**(6) pp.638-642.

Smith, P., 2008. Compassion and smiles: what's the evidence? *Journal of Research in Nursing* **13**(5) pp.367-370.

Smith, R., 2009. 'Cruel and neglectful' care of one million NHS patients exposed. *The Telegraph* 27 August. Accessed online from <http://www.telegraph.co.uk/health/healthnews/6092658/Cruel-and-neglectful-care-of-one-million-NHS-patients-exposed.html> on 9th December 2011.

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) pp.128–136.

Spandler, S., Stickley, T., 2011. No hope without compassion: the importance of compassion in recovery-focused mental health services. *Journal of Mental Health* **20**( 6) pp.555-566.

Sprinks, J., 2013. Universities demand that new students demonstrate empathy. *Nursing Standard* **27**(21) pp.12-13.

Strachan, H. 2011. Summary of Scoping of the Literature for the Care Governance Measurement Framework. Accessed online from <http://www.knowledge.scot.nhs.uk/qualitycouncils/support-workstreams/care-governance-measurement-and-ehealth.aspx> on 10th December 2011. 10/12/11.

Strachan, H., 2012b. *Assuring care experience: a person-centred approach*. Full report. Accessed online <http://www.wenurses.co.uk/MyNurChat/archive/LDdownloads/AssuringCareFullreport4.pdf> on 24th February 2014.

Stockwell, F., 1972. *The Unpopular Patient* London: RCN Publications.

Straughair, C., 2012a. Exploring compassion: implications for contemporary nursing. Part 1. *British Journal of Nursing*. **21**(3) pp.160-164.

- Straughair, C., 2012b. Exploring compassion: implications for contemporary nursing. Part 2. *British Journal of Nursing*. **21**(4) pp.239-243.
- Sturgeon, D., 2008. Measuring compassion in nursing. *Nursing Standard*. **22**(46) pp.42-43.
- Sussman, M.B., 1995. *A Perilous Calling: The Hazards of Psychotherapy Practice* John Wiley and Sons.
- Suwanski, M., 2004. Getting through the night. *Hospital Nursing* **34**(7) p.32.
- Taylor, J., 2011. The intimate insider: negotiating the ethics of friendship when doing insider research *Qualitative Research* **11**(1) pp.3–22.
- The Independent, 2011. Leading article: Treatment of the elderly is a national disgrace: It is too easy to blame budget cuts or work pressures and look no further. *The Independent* October 14. Accessed online from <http://www.independent.co.uk/voices/editorials/leading-article-treatment-of-the-elderly-is-a-national-disgrace-2370154.html> on 15th October 2011.
- The King's Fund, 2009. *Point of Care Project*. Accessed online from [www.kingsfund.org.uk/current\\_projects/the\\_point\\_of\\_care/](http://www.kingsfund.org.uk/current_projects/the_point_of_care/) on 21<sup>st</sup> December 2011.
- The King's Fund, 2011. *Patient-centred Care Project: Evaluation Report* Accessed online from [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/patient-centred-care-project-evaluation-aug11.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/patient-centred-care-project-evaluation-aug11.pdf) on 19th January 2012.
- The King's Fund, 2013. *The Francis Inquiry: creating the right culture of care*. Accessed online from <http://www.kingsfund.org.uk/projects/francis-inquiry-creating-right-culture-care> on 30th March 2013.
- Tobin, G.A., Begley, C.M., 2004 Methodological rigour within a qualitative framework. *Journal of Advanced Nursing* **48**(4) pp.388–396
- Tolson, D., 1999. Practice innovation: a methodological maze. *Journal of Advanced Nursing* **30**(2) pp.381-390.
- Tolson, D., McIntosh, J., Loftus, L., Cormie, P., 2007. Developing a managed clinical network in palliative care: a realistic evaluation. *International Journal of Nursing Studies* **44**(2) pp.183-195.
- Torjul, T., Elstadd, I. & Sørli, V., 2007. Compassion and responsibility in surgical care. *Nursing Ethics* **14**(4) pp.522-534.
- Trajkovski, S., Schmied, V., Vickers, M., Jackson, D., 2013. Implementing the 4D cycle of appreciative inquiry in health care: a methodological review. *Journal of Advanced Nursing* **69**(6) pp.1224-1234.
- Tresolini, C.P., 1994. *Health Professions Education and Relationship-centered Care*. San Francisco, CA: Pew Health Professions Commission.
- Urquhart, G., 2011. Person Centred - Presentation - NMAHP Leaders' Event - 6 May 2011 Edinburgh. Accessed online from

<http://www.knowledge.scot.nhs.uk/qualitycouncils/resources-library/resource-detail.aspx?id=1010301> on 10<sup>th</sup> December 2011.

Van Bogaert, P., Meulmans, H., Clarke, S., Vermeyen, K., Van de Heyning, P., 2009. Hospital nurse practice environment, burnout, job outcomes and quality of care: test of a structural equation model. *Journal of Advanced Nursing* **65**(10) pp.2175–2185.

Van der Cingel, M., 2011., Compassion in care: A qualitative study of older people with a chronic disease and nurses. *Nursing Ethics* **18**(5) pp.672-685.

Wainwright, S.P., 1997. A new paradigm for nursing: the potential of realism. *Journal of Advanced Nursing* **26** pp.1262-1271.

Walshe, K., 2007. Understanding what works – and why – in quality improvement: the need for theory-driven evaluation. *International Journal for Quality in Health Care* **19**(2) pp.57-59.

Wand, T., White, K., Patching, J., 2010. Contemporary mental health program implementation and evaluation. *Issues in Mental Health Nursing* **31**(11) pp.716-722.

Waterman, H., Tillen, D., Dickson, R., & de Koning., 2001. Action research: a systematic review and guidance for assessment. *Health Technology Assessment* **5**(23).

Watson, J., 1985. *Nursing: The Philosophy and Science of Caring*. Colorado Associated University Press, Boulder.

Watson, J., 2002. *Assessing and Measuring Caring in Nursing and Health Science* New York: Springer Publishing Company.

Webster, J., 2007. 'We all need to challenge practices that do not value a person's right to dignity' *Nursing Times* **103**(15) p.10.

Weiss, C. H., 1998. *Evaluation: Methods for studying programs and policies 2<sup>nd</sup> Edition*. New Jersey: Prentice Hall.

Welsh Assembly Government, 2006. *National Service Framework for Older People in Wales*. Accessed online from <http://new.wales.gov.uk/publications/circular/circulars2006/1552921/?lang=en> on 22<sup>nd</sup> March 2009.

Welsh Assembly Government (2008) *Free to Lead, Free to Care: Empowering Ward Sisters/Charge Nurses Ministerial Task and Finish Group*. Accessed online from <http://www.wales.nhs.uk/documents/Cleanliness-Report.pdf> on 1st May 2013.

West, E., Barron, D. N., Reeves, R., 2005. Overcoming the barriers to patient-centred care: time, tools and training. *Journal of Clinical Nursing* **14**(4) pp.435–443.

Whyte, A., 2008. What is going on? *Nursing Standard* **22**(23) pp.18-22.

Wilkinson, H., & MacArthur, J., 2009. *NHS Lothian Values Based Framework Improving Experience Briefings*. Accessed online from



[http://www.cfr.ac.uk/researchprojects/rp\\_kesustain.html](http://www.cfr.ac.uk/researchprojects/rp_kesustain.html) on 28th November 2011  
Williams, C. R., 2008. Compassion, suffering and the self: a moral psychology of social justice. *Current Sociology* **56** (1) pp.524.

Williams, L., Burton, C., Rycroft-Malone., 2013. What works: a realist evaluation case study of intermediaries in infection control practice. *Journal of Advanced Nursing* **69**(4) pp.915-926.

Wilson, A.N., 2011. Yes, most are still angels. But why is Britain now producing nurses without a scintilla of compassion? *The Daily Mail*. 27 May. Accessed online from <http://www.dailymail.co.uk/debate/article-1391379/Why-Britain-producing-nurses-scintilla-compassion.html> on 21<sup>st</sup> October 2011.

Wilson, V.J., McCormack, B.G., & Ives, G., 2005. Understanding the workplace culture of a special care nursery. *Journal of Advanced Nursing* **50**(1) pp.27-38.

Wispé, L., 1986. The distinction between sympathy and empathy: to call forth a concept, a word is needed *Journal of Personality and Social Psychology* **50**(2), pp.314-321.

Wong, C.A., Cummings, G.C., 2007. The relationship between nursing leadership and patient outcomes: a systematic review. *Journal of Nursing Management* **15**(5) pp.508-521.

Wright, J., McCormack, B., Coffey, A., McCarthy, G., 2006. Developing a tool to assess person-centred continence care. *Nursing Older People* **18**(6) pp.23-28.

Wright, S., 2007. Powerful presence. *Nursing Standard* **22**(10) pp.24-25.

Yoffe, S.J., Moore, R.W., Dadfar, N.M., McKay, R.L., Mclellan, D.A., Huang, T.Y., 2011. A reduction in emergency department use by children from a parent educational intervention. *Family Medicine* **43**(2) pp.106-11.

Youngson, R., 2008. cited in NHS Confederation, 2008. *Futures debate: compassion in healthcare – the missing dimension of healthcare reform?* Futures Debate Series May: Paper 2, p3. Accessed online from <http://www.debatepapers.org.uk> on 20<sup>th</sup> June 2008.

Yu, J. & Kirk, M., 2008. Measurement of empathy in nursing research: systematic review. *Journal of Advanced Nursing* **64**(5) pp.440-454.

Yu, J., Kirk, M. 2009. Evaluation of empathy measurement tools in nursing: systematic review. *Journal of Advanced Nursing* **65**(9) pp.1790-1806.

## Appendix 1 Literature Review – Search Strategy

A number of approaches were taken for the literature review.

Stage 1: September 2007 – December 2009

- Systematic search of the following databases: British Nursing Index, Medline, CINAHL, Embase, PsychInfo, Health Management Information Consortium (HMIC) and Google Scholar
- Key terms ‘compassion’, ‘compassionate care’, ‘nursing’, ‘older people’, ‘hospital’, ‘empathy’, ‘sympathy’, ‘dignity’, ‘person-centred care’, ‘patient-centred care’.
- Dates for the searches were from 1996 – 2009.
- Criteria for inclusion were not based on the quality of any studies, but on their relevance to my examination of the concepts themselves and as a means to identify whether there were relevant empirical studies.

Stage 2: December 2009 to present

- Continuation of search strategy outlined in Stage 1
- Creation of alerts following choice of research methodology and formulation of research questions:
  - ‘Zetoc’ database - ‘compassion’, ‘compassionate care’, ‘person-centred care’, ‘dignity’, ‘empathy’, ‘emotional labour’, ‘realistic evaluation’
  - Google – ‘compassionate care’
- These alerts allowed me to keep abreast of emerging literature, although many of the studies or commentaries on compassionate care were unrelated to nursing there were interesting insights into its use in relation to social care programmes (for example Compassionate Care Benefits for employment insurance in Canada), the medical use of cannabis (for example the Kansas Cannabis Compassionate Care Bill in the USA) and an increasing recognition of ‘compassion fatigue’ in a whole range of professional groups.
- Regular monitoring of news reports via a range of media – online, radio and television.

## **Appendix 2: Interview Schedules**

### **A. Practitioner Stakeholders (LCC Senior Nurses) (Phase One)**

- Definition of compassionate care
- Choice of terms compassion for Programme and reaction to it
- Perception of how staff & patients would describe what compassionate care looks like in practice
- Perception of need for a programme of this nature (situation of nursing)
- Expectation of change that the LCC Programme will influence at individual clinical and organisation level
- Features of Programme that are likely to bring about change – LCC Team's interventions and how these will impact on staff perceptions of compassionate care and patients' experience of compassionate care
- End points of LCC Programme – key outcomes and representation of success
- Key macro and micro forces impacting on the success and outcomes of the Programme (enabling and limiting)
- Features of Beacon wards that impact on their ability to deliver compassionate care
- Types of wards and departments most likely to benefit from the LCC Programme

### **B. Policy Maker Stakeholders (Phase One)**

- Personal involvement at inception of Programme
- Rationale for decision to use term compassion
- Definition of compassionate care
- Perception of how staff & patients would describe what compassionate care looks like in practice
- Perception of need for a programme of this nature (situation of nursing)
- Expectation of change that the LCC Programme will influence at individual clinical and organisation level
- Features of Programme that are likely to bring about change
- End points of LCC Programme – key outcomes and representation of success
- Level of support for the Programme at Board level and amongst peers
- Key macro and micro forces impacting on the success and outcomes of the Programme (enabling and limiting)
- Features of Beacon wards that impact on their ability to deliver compassionate care
- Types of wards and departments most likely to benefit from the LCC Programme

### **C. Subject Stakeholders (Beacon Ward Charge Nurses) (Phase One)**

- Definition of compassionate care
- Choice of terms compassion for Programme and reaction to it
- Reaction to Programme when announced and rationale for putting selves forward as Beacon Ward
- Perception of how staff & patients would describe what compassionate care looks like in practice
- Perception of need for a programme of this nature (situation of nursing)
- Expectation of change that the LCC Programme will influence at individual clinical and organisation level
- Features of Programme that are likely to bring about change
- Experience of LCC interventions and reactions of ward team
- End points of LCC Programme – key outcomes and representation of success
- Level of support for the Programme at Board level and amongst peers
- Key macro and micro forces impacting on the success and outcomes of the Programme (enabling and limiting)
- Features of own ward that impact on ability to deliver compassionate care

### **D. Subject Stakeholders ('Other' Charge Nurses and Consultant Nurses) (Phase One)**

- Reaction to Programme when first heard about it including choice of term compassion
- Definition of compassionate care
- Perception of how staff & patients would describe what compassionate care looks like in practice
- Factors that impact on delivery of compassionate care in own ward ('Other' Charge Nurses)
- Perception of need for a programme of this nature (situation of nursing)
- Expectation of change that the LCC Programme will influence in own setting ('Other' Charge Nurses and organisation level (both))
- End points of LCC Programme – key outcomes and representation of success
- Level of support for the Programme at Board level and amongst peers
- Key macro and micro forces impacting on the success and outcomes of the Programme (enabling and limiting)

### **E. Interview Schedule for Clinical Nurse Managers (Phase One)**

- Involvement with LCC Programme to date
- Reaction to Programme and use of 'compassion'
- Own definition of compassionate care
- Perception of how staff & patients would describe what compassionate care looks like in practice
- Perception of need for a programme of this nature (situation of nursing)

- Expectation of change that the LCC Programme will influence at individual clinical and organisation level
- End points of LCC Programme – key outcomes and representation of success
- Features of Beacon wards that impact on their ability to deliver compassionate care
- Impact of LCC Programme (to date) in the Beacon Wards and reasons for this
- Experience of techniques used by Senior Nurses and their potential application in other areas of practice
- Level of support for the Programme at Board level and amongst peers
- Comparison of LCC Programme with Releasing Time to Care and Leading Better Care
- Key macro and micro forces impacting on the success and outcomes of the Programme (enabling and limiting)
- Types of wards and departments most likely to benefit from the LCC Programme
- Sustainability issues – locally and within the organisation

#### **F. Practitioner Stakeholders (LCC Senior Nurses) (Phase Two Focus Group)**

- Evidence of change in Beacon Wards
- Experience of using appreciative inquiry
- Development of the LCC Programme practice development processes – deliberate pathway or iterative process?
- Shift in thinking about compassionate care by Beacon Ward staff and LCC Team
- Differences between Beacon Wards in terms of response to LCC processes
- Projected outputs from Beacon Ward phase in terms of LCC ‘toolkit’
- Key enablers from LCC Programme to date
- Key organisational enablers to date
- Critical success factors in the Beacon Wards
- Lessons learned as move forward to Development Site Phase

#### **G. Development Site Charge Nurses (Phase Two)**

- Motivation to become involved as Development Site and expectations
- Perception of need for a programme of this nature - situation of nursing generally and own experience locally
- Definition of compassionate care before involvement
- Perception of how staff & patients would describe what compassionate care looks like in practice
- Learning about compassionate care since involvement in Programme

- Reaction to and use of Compassionate Care Themes (caring conversations; flexible person-centred risk taking; feedback; knowing me, knowing you; involving, valuing and transparency; environment)
- Features of own ward that impacts on ability to deliver compassionate care
- Expectation of change that the LCC Programme will influence at individual clinical and organisation level
- End points of LCC Programme – key outcomes and representation of success
- Experience of techniques used by Senior Nurses and their potential application in other areas of practice
- Reaction of staff to participation in the Programme including response to appreciative inquiry
- Experience of participation in the Leadership Programme
- Key macro and micro forces impacting on the success and outcomes of the Programme (enabling and limiting)

#### **H. Charge Nurses Development Units (Phase Three)**

- Motivation to become involved as Development Unit and expectations
- Definition of compassionate care before involvement
- Experience of appreciative inquiry
- Reaction of staff to involvement of Senior Nurse
- Identification of specific practice development techniques (e.g. emotional touchpoints, beliefs and values clarification, imagery) that have been particularly successful. Those most likely to be continued.
- Degree of involvement of whole clinical team
- Experience of any resistance
- Experience of participating in the Leadership Programme
- Learning about compassionate care since involvement in Programme
- Reaction to and use of Compassionate Care Themes (caring conversations; flexible person-centred risk taking; feedback; knowing me, knowing you; involving, valuing and transparency; environment)
- Impact of participation in Programme to date for own individuals, ward and organisation
- Main outcomes to date for ward and organisation and ways in which these can be demonstrated
- Way in which Programme perceived by members of the multidisciplinary team
- Ways in which the health service has changed during period of involvement in Programme and whether this has influenced delivery of compassionate care
- Interface between LCC Programme and Leading Better Care and Releasing Time to Care
- Main factors influencing success of Programme in own area at macro and micro level
- Sustainability issues in own ward and within the organisation beyond the lifetime of the Programme

## Appendix 3: Subject Information Sheet



**NAPIER UNIVERSITY**  
EDINBURGH

NHS Lothian  
Royal Infirmary of Edinburgh  
51 Little France Crescent  
Edinburgh  
EH16 4SA

### **Participant Information Sheet – Stakeholder Group**

#### **Embedding compassionate care in local NHS practice: a realistic evaluation of the Leadership in Compassionate Care Programme**

I would like to invite you to take part in a research study, taking place from April 2008 to October 2010. This study forms the basis of my PhD being undertaken at Napier University.

#### ***What is the purpose of the research study?***

The purpose of this research study is to develop an understanding of the impact of the Leadership in Compassionate Care Programme (the 'Programme') in embedding the concept of person-centred compassionate care in practice. The term 'realistic evaluation' relates to a specific method of enquiry that focuses on a number of inter-related factors connecting the context of the project, with the methods involved in facilitating its aims and the outcomes. This study will examine these issues from the perspective of a range of stakeholders associated with the project and the organisation.

#### ***Why am I inviting you to take part?***

You have been invited to take part in this study because you are someone who has a specific role in the project and are seen as forming one of three stakeholder groups. You are either a member of the Executive Board or one of the operational committees ('policy maker' stakeholder), a member of the Compassionate Care team ('practitioner' stakeholder), or a charge nurse in one of the wards directly linked to the Programme ('subject' stakeholder).

Or you are being invited to take part in the study because you are a charge nurse or consultant nurse working in NHS Lothian but, at this stage, are not directly involved in the Programme. It is hoped that your involvement will be to give a different perspective on examining the research questions from a wider organisational perspective.

At the same time as this study is being undertaken, there is other research associated with the Leadership in Compassionate Care Programme that will involve working with other staff, patients and relatives in wards during the project as well as with students, newly qualified staff, and lecturers.

***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 study at any time without giving a reason.

***What will happen to you if you take part?***

You will be asked to be involved in this research for the 3 years of my study and this will involve ongoing dialogue, discussion and access to different types of organisational information. At a minimum you will be asked to take part in one interview but depending on your role this may extend to three at different stages of the Programme. The first interview will be to determine your thoughts about compassionate care, expectations of the project and how you will determine whether it has been successful or not. The second interview will be 12 months later where you will be asked to consider the progress of the project and how it is impacting on patient care, learning and wider organisational issues. The third interview will be another 12 months later where the focus will be on continuing impact and sustainability of the work that has come out of the project.

In addition to the interviews you may be approached at other times for discussion or specific requests for information about the Programme.

It is expected that the interviews will take about 1 hour at any one time. These will be recorded in order that they can be transcribed and analysed in detail at a later stage. You will be given the opportunity to read the transcripts of the



interviews and to make comments on the analysis made of them. You will also be given a copy of the draft report before it is finalised and asked to verify the findings that relate to your input.

***What could be the risks or disadvantages of taking part?***

The study will involve discussing issues about your expectations and experiences of being involved in the project and your perceptions about the delivery of person-centred compassionate care. Given the nature of the topic it is potentially possible that you may find aspects of the discussion upsetting or difficult. If this is the case, then the interview would be stopped. If at any stage during or after the interview you feel that there have been issues raised that cause you ongoing concern then these can be explored in private outside the context of the data collection. If necessary, and with your permission, this could lead to referring you to an appropriate individual who is independent of the project and research study or NHS Lothian's Staff Support and Confidential Counselling Service for ongoing support.

As one of a small group of people involved in each stakeholder group it may be difficult to fully protect your identity. However, measures will be taken to preserve your anonymity as far as possible. You will not be named as an individual in any part of the research, but will be referred to by your stakeholder group and a pseudonym. Nevertheless your position in relation to the project is likely to be known by some of the people who will be reading the findings of the research. As you will be given the opportunity to review the research findings before they are made public, if you feel there is anything that too strongly identifies you in a way that you are unhappy about then this would be removed.

***What happens when the research stops?***

At the end of the study I will share the findings and recommendations, which will be for the NHS, higher education and patients. The results of the research will also be published. The detailed data from the research will be kept at NHS Lothian for 5 years. Then all of this information will be confidentially destroyed.

***Will your taking part in the research be kept confidential?***

I will follow ethical and legal practice and all information about you will be handled in confidence. Having said that, the Leadership in Compassionate Care Programme will be quite high profile during the period of the research and so others are likely to know you are taking part in aspects of the evaluation. However, all information obtained will be treated in confidence and personal references and identifying information will be removed from any publication.

All information collected during this research will be held in a research office at the Royal Infirmary of Edinburgh. Only I will have access to the data provided by you and will ensure that it is kept in a confidential and secure way, in accordance with the Data Protection Act, 1998.

Information from audio recordings, notes, documents and observations 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. If in any future reports or publications I use a direct quote from your, only your position as a member of a particular stakeholder group will be identified not you as an individual.

You can view copies of any information held on you at any time on request. All information will be kept securely for 5 years then destroyed confidentially.

***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.

***What if there is a problem?***

If you have a concern about any aspect of this research you can contact Professor Morag Gray who is the Chief Investigator of the overall research programme and supervisor of my PhD. She can be contacted by telephone on 0131 455 5687 by post at School of Nursing, Midwifery and Social Care, Napier University, 74 Canaan Lane, Edinburgh, EH9 2TB.

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, researcher at Napier University. She can be contacted on 031 455 5620.

***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. The results will also be used to inform future service and educational developments.

***Who is organising and funding the research?***

The Leadership in Compassionate Care Programme is being organised by the NHS Lothian and Napier University and is being funded by a private benefactor. My PhD studies have been funded by a studentship from NHS Lothian and the Centre for Integrated Healthcare Research.

***Who has reviewed the research study?***

The research has reviewed and approved by Napier University's Research Ethics Committee. It has also been awarded management approval by NHS Lothian's Research and Development Director, Professor Heather Cubie.

## Appendix 4: Consent Form

NHS Lothian  
Royal Infirmary of Edinburgh

51 Little France Crescent



**NAPIER UNIVERSITY**  
EDINBURGH

Edinburgh

EH16 4SA

Date:

Participant ID number:

### CONSENT FORM

Title of Project: **Leadership in Compassionate Care Programme**

Please initial  
box

Name of Researcher: \_\_\_\_\_

1. I confirm that I have read and understand the Participant Information Sheet Version 4 dated 15/04/2008 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 work or legal rights being affected.

3. I agree to interviews / meetings being audio recorded.

4. I agree to the researcher having access to documents written by me

5. I agree to take part in the above research study.

Name of Participant

Date

Signature

Name of Person  
taking consent

Date

Signature

## Appendix 5: Conference and Seminar Presentations

- June 2012 Embrace people, enjoy what you are doing, work with them without an agenda': Lessons Learned from the Leadership in Compassionate Care Programme. *3<sup>rd</sup> International Conference on Compassionate Care, Edinburgh Napier University.*
- May 2012 Leadership in Compassionate Care Programme: embedding compassionate care in local NHS practice. *Edinburgh Napier University Post Graduate Research Conference (3<sup>rd</sup> presentation)*
- June 2011 Reflection of three leaders of compassionate care: it's about confidence, determination and relationships *Second International Conference on Compassionate Care, Edinburgh Napier University*
- May 2011 Leadership in Compassionate Care Programme: embedding compassionate care in local NHS practice. *Edinburgh Napier University Post Graduate Research Conference (2nd presentation - poster)*
- May 2010 Leadership in compassionate care - understanding the organisational issues that influence its success. *Inaugural International Conference on Compassionate Care, Edinburgh Napier University*
- May 2009 Compassionate care in action: Meeting the challenge of complexity (Symposium) Paper: A Realistic Evaluation of the Leadership in Compassionate Care Symposium *RCN International Research Conference, Cardiff*
- April 2009 Leadership in Compassionate Care Programme: embedding compassionate care in local NHS practice. *Napier University Post Graduate Research Conference (1<sup>st</sup> presentation).*