Illuminating the importance of craftsmanship in compassionate caring and facilitating its development in student nurses

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Declaration of Authorship

I declare that this is my own work and has not been submitted for any other qualification or to any other institution. In every first authored paper in this application I was the principal or only researcher and responsible for designing, undertaking the research and for coordinating and contributing to all aspects of the publications.

In the one paper where I am second author, I contributed to the study design, co-facilitation of the focus groups, data analysis and all aspects of the publication.

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My lovely family and friends.

Abstract

This thesis provides a critical reflection on my original contributions to knowledge in the field of nursing practice and nurse education over the last decade. Collectively my eight selected papers demonstrate an ongoing and incrementally developing conceptual approach. This culminates in the presentation, within my final capstone paper, of my original recombinant innovation. In this paper, application of the innovation is articulated through a compassionate craftsmanship relational model, which fuses multivalent ideas from the fields of compassionate care and craftsmanship. Combining these disparate and frequently tacit elements together required diligence and courage in a world where fixed solutions are increasingly prominent. My innovative relational model is, however, importantly designed to be used as a heuristic device to promote reflection within nurse education and compassionate care.

The papers are grouped into three sets. The initial group of papers focus on the nature of nursing expertise and compassionate care. They illuminate important elements of care practice made possible through possession and application of often hidden tacit knowledge stored up in the mind of the nurse. The implicit underpinning concepts revealed in this research became progressively more explicit and well-articulated over the ten-year period as I developed my approach and thinking in relation to similarities between compassionate nursing expertise and craftsmanship.

A second suite of papers shares a common methodological focus where qualitative approaches were used to gather stories in a novel way. The “emotional touch-points” method was used to capture stakeholder experiences of compassionate care and caring. The stories served as a powerful mechanism to

gain insights into the lived experience of others. This approach held pragmatic value for patients, nurses and students, because the stories transformed thinking and motivated action, importantly feeding into the golden thread of compassionate craftsmanship.

The third set of papers demonstrates my interest in applying ideas from my practice-based research to educational environments by integrating the findings and stakeholder stories in a range of original pedagogical initiatives. Through implementation of these novel approaches, development in compassionate care and nursing ‘know-how’ was facilitated in student nurses. The educationally oriented papers articulate the positive impact and contribution to the fields of nursing and nurse education achieved through supporting learning in this area.

1.0 Chapter 1 Introduction to the critical commentary

1.1 Chapter introduction

This introductory chapter establishes my personal interest in care and caring and provides my rationale for embarking on the research journey central to this thesis. Key terms are clarified and an outline of my critical commentary structure is also included.

1.2 Rationale for the research

This critical commentary focuses on my collective body of original research and scholarly work, which contributes to knowledge generation in the fields of nursing and nurse education. I adopted an incrementally developing approach which led to the development of a recombinant innovation that combines compassionate care with craftsmanship (Syed, 2019). Recombinant innovations relate to fusion of ideas from different fields as demonstrated here through merging compassionate care with craftsmanship across multiple disciplines.

My research journey has been underpinned by my personal interest in the lived experience of caring and how this helps reveal what matters most to patients and their families, and how this could be conveyed to students in a meaningful way to positively influence their care practice.

I have grouped my selected core papers into three interrelated sets. The papers are explained in greater depth in chapter 3 and the underpinning research is critiqued in chapter 5. The first set of papers is focused on research undertaken in a range of practice contexts. It relates to giving and receiving compassionate care. These papers shed light on the nature of nursing expertise, and began to uncover the important but often hidden elements of care practice that make it compassionate. The inherent underpinning concepts within these initial papers

became progressively more explicit and well articulated over the ten-year period as I developed my original approach. The second set of papers share a common focus on stakeholder stories about their care experience gathered through the emotional touch points research method. The third set of papers demonstrate my interest in applying ideas generated by the practice based research to educational environments achieved through integrating them in a range of pedagogical contexts. The ultimate aim was to maximise the learning opportunities for student nurses by scaffolding the development of nursing craft and 'know-how' and the educationally oriented papers articulated some of the underpinning benefits and challenges associated with this. My final capstone paper integrates my evolving ideas and concepts concerning compassionate care with multi-disciplinary literature and thinking on craftsmanship. Though there from the beginning the concept of compassionate craftsmanship is not explicitly named until this final paper.

The research was undertaken over a decade while I engaged in the education of nurses as lecturer, senior lecturer, senior teaching fellow and associate professor within the School of Health and Social Care at Edinburgh Napier University. Importantly, to place the research in context at the start of my research journey, care and caring were high on the political agenda. In the first decade of the 2000's reports of poor care rocked public opinion, and undermined confidence in nurses' ability to consistently care compassionately (Stenhouse, Ion, Roxburgh, French Devitt, & Smith, 2016). In Table 1 (Government reports which situate and map my research and associated papers with policy), I map my research and selected papers against this backdrop and influential policy which drove healthcare at the time.

Compassionate care is a thread that runs through my papers and contributes significantly to the development of this recombinant innovation, which I have named compassionate craftsmanship. It is widely held in the literature that compassionate care is at the heart of nursing and should be inherent in acts of care regardless of situation (Fry et al., 2013; McSherry, Timmins, de Vries, & McSherry, 2018). This includes consideration of cultural beliefs, behaviours and specific needs of those cared for (Papadopoulos, 2011). However patients also want the assurance of nurses who are skilled and clinically competent (Sharp, McAllister, & Broadbent, 2016). This combination of compassionate care and developed skill provides optimum care for patients (Fry et al., 2013; Sharp et al., 2016).

A key element to surface in my early studies and which I discerned to be a significant influence in the complex practice of compassionate caring, is the application of tacit knowledge also associated with craftsmanship. This gradually emerged as a fascinating and complex topic area in my early research and continued to surface in a range of contexts as I progressed my research journey. Early in this journey my interest in this nursing knowhow led me to the seminal work of Professor of Humanities Richard Sennett who had re branded craftsmanship as being much more than skilled manual labour and importantly, applicable to nursing (Sennett, 2008). This helpfully fuelled my evolving theory, whereby I used the scholarship of integration to amalgamate compassion with craftsmanship.

The expert nurses caring compassionately within my early research exhibited other craftsmanship abilities identified in literature (Carmel, 2013; Nonaka & Von Krogh, 2009; Sennett, 2008). These are firstly, the ability to identify the problem or

care need and focus or zoom in on it. Secondly, the ability to question, ponder, reflect and investigate the care need. Thirdly, the ability to draw on tacit knowledge (know-how) and apply fresh thinking to do things differently when required to achieve the best outcome. Underpinning these abilities is a disposition and resolve to “do a good job for its own sake” (Sennett, 2008).In my early research studies these were demonstrated by the expert nurses in their care practice and were also described and discussed by other group of stakeholders who shared their stories through narrative interviews.

Recognition of this spurred on my emergent thinking and led me to highlight and further develop the concept of compassionate craftsmanship.

The process of developing this reflective commentary has been extremely productive as the process enabled me to recognise in my papers and critical analysis how the concept of compassionate craftsmanship has developed incrementally and how my work has informed and influenced nursing curriculum. Methodological strategies utilised to raise awareness of, in particular tacit knowledge, and facilitate its development in nursing students feature in my later publications. These strategies described by Sennett (2008) are discussed in detail in chapter 4.

Overall, I present a carefully selected range of peer reviewed papers to demonstrate my contribution over time to the fields of Nursing and Education through the Scholarship of Integration. In my critical appraisal, the concept of compassionate craftsmanship is presented as a recombinant innovation and broad and encompassing theme. I draw on my own research, including supplementary papers, wider literature from healthcare and that of other disciplines, to raise awareness of this emergent concept and its importance for the

development of compassionate care practice. Literature from other disciplines provided a different lens through which to view craftsmanship.

In summary, taken as a whole, my selected publications and my model of compassionate craftsmanship blend two important elements of caring (compassion and expertise) to help address the issues raised earlier concerning provision of compassionate care.

Table 1 Government reports which situate and map my research and associated papers to influential policy

Report	Time	My empirical based studies	Paper
Living and Dying Well (Scottish Government) https://www2.gov.scot/resource/doc/239823/0066155.pdf	2008, 2013	Using syringe drivers in palliative care within a rural community setting: Capturing the whole experience	1 and 2
End of life Care Strategy 2010 (Department of Health) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/136486/End-of-Life-Care-Strategy-Fourth-Annual-report-web-version-v2.pdf	2010		
Poor care uncovered in Mid Staffordshire https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf	2010	Leadership in Compassionate Care Programme	3, 4 and 5
Frances report (NHS Foundation Trust) https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry https://www.kingsfund.org.uk/projects/francis-inquiry-report	2010, 2013		
Standards for pre-registration education- compassionate care made explicit in response to Frances report (NMC) https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-competence-for-registered-nurses.pdf	2010		

Report	Time	My empirical based studies	Paper
NMC introduce proposal for revalidation for registered nurses in response to Frances report (NMC) https://www.nmc.org.uk/about-us/policy/position-statements/francis-report/	2010	Feedback in clinical practice: Enhancing the student experience through action research	6
Transition from hospital to community NICE) https://www.nice.org.uk/guidance/ng27	2015	Exploring the experiences of patients attending day hospitals in the rural Scotland: capturing the patient's voice	5
Shift in care from hospital to community (Department of Health and Scottish Government) https://www.health-ni.gov.uk/articles/community-care https://www.gov.uk/guidance/moving-healthcare-closer-to-home	2008 2015		
Integration of health and social care (Scottish Government) https://www2.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration https://www.england.nhs.uk/expo/wp-content/uploads/sites/18/2018/09/13.45-The-challenge-of-health-and-social-care-integration.pdf	2018		

Report	Time	My empirical based studies	Paper
Standards for pre-registration education- Importance of mentor feedback (NMC) https://www.nmc.org.uk/standards/standards-for-nurses/standards-for-pre-registration-nursing-programmes/	2010 2015 2017	Exploring the experiences of patients attending day hospitals in the rural Scotland: capturing the patient's voice	
Toolkit for student learning in practice (RCN) file:///C:/Users/SHSC/AppData/Local/Packages/Microsoft.MicrosoftEdge_8wekyb3d8bbwe/TempState/Downloads/PUB-006035%20(1).pdf	2017	Feedback in clinical practice: Enhancing the student experience through action research	
Standard for nurses: Cultural congruent practice (American Nursing Association) http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-22-2017/No1-Jan-2017/Articles-Previous-Topics/Implementing-the-New-ANA-Standard-8.html	2017	Culture, Courage and Compassion: Exploring the experience of student nurses on placement abroad	7
Compassionate care across cultures and languages (Schwartz Centre) https://www.theschwartzcenter.org/compassionate-care-across-cultures-and-languages-finding-common-ground/	2016		

1.3 Conclusion to this chapter

This chapter has established the personal, professional and political context in which my research has been placed over the last decade and given an overview of how my selected outputs have demonstrated the gradual incremental progressions of my contributions culminating in what I term compassionate craftsmanship in my capstone paper. I will now explain the structure of the critical commentary in chapter 2 and clarify key terms used.

2.0 Chapter 2 Structure of the critical commentary

2.1 Chapter introduction

This chapter outlines the structure of my critical commentary, offers an appraisal of my research outputs and clarifies key terms.

2.2 Overarching structure of the critical commentary

In what follows I present a brief overview of each chapter

Chapter 1: Introduces the personal, professional and political context of my research over ten years

Chapter 2: Outlines the structure of the critical commentary

Chapter 3: Highlights my work as a coherent whole

This chapter presents a diagrammatical model of my research studies and associated selected core papers to highlight my work as a coherent whole. I draw on the metaphor of a Greek Temple to represent the coherence of my research journey and draw attention to the relationship between the studies and papers. My work is based on a foundation stone of reflective practice on which three pillars stand. The pillars represent suites of research outputs with a shared theme. Over this sits the critical commentary as a crowning pediment. Coherence of the overall work is discussed further in chapter 7.

Chapter 4: Background and Literature

The purpose of this chapter is to provide an overview of the literature that informed the development of a recombinant innovation that integrates compassionate care with craftsmanship to present what I have named “compassionate craftsmanship”. It also situates my research in context in relation to key messages, debates and influences on my work.

Chapter 5: Core papers and critical appraisal of research

This chapter introduces the work of Boyer (1990) and uses his four interrelated scholarships as a frame of reference which positions my research and scholarly activity. This framework embodies the diverse aspects of my particular expertise, embracing the multi-dimensional aspects of the scholarships which inform compassionate caring practice and which together, are relevant to the pursuit of excellence in care practice and the practice of nurse education.

It includes Figure 2, which provides a visual depiction of the interrelated core papers and research journey. This chapter offers a critical appraisal of my empirical research and demonstrates how I have applied it to the findings to both inform and integrate it with teaching and the work of other disciplines to present an emergent concept of compassionate craftsmanship.

Chapter 6: Theoretical influences

This chapter focuses on the underpinning theoretical influences on my research and my incrementally developing concept. Here I discuss the theory of craftsmanship, identifying the key attributes and abilities of the craftsman, which my own research in nursing practice revealed. I also discuss the influence of experiential learning theory in my pedagogical studies through students' application of theory in direct care practice and provision of feedback from nurse experts. Narrative and transformative learning theories also influenced my research as I adopted a pragmatic problem solving approach to the apparent compassionate care deficit alluded to earlier. I found the stories gathered in practice, which conveyed care experiences, to be personally transformational for me, and this prompted me to use them as a learning tool within my pedagogical approaches. My own learning prompted personal reflections about the powerful arresting nature of stories and the underpinning influence of both narrative and

transformational learning theory on my work. Reflective learning is an essential: interwoven element of each of these and serves to underpin the work overall (presented diagrammatically in Chapter 2).

Chapter 7: Coherence and evidence of the key theme

This chapter expands on the key theme of my research. It introduces the concept of compassionate craftsmanship and provides evidence of coherence.

Chapter 8: Originality and Chapter 9: Significance

These chapters summarise and present evidence of originality and my contribution to knowledge in the field of nursing and nurse education.

Chapter 10 Reflexivity and next steps

This chapter is focused on personal reflections of my research journey to date and my plans for future work to build further on my research I have undertaken during the last decade.

Chapter 11 Conclusion

This chapter summarises the content and key messages of my critical commentary.

2.2.3 Clarification of Key terms

For the sake of clarity, I unpack some of the key terms used throughout my critical commentary to convey the sense in which I use them.

Many definitions of compassion exist however the following one helpfully shared by Peters, I find conveys the meaning effectively,

“ compassion is a deep feeling of connectedness with the experience of human suffering that requires personal knowing of the suffering of others, and evokes a

moral response to the recognised suffering and results in caring that brings comfort to the sufferer" (Peters, 2006, p. 184).

Thorlindsson and associates helpfully explored and summarised the early published work on craftsmanship (Becker, 1978; Berger, 2003; Fine, 2003; Gawande & America, 2007; Harper, 1987; Mills, 1980; Sennett, 2008)and provide the following definition

> "craftsmanship is characterized by intrinsic motivation, engagement in the task at hand, holistic understanding, emphasis on informal learning, and the honing of skills that are needed to accomplish the task at hand" (Thorlindsson, Halldorsson, & Sigfusdottir, 2018, p. 115).

Sennett's definition is important in my work as he relates it to nursing. He explains that craftsmanship is underpinned by the desire to do a job well for its own sake and goes on to identify three abilities held by the craftsman (already outlined in chapter 1).

My thesis (critical commentary and published papers) combines compassion and craftsmanship as a recombinant innovation. I use the term Compassionate craftsmanship to depict the practice of the attributes and abilities of craftsmanship in the provision of compassionate care.

Recombinant innovation is defined as the fusion of two ideas from different fields (Syed, 2019).

I recognise that there are potentially unhelpfully gendered connotations in the term "craftsman". I use it for consistency and because it is most commonly used in literature, however I intend it as a gender-neutral term.

Throughout my critical commentary, I draw on the term “attribute” as an essential underpinning characteristic of the craftsman, which is in particular, doing a good job for its own sake.

Reference to the “abilities” of the craftsman also feature throughout and refer to a person’s capability to do something.

2.4 Conclusion to this chapter

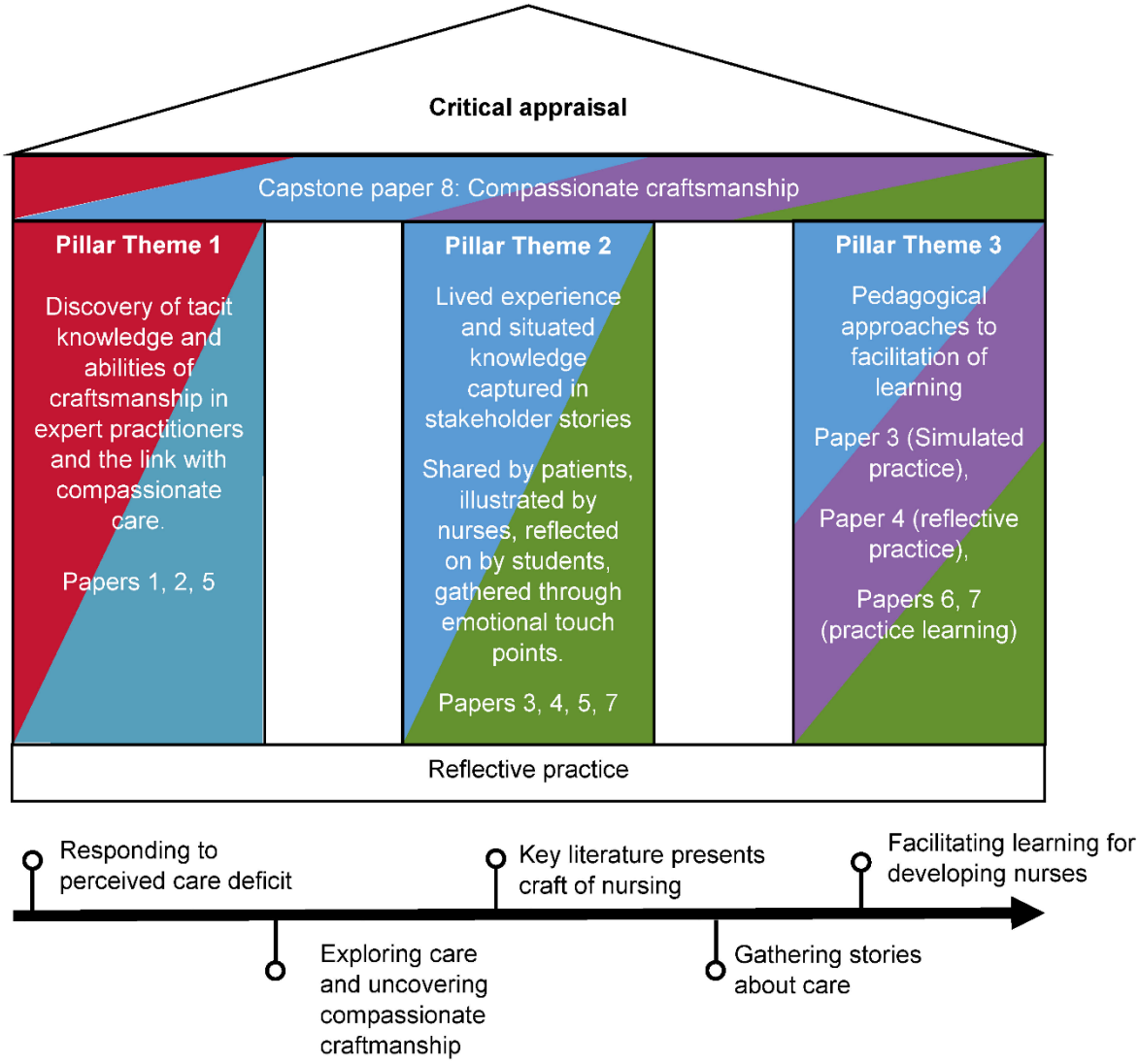
Chapter 2 has provided an outline of the structure of the critical commentary and clarified key terms which feature throughout.

3.0 Chapter 3 The work as a coherent whole

3.1 Chapter introduction

Chapter 2 outlined the structure of the critical commentary and clarified key terms. This chapter presents the rationale and impetus for the research discussed which is my personal and professional commitment to finding solutions to poor care through hearing directly from those who give and receive it and by positively influencing nurse education. I draw on a model of the Greek temple to demonstrate interconnectedness of the work and to convey it as a coherent whole.

Figure 1 Temple Diagram: Relationships between my core papers, my critical appraisal and the timeline of my research



3.2 The temple as a metaphor

To illustrate and highlight my work's coherence I have utilised the model of a Greek temple analogy introduced by Maxwell and Kupczyk-Romanczuk (Maxwell & Kupczyk-Romanczuk, 2009), and further developed by Muldoon (2010).

The foundation of my research is reflective practice and is represented by the foundation stone to the temple. Reflection is fundamental to nursing practice, thought to be a contributor to development of tacit knowledge (Rykkje, 2017), and a positive influence on care quality (Van Der Zande, Baart, & Vosman, 2014). It therefore provides a perfect bedrock for research that centres on compassionate caring. Three pillars rise from this foundation and represent three research themes within which the core papers and associated research reside. The first represents the discovery of tacit knowledge and craft abilities in expert practitioners and represents research and associated core papers that captured and reported the care experiences of nurses, and those for whom they care. Tacit knowledge in caring practice is knowhow built up in the care craftsman through experience and connectedness with those cared for. This patient-nurse interaction enables the carer to gain insights into the complex needs of an individual which informs effective compassionate care decisions (Reinders, 2010). Care judgements are informed by supposition and tacit habits while at the same time critiqued and corrected in an interplay between tacit knowledge and explicit awareness of the situation at hand (Sennett, 2008).

The second pillar centres on stories gathered from all stakeholders that uncovered the unique lived experience of compassionate caring and what it means to givers and receivers of care. A commonality within the story gathering and associated core papers is use of emotional touch points. Emotional touch points were used so that participants to describe not only what happened but how they felt at key

points in time across their experiential journey, (Odell, 2014). Participants are invited to choose specific stages of their experience (touch points), and a selection of positive and negative emotional words from which they select the ones that help them tell their story.

The third pillar is focused on pedagogical approaches that facilitate learning the craft of compassionate caring. Stories gathered in practice were reflected on by student nurses to facilitate learning about compassionate care. Bridging these pillars is a capstone paper (Core paper 8) which forms the facia and integrates the research presented here with multidisciplinary literature findings on craftsmanship. The emergent concept of compassionate craftsmanship is presented and discussed in this paper including a model of compassionate craftsmanship informed by my own research and multidisciplinary literature.

Nursing as craftsmanship was introduced in Sennett's (Sennett, 2008) seminal work, The Craftsman. At a time when poor care was investigated through the Francis enquiry and questions raised concerning nursing indifference to the suffering of vulnerable people (Francis, 2013) the craftsman's persistent motivation to do a job well for its own sake was in opposition to this and resonated with my research findings concerning nurse experts. Examples of this could also be found in the literature, such as the nurse who was going off duty after a tiring day, and seeing a distressed patient who needed help paused. Compelled to respond they intervened with appropriate action (Reinders, 2010). This compassionate "going the extra mile" reverberates with a craftsman's impulse to do a good job for its own sake.

Development of the model helped me to draw out the concept of compassionate craftsmanship and consider it in terms of enablers to its development, attributes of the compassionate craftsman, and anticipated outcomes when nurses put this into

practice. The process of developing this capstone paper is discussed further in chapter 5 (core papers and critical appraisal of research studies).

The pinnacle of the temple model is this critical appraisal represented by the pediment, which is presented in the chapters to follow. This critical commentary represents the

> "conceptual glue holding the work together"(Maxwell & Kupczyk-Romanczuk, 2009, p. 140).

Underneath the temple, I have indicated the timeline of my overall research journey to highlight key points, influences and activities.

3.3 Conclusion to this chapter

In this chapter, the work that is central to this thesis is presented in pictorial form to highlight its coherence and interconnectedness.

I will now turn in chapter 4 to discuss literature that relates to craftsmanship and compassionate care which influenced my thinking and development of the emergent concept.

4.0 Chapter 4 Background and Literature

4.1 Chapter introduction

Chapter 3 introduced the visual metaphor of the Greek temple, and presented my research and scholarly activity central to this thesis as a coherent whole. The purpose of chapter 4 is to provide an overview of the literature that informed the development of the emergent concept, compassionate craftsmanship. The overview includes that which is focused on craftsmanship in nursing and wider contexts. This literature induced my reflective, developmental thinking about how to facilitate learning experiences for nursing students that would help them develop craft skills and compassionate know how. This chapter also situates my research in the context of compassionate care with an emphasis on key messages, debates and influences within the literature at the time. The emphasis is on progression of my thinking, rather than providing a more traditional comprehensive review and methodological analysis (Griffiths & Norman, 2005). Finally, I will provide a summary of more recent compassionate care literature and areas of emphasis that help to demonstrate where my research has made a contribution.

4.2 Part one Craftsmanship

4.2.1 The craft of nursing

My claim is that compassionate craftsmanship is a valuable construct to illuminate attributes identified in expert nurses, which allow them to care compassionately. In what follows this concept will be utilised to embody and highlight how the attributes and abilities identified with craftsmanship, when merged with compassion, enable the nurse to overcome complexities and challenges of a situation and take action to relieve suffering and to provide care.

Whether nursing should be considered a craft, art or science has been debated for some time (Edwards, 1998; Jenner, 1997; LeVasseur, 1999). Some say that craft and art cannot be separated from one another (Diers, 1990) as art is purported to be associated with intuition, caring, embodied skill and doing a thing well (LeVasseur, 1999), however these are qualities are also identified with craftsmanship (Meal & Timmons, 2012; Sennett, 2008). Furthermore these same attributes were also identified in the work of expert nurses in my own research (Adamson, Pow, Houston, & Redpath, 2017; Cruickshank, Adamson, Logan, & Brackenridge, 2010; Edinburgh Napier University & NHS Lothian, 2012), which collectively supplies the rationale for proposing this relationship between craftsmanship and compassionate care.

When Sennett's seminal work was published in 2008 the idea of nursing as a craft was revitalised as he introduced craftsmanship as more than technical skill (Meal & Timmons, 2012) . He discussed the abilities of the craftsman outlined in chapter 1 (the ability to identify and focus on the problem, to question and to do things differently to achieve the best outcome). He associated this with healthcare practice and nursing. Gwande & America (2007) also proposed attributes essential for providers of good healthcare which aligned with these and were diligence, commitment to do a good job and creativity.

Sennett also introduced the idea of social craftsmanship, which was relationship focused and where knowledge was transferred. Barker and Buchannan-Barker placed a different emphasis on relationship in nursing craft as

> "something negotiated between the nurses and the patient where the value is appreciated by both. Value is defined by those who receive it yet the nurse also brings value through carefulness and expertise"(Barker & Buchanan-Barker, 2004, p. 18)

Both highlight shared involvement and mutual benefit.

The nurse craftsperson is sensitive and responsive to the care situation at hand and to the patient (Goodman, 2013). Tacit knowledge is operationalised as consideration and imagination of the best outcome (Hayes et al., 2005; Reinders, 2010). This notion of adaptation, consideration and action was also proposed by Benner (2009). She focused on the development of expertise in nursing and saw the ability to understand the nature of a given situation and take appropriate action as a key marker (Benner & Tanner, 2009)

In order for students to develop these skills educators can and should create learning environments which enable this. Nursing theorists such as Benner refers to these skills collectively as practical judgment and advocates the use of pedagogical strategies that facilitate their development (Benner & Tanner, 2009).

Though not confined to healthcare, Sennett (2008) advocates the use of expressive instruction to unpack tacit knowledge and share this with learners through use of imaginative language (Sennett, 2008). He offers three approaches which can be used to help student nurses to understand the “how” of caring (Frayling, 2012) and develop their own tacit knowledge (Meal & Timmons, 2012; Sennett, 2008). The approaches outlined in Sennett’s seminal work can be used in the classroom (Sennett, 2008) and indeed were used and described in the work discussed here (Adamson & Dewar, 2011, 2015). These are 1) **Sympathetic illustration** where the teacher and expert returns emotionally to the position of novice and shares accounts of difficulties they experienced and strategies they applied to overcome them. 2) In **Scene Narrative** the learner is conveyed to an unfamiliar situation through vivid description of a scene, and encouraged by imagination and reflection to place themselves there in another person’s shoes. This could be accomplished through listening to a patient describe their unique

experience of illness and care. 3) **Instruction Through Metaphors** involves use of examples from other occupations or activities more familiar to the learner such as cooking, which are used to describe and communicate what is required of the healthcare situation at hand. An example might be to convey the required quantity of ointment application to the skin by comparison to the fine layer of egg brushed on pastry prior to baking. The active engagement of teacher and students in simulated patient care lends itself to these expressive imaginative dialogic teaching methods and embraces the social nature of craftsmanship (Sennett, 2008).

Within the UK 50% of nursing education takes place in clinical placement using an apprenticeship model where students learn through observation and under supervision by a nurse expert. However learning these skills is not automatic and requires careful facilitative teaching with provision of feedback. Nursing is relational and nurse experts transfer knowledge to students through acts of showing, unpicking and describing the steps of what may now be second nature to the expert (Sweet & Broadbent, 2017). The learner then needs to try this out and receive feedback (Sheehan et al., 2010).

Smith refers to this as as showing less experienced people the ropes (Smith, 2001), while Sennett alludes sharing knowledge as social craftsmanship (Sennett, 2008). Responsibility for this transfer of knowledge is shared. As discussed in my body of work, learners have an important part to play therefore preparation of student nurses in terms of confidence, purpose and resolve to actively pursue development of expertise is also vital (Adamson et al., 2018).

This summary presents the notion of nursing craftsmanship as more than technical skill, closely connected with tacit knowledge, identified in the expert practitioner and as something that can be developed in students through

engagement in innovative teaching methods. Attributes and abilities of craftsmanship observed across a range of disciplines will now be discussed.

4.2.2 Craftsmanship in other disciplines

Craftsmanship can be traced as far back as the bible in the building of the temple (King James, 2017), and has always been associated with exceptional skill, value and respect. Later in a time when machines had gained prominence and the worker divorced from direct contact with the outcome of their work, John Ruskin urged a return to ways of life where people had a greater connectedness with their environment and the result of their labour, and the Arts and Crafts movement was born (Levine, 1987).

Early literature focussed on an interest in the expertise and "how "of craft work and conveyed the idea of high quality performance, artistry, skill and outstanding ability (Chan, 2014). This value for craftsmanship has flourished and is increasingly associated with a range of disciplines including the world of business (Nonaka, 2008) the craft of leadership (Taylor, 2012) and provision of healthcare (Coeckelbergh, 2013; Sennett, 2008), as well as the more traditional creative industries (Ingold, 2011). What they do (Maynes, 2017) and to producing good work (Balık & Allmer, 2017; Frayling, 2012; Schaefer, 1958; Sennett, 2008). Coeckelberg describes intrinsic motivation to achieve high quality outcomes in the care craftsman (Coeckelbergh, 2013), while Balik and Allmer (2017) focus in on theoretical knowledge, practical skill and experience woven together. The craftsperson is fully engaged in the task (Mills, 1980) as they focus in on the matter at hand and find the problem (what is required), then set about solving it through patient creative thinking (Harper, 1987).

Just good enough is not good enough for the craftsman (Gawande & America, 2007). They are committed to personal and professional improvement as they

hone and adjust their skill by diligent practice and developed ‘knowhow’ also referred to as tacit knowledge (Harper, 1987). This is directly associated with expertise and mastery (Polanyi, 2009).

Both explicit and tacit knowledge are important. Explicit knowledge is articulated and captured in text or drawing whereas tacit is not easily voiced, involves the senses, physical experiences and intuition. It consists of both cognitive (ability to perceive and define in the context of one’s world) and technical (knowhow) elements (Nonaka, 1994; Nonaka & Von Krogh, 2009). For the learner this can seem mystical and unattainable (Frayling, 2012).

Further characteristics of the craftsperson discussed in the literature include the ability to explore and deconstruct until they make sense of what is before them (Maynes, 2017). The craftsperson makes sense of the situation by pulling on experience while keeping an open mind. They question, revise and renew their sense making (Taylor, 2012 page 38).

There is a unique relationship between perception and action of the craftsperson as they respond to the emergent needs of the situation.

> “Their movements are continually and subtly responsive to the ever changing conditions and the quality of the outcome depends at every stage on their care and judgement” (Ingold, 2011, p. 59).

The craftsperson is considered and reflective, curious and questioning as they focus on the need before them, patiently and carefully activate a solution; being open to adjust and do things differently as required (Harper, 1987; Sennett, 2008). This description encapsulates the abilities of the nurse craftsman illuminated in my research. Motivated by compassion the nurses who featured in my clinically based research activated these abilities in practical responsive actions to bring relief and

comfort. I now move on to consider literature that relates to compassionate care and provide a context for my research.

4.3 Part 2 Compassionate care

4.3.1 The world then (1995 to 2011)

This section provides the background for my research. Within the core papers, the focus of the literature that I drew upon varies according to the distinct aim of each study. For example, the first study is concerned with end of life care. However although less explicit, compassionate care and the experience of those giving and receiving it was an important element.

Compassion has been considered to be integral to nursing from the earliest days of the profession and therefore expected to be implicit in all care practice (Von Dietze & Orb, 2000). This has tended to be taken for granted but publications began to raise concerns that it may have been lost in a climate of prudent efficiency and advancement in technology, diagnosis and treatment (Graber & Mitcham, 2004). In 2007 The Kings Fund Point of Care Programme was launched to improve experiences of care (Firth-Cozens & Cornwell, 2009), and concerns about older peoples' care. This prompted several initiatives such as that of the Healthcare Commission (Britain, 2007), and a Person Centred Nursing Framework developed to guide practice (McCormack & McCance, 2011). However only when accounts of poor care as discussed further in the text below placed nursing practice under the spotlight did compassion become a common focus in literature and healthcare policy.

Some earlier research had focused on the nature of caring and a literature review on the concept of caring identified key caring constructs. These were compassion, comfort, support, trust, stress alleviation and interestingly, showing concern (Kyle, 1995). In later accounts of neglect and failure to care compassionately, the failure

was attributed to staff indifference and lack of concern (Parliamentary & Ombudsman, 2011).

In a qualitative study conducted by Attree (2001), 34 patients and 7 relatives were interviewed about their perceptions of care quality. He suggests that at the time, healthcare evaluation methods tended to be confined to surveys, which focused on technical aspects of care and failed to the address the psychosocial elements. He found that the interpersonal skills of the caregiver was a key influence on the care experience and demonstration of kindness, concern, sensitivity and compassion highly rated (Attree, 2001).

An American study surveyed 800 US patients recently cared for in hospital and their 510 physicians within the US were asked about essential characteristics, which they defined as elements of compassionate care. The most highly rated aspects of care by both patients and physicians were respect, effective communication and being treated as a person not an illness. Compassion was associated with the expression of sensitivity and care about the patients' situation. All participants agreed that compassionate care was important though interestingly 78% of physicians said that they cared for individuals compassionately while only half the patient participants (54%) felt they received this. The authors emphasised the importance of listening to patients and introduction of systematic approaches to teach compassionate care (Lown, Rosen, & Marttila, 2011).

Though the literature indicated that compassionate care was important, what made care compassionate was and remains to be elusive and complex, though researchers have attempted to discover this. In one American phenomenological study conducted within two hospitals where 24 clinicians believed to be particularly compassionate were recruited to the study, and their lived experience of caring explored through interviews using questions aimed to focus in on interpersonal

skills. Interestingly, closeness between patient and practitioner, and the ability to care holistically were found to be the hallmark of their practice (Graber & Mitcham, 2004). However, managers rather than patients and families selected the participants for potential inclusion, which could have been a limitation. In a discussion paper by Goodman (2004) he highlights the changing trend within healthcare where patients and families are becoming more involved in care decisions (Goodman, 2004). Motivated by a personal experience of unsafe practice he stresses the need for care to be safe as well compassionate and therefore that competence and expertise are equally important. He suggests that interpersonal skills are key factors in all aspects of care, not only the affective elements and associated patient satisfaction.

An Australian discussion paper that focused on the nature and definition of compassionate care specifically in relation to nursing, also emphasised in particular taking appropriate action as a key marker of compassion. They also concluded that relationship between nurse and patient was key (Von Dietze & Orb, 2000).

Recognition that compassion in caring could not be taken for granted came in 2010 when alarmist discourses about quality of care began to emerge in the popular press (BBC, 2010). These crisis accounts of neglect and poor care for the most vulnerable sent shock waves across the UK. In response, compassion moved to the forefront of national and international policy, practice and educational debates (Department of Health, 2012; Local Government Association, NHS Confederation, & Age UK, 2012; Lown & Manning, 2010; Mcfarland, 2007; Mid Staffordshire & Francis, 2013; Moore, Strachan, O'Shea, & Leitch, 2012; Tadd et al., 2011).

In particular events within the Mid Staffordshire NHS Foundation Trust highlighted suffering amongst patients, and lack of compassion amongst staff. The government commissioned a formal inquiry into the apparent failings and the report acted as a significant catalyst for change. Key recommendations within the outcome report included placing patients first in all that is done, creation of a culture of care that extended beyond acute care to include care in the community, and placing compassionate care and professionalism at the centre of nurse education. Also that nurses education should adopt a greater emphasis on the practical application of knowledge and skill (Mid Staffordshire & Francis, 2013).

It is interesting to note that when Florence Nightingale established the nursing profession she emphasised the need for both compassion and technical skill and this remains true today (Rafferty, 2011). I will now go in to discuss literature that is more recent.

4.3.2 The world now (2013-2019)

I conducted a literature search in Medline, CINAHL and Google Scholar for sources published post 2012 that related to compassionate care. This process identified papers with a focus on both the clinical and educational aspects. A broad and extensive literature on compassionate care was found and there is not scope to discuss it in its entirety. I therefore present key messages in order to further situate my own research and contribution to knowledge within the larger collection of papers.

The analysis revealed firstly that authors continue to grapple with the definition and meaning of compassionate care (Bramley & Matiti, 2014; Tierney, Seers, Tutton, & Reeve, 2017). Several literature reviews conducted from 2016-2018 provide a helpful synthesis of empirical research each with a different approach and slightly different emphasis. In a scoping review of studies that explored

perceptions of compassionate care by Sinclair and associates (2016) 44 empirical studies were included (Sinclair et al., 2016a). They used a narrative approach to synthesize the findings and identified six themes. These were perceptions of compassionate care, the nature and development of compassion, interpersonal factors, action and practical application, barriers, enablers and outcomes of compassion. They highlight that two thirds of the studies do not include the views of patients, and conclude that the meaning of compassionate care remains unclear. A second scoping review used Joanna Briggs methodology to define caring which included compassionate care. They focused on four sources, two of which emerged from government policy, one from literature that focused on nursing attributes and behaviours, and the fourth from the themes identified in the Leadership in Compassionate Care Programme (LCCP). This is a three-year collaborative programme between Edinburgh Napier University and the NHS and is the focus of two of my core papers. The authors conclude that delivery of fundamental care can be inhibited by the current lack of theoretical consistency (Feo, Kitson, & Conroy, 2018).

Durkin and associates (2018) conducted a systematic review to explore how compassion is expressed by nurses and received by patients. They used the Critical Appraisal Skill Programme to examine the papers retrieved and included 11 in the review. They conclude that compassionate care is ambiguous but also interestingly highlight that it is subjective (Durkin, Gurbutt, & Carson, 2018). This supports my own position that hearing directly from patients is important.

An alternative to further pursuit of definition therefore could be an approach to caring that is open minded where the practitioner does not apply a particular formula according to what they perceive compassionate care to be. The LCCP emphasised the importance of working with patients and families, checking out

with individuals what matters to them and then negotiating what is possible through shared decision making (Dewar & Nolan, 2013; Edinburgh Napier University & NHS Lothian, 2012).

The six themes identified by the LCCP embrace this approach to facilitating compassionate care (Edinburgh Napier University & NHS Lothian, 2012). These are:

- Having caring conversations, for example about what matters to patients and what works for them;
- Being flexible and creative, which may mean taking a risk to be do things differently;
- Giving and receiving feedback about care experiences;
- Knowing the person and their priorities so that you can negotiate how things are done;
- Involving everyone in how things are done including patients, families, and staff.
- Considering and adapting the wider environment to facilitate compassionate car;

Dunkin (2019) also highlight lack of time to care compassionately (Durkin, Usher, & Jackson, 2019). However, others would challenge this as a myth about compassionate care (Dewar, Adamson, Smith, Surfleet, & King, 2014). Bramley & Matiti (2014) conclude that compassionate care can take momentary elements of time (Bramley & Matiti, 2014). Even in care settings of high patient turnover care can be compassionate as it concerns the how, rather than the what of caring (Dewar & Nolan, 2013; Youngson & Blennerhassett, 2016). Youngson and Blennerhassett suggests that it needs no additional resources, only being there,

listening, responding to suffering and showing kindness and appreciation (Youngson & Blennerhassett, 2016). This can be woven into day-to-day care delivery.

Despite the increasing emphasis in government policy concerning the importance of listening to patients, the majority of papers report views of healthcare professionals. My own research made a significant contribution to the literature focused on capturing the patient voice (Adamson et al., 2017; Cruickshank et al., 2010). This study built on the work and findings of the LCCP to gather data within community care. Patients were interviewed in their own homes to encourage them to share their care experience without inhibition.

Bramley and Matiti (2014) also gathered data from 10 patients though in a UK hospital and used semi-structured interviews to capture the experience. They found that feeling known as a person and that their situation was understood was important to participants, as was effective communication (Bramley & Matiti, 2014). However the patients were interviewed while in hospital which may have restricted the participants' responses.

Straughair (2019) also set out to increase understanding of compassionate care from the patients' perspective. Using a grounded theory approach, she interviewed 11 patients and invited them to draw on examples from their care experiences to express their perceptions of compassionate care. Findings highlighted the role that systems and processes play in provision of compassionate care, and the influence of leaders and role models of compassionate care. Participants expressed a belief that nurses had a predisposition to compassionate care but that it should be nurtured further through education (Straughair, 2019).

The role that education and educators plays in provision of compassionate care has been growing more prevalent in the literature (Adam & Taylor, 2014; Burridge & Foster, 2019; Geraghty, Lauva, & Oliver, 2016; Mackintosh-Franklin, 2016; Richardson, Percy, & Hughes, 2015; Rosser et al., 2019; Strube, Henderson, Mitchell, Jones, & Winch, 2018) . Several papers reviewed educational research that relates to compassionate care (Coffey et al., 2019; Durkin et al., 2019; Feo et al., 2018; Sinclair et al., 2016b; Younas & Maddigan, 2019). My own work met the criteria for inclusion in each of these systematic reviews (papers 3 & 4), strengthening my assertion of contribution to knowledge. Inclusion in this work provided valuable peer feedback on my work for example that it contributed to addressing a gap in teaching and learning strategies that foster development of compassionate students (Younas & Maddigan, 2019). These authors recommend use of compassionate care indicators within the curriculum. These include strategies that help students to make a deliberate effort to identify needs and concerns, and a resolve to make a conscious effort to understand the patients' situation. I would suggest that this could be by focusing in and listening intently to gain insights concerning the patient's perspective. Sinclair and associates (2016) also reported improved compassion through use of reflective learning evidenced in our study (Sinclair et al., 2016b).

Durkin expresses concern that overall more should be available that explains how compassionate care is taught to students (Durkin), and that nurses need to be able to work with uncertainty, to question and to challenge practice in order to care compassionately (Durkin et al., 2019). In relation to my research, they conclude that although perceived to be a useful learning tool, that the reflective learning was not convincing enough. Hofmeyer and associates (2018) agree with this view in that that although learning in the classroom was well evidenced in the paper that

the reflective learning through the digital platform was limited (Hofmeyer et al., 2018).

Coffey focused her literature review on nurse education and highlighted the benefits for students of reflecting on real life stories such as the process used in our study, as useful for emotional engagement with patients (Coffey et al., 2019).

Narratives used to initiate reflection on an individual's experience of illness is a strong focus in LCCP, including my own research, and other authors have published on this topic. Hanson applied transformative learning principles to design a learning activity using narrative to kick start reflection and enhance development of affective attributes (Hanson, 2013). Brady and Asselin conducted an integrated review of literature that focused on narrative pedagogies. They emphasised the perceived benefits of gaining understanding about the context of an illness experience, which can help nurses provide individualised care. They also suggest that the interconnectedness that narrative pedagogy achieves can increase cultural sensitivity. They caution however the difficulty in reliably measuring the effects (Brady & Asselin, 2016). Newman and associates (2019) studied the influence of published narratives about experiences of care and illness on perceptions of nurse educators. 41 participants from five universities in the UK, Canada and Ireland participated using an online questionnaire (Newham et al., 2019). Findings indicated that narratives makes the person visible and in a central position for the reader. They also made an interesting differentiation between being cared for and being cared about, which aligns with the LCCP theme relating to involving everyone in how things are done

Healthcare culture and the practice-learning environment also remains a focus of the literature. Policy names compassionate care as a core value (Department of Health, 2012), while at the same time there is an increased drive for productively

which is perceived to be a negative influence on care quality (Bramley & Matiti, 2014; Dev, Fernando III, Kirby, & Consedine, 2019; Henshall, Alexander, Molyneux, Gardiner, & McLellan, 2018; Nijboer & der Cingel Van, 2018; Pryce-Miller & Vernel, 2014).

Educational interventions have been implemented at organisational level with an aim to improve care within practice (Burnell & Agan, 2011; Gould et al., 2018; Youngson, 2014; Zubairu et al., 2017).

One example is a learning environment for compassionate care developed by Gould and associates and which focused on ward leader support through action learning, team-building activities such as values clarification and understanding patients' experiences. They also undertook observations of practice with feedback to team members. The study was set in two hospitals and included six wards. Two served as controls and four were experimental.

Evaluation was conducted using observations of staff patient interaction (120hs) and rated as positive or negative. Validated questionnaires were used for measurement of patient perceptions of emotional care and staff self-reported empathy. The authors did not provide a rationale for the choice of instruments and measurement of empathy I would argue does not indicate compassionate care.

Findings showed that the intervention was difficult to sustain and dependent of organisational support. A limitation was that staff behaviour could have been influenced by observation.

A second paper reported evaluation of the Care Maker project introduced in England to support The Compassion in Practice Strategy (Department of Health, 2012). Care makers acted as promoters of the 6 C's (care, compassion,

competence, communication, courage and commitment) within their area of practice.

Evaluation was through staff questionnaires and telephone interviews and focused on Care Makers' perceptions of the impact that the programme had on awareness of the 6 c's and encouragement for staff to demonstrate them in practice. Care makers were highly motivated and raised awareness amongst staff, but the initiative again required ongoing facilitation.

Compassionate care is complex and in the current healthcare landscape the nurse must utilise knowledge and skill to work flexibly within restrictive environments and cultures to provide what is best care in that moment. Interpretation of each situation will vary according to contextual factors (Tierney, Seers, Reeve, & Tutton, 2017). This is the nature of compassionate care and the nurse needs to do what is required to relieve suffering regardless of difficult the circumstances (Campling, 2015). This choice to do a good job is not as a result of a contractual agreement to care compassionately, but is the outcome of a disposition and individual choice (Wang, 2016).

As the LCCP found, environments do influence provision of compassionate care and poor care has been blamed on situational factors and compassion fatigue (Paley, 2014). Others argue that despite the complexities faced and wicked problems encountered, poor care and neglect is unacceptable (Darbyshire, 2014). Darbyshire goes on to state that as patient advocates, nurses must be custodians of compassionate care which takes development of professional values and commitment to high standards. I would argue that it takes craftsmanship.

4.4 Conclusion to this chapter

This chapter presented and critiqued key literature that influenced development of my incrementally developing concept of compassionate craftsmanship. It also helps to situate my work within the historical context and literature. In summary, the literature shows how compassionate care has evolved and my papers contributed to this. Craftsmanship has also been revitalised and is increasingly valued by a range of disciplines and which I would argue includes compassionate nursing. This realisation further advanced my thinking and led to a synthesis of developing ideas expressed in the capstone paper and presented as a recombinant innovation that integrates compassionate care.

The core papers and research studies will now be presented and critically appraised.

5.0 Chapter 5 Core papers and critical appraisal of research studies

5.1 Chapter introduction

The last chapter situated my work in its historical context and critically analysed relevant literature, demonstrating the development of preoccupations around the provision of compassionate care.

In this chapter, I outline and critique the research which I conducted to inform the core papers. I use Boyer's four scholarships as a frame of reference, and firstly position my studies within these four overlapping functions in order to convey the contribution made to each interconnected domain.

I selected eight particular papers from my wider raft of publications because they a) convey the range and scope of my research activity, and b) taken as whole evidence my ongoing contribution to compassionate caring and craftsmanship in nursing. I will critique the studies in chronological order to highlight my developing emergent theme of compassionate craftsmanship. The titles of the studies on which the papers are based correspond to those used in applications for funding and ethical scrutiny. Though there from the beginning, the concept of compassionate craftsmanship was not explicitly named until the final paper, in which I illuminate comparable attributes associated with both craftsmanship and compassionate nurse expertise. The core papers are all peer reviewed publications and based on a collection of externally and internally funded studies. I was the principal investigator in four.

5.2 Boyer's Scholarships as a frame of reference

I have chosen to use Boyer's four scholarships as a frame of reference as it places emphasis on the multi-dimensional aspects of scholarship which informs

academic practice especially in professional orientated areas such as nursing (Fitzpatrick & McCarthy, 2010).

Boyer's four forms of Scholarship; Discovery, Teaching, Application and Integration, have distinct but overlapping functions (Smith & Crookes, 2011). I have chosen this framework because it embodies the diverse aspects of my particular expertise, embracing the multi-dimensional aspects of my scholarship. Together they are relevant to the pursuit of excellent compassionate care in nursing practice and nurse education (Pope, 2002). In addition, they are essential to the professional growth of nursing in relation to solving healthcare problems (American Association of Colleges of Nursing, 2016).

Scholarship in nursing has traditionally been restricted to research activities associated with the scholarship of discovery as an exclusive path to new knowledge. Boyer helpfully suggests a broader approach to scholarship as follows.

> "The work of the Scholar also means stepping back from ones' investigation, looking for connections, building bridges between theory and practice and communicating ones' knowledge effectively to students" (Boyer, 1990 page 68).

My own body of work resonates strongly with this philosophy as it embraces all four domains in some measure. Smith and Crookes (2011) suggest that nursing research is an active process where findings are integrated into teaching and learning and also into practice (Smith & Crookes, 2011).

The pursuit of knowledge based on insights into the lived experience of others can be seen throughout my work. Application of this knowledge to enhance both

clinical practice and nurse education is equally important, and this is achieved in part through sharing the process and findings through publication.

From this perspective research and teaching activities are reliably considered to represent scholarship when they are “communicated to and validated by peers, and reach beyond the University” (McGrath, 2006 page 3).

In what follows I present my selected papers and a critique of the studies.

5.3 The core papers

1. Using syringe drivers in palliative care within a rural community setting: capturing the whole experience.
2. A good death at home; Community nurses helping make it possible.
3. Compassion in the nursing curriculum: making it more explicit.
4. Compassionate Care: Student nurses' learning through reflection and the use of story.
5. Exploring the experiences of patients attending day hospitals in the rural Scotland: capturing the patient's voice.
6. Feedback in clinical practice: Enhancing the students’ experience through action research.
7. Culture, Courage and Compassion: Exploring the experience of student nurses on placement abroad.
8. Helping Student Nurses Learn the Craft of Compassionate Care: A Relational Model.

I am the lead author for all but one of the selected publications and sole author of two. In healthcare and educational research, collaboration is encouraged in order

to build capacity and capability. In addition, involvement of colleagues from practice in the research and writing process contributed current clinical and educational experience which enriched the data and the projects overall. Each study in this body of research was subjected to ethical scrutiny by either the NHS or the University Ethics and Governance committees.

A full outline of my research activity is presented in Table 2: Core papers. This sets out for each paper a summary of the methodology and significance, authorship and my individual contribution to each study. Beneath each paper I also supply supplementary information including additional linked papers and other outputs, plus evidence of impact and dissemination. The supplementary outputs further illustrate my sustained and ongoing contribution to the field of enquiry. These are also referenced in my CV (Appendix 1). Confirmation of my contribution by co-authors can be found in Appendix 2.

Table 2 Core Papers

Core Publication	Methodology and significance	Authorship and my particular contribution to the study
1. Cruickshank, S., **Adamson, E.,** Logan, J. & Brackenridge, K. (2010). Using syringe drivers in palliative care within a rural community setting: capturing the whole experience. *International Journal of Palliative Care*, *16*(3), 126-132.		
Journal paper Double blind peer reviewed Funded by Centre for Integrated Healthcare Research Pump Priming fund £14,985 The aim of IJPN is to provide nurses with essential information to help them deliver the best possible care and support for their patients	This phenomenological study used in depth unstructured interviews and focus groups to explore the lived experiences of patients, informal carers and community nurses when a syringe driver was introduced at the end of life. It highlighted the need for education and support for nurses and the holistic and complex nature of care at this time. The unique role played by the community nurses was apparent in the findings as was their application of tacit as well as explicit knowledge to provision of care	Contributed to conceptual ideas for the study, data collection, data analysis. Contributed to all sections of paper including final review. See attached co-authors' letters (Associate Professor Susanne Cruickshank and Janice Logan)
Dissemination and Impact -- Google Scholar 18 citations Using syringe drivers in palliative care: capturing the experience of patients, carers and community nurses: 15th International Cancer Care Nurse Conference Singapore, 2008.		

2. **Adamson, E.** & Cruickshank, S. (2013). A 'good death' at home: community nurses helping to make it possible. *British Journal of Community Nursing*, *18*(1),40-42		
Journal paper Invited by the editor to submit a publication Double blind peer reviewed Funded by Centre for Integrated Healthcare Research Pump Priming fund 2010 £14,985 BJCN is a leading peer-reviewed journal for district nurses, containing the most up-to-date clinical coverage and research on primary care nursing.	This paper dew upon the findings from the study introduced in paper 1 and discussed the current end of life policies, how community nurses were central to their implementation and made recommendations for practice.	Contributed to conceptual ideas for the study (as detailed above), and coordinated writing the paper As lead author, I contributed to all sections of paper including final review. See attached co-authors letters (Associate Professor Susanne Cruickshank and Janice Logan
Google Scholar 10 citations		

3. Adamson, E. & Dewar, B. (2011). Compassion in the nursing curriculum: making it more explicit. *Journal of Holistic Healthcare*, *8*(3), 42-45.		
Journal Special edition. Invited to submit a paper following contribution to an International Symposium for Compassionate Care, Greenwich 2011 Double peer reviewed Leadership in Compassionate Care Programme (LCCP), £1,000, 000 over three years: External benefactor, 2007-2010.	This participatory action research action project focused on making compassionate care explicit within an acute nursing simulation and online learning experience and assessing it. The findings from the clinical practice (Beacon Wards) strand of the LCCP were used to inform an educational experience designed to help students develop knowledge and skill in caring compassionately through simulation and reflection. Student data were gathered through a survey and focus groups with staff and simulated patients. Research conducted in clinical practice directly informed the educational development through a strong partnership between practice and education facilitated by the wider ethos of the LCCP.	Contributed to securing the LCCP programme funding which included the undergraduate strand within which this project was positioned and progressed. Contributed to conceptual idea for the project. Led on each step of the action research cycle. Contributed to all sections of the paper including review and revision. The work is also reported in the LCCP overall programme final report. See attached co-authors letter (Professor Belinda Dewar)

Dissemination and impact- Google Scholar 24 citations – Inclusion in two reviews of literature which focus on nursing and development of a policy framework for nurses education as follows:

Durkin, M., Gurbutt, R., & Carson, J. (2018). Qualities, teaching, and measurement of compassion in nursing: A systematic review. *Nurse education today*, *63*, 50-58.

Feo, R., Kitson, A., & Conroy, T. (2018). How fundamental aspects of nursing care are defined in the literature: A scoping review. *Journal of clinical nursing*, *27*(11-12), 2189-2229.

Personal invitation to facilitate a workshop for medics: Workshop: Patient stories. **Scottish Clinical Skills Network Edinburgh 2012:**

Workshop: Patient stories: **NHS Lothian and Edinburgh Napier University Inaugural International Conference on Compassionate Care, 2012**

Embedding compassionate caring elements into an UG nursing module: **NHS Lothian and Edinburgh Napier University Inaugural International Conference on Compassionate, 2012**

Making compassionate nursing practice explicit within the pre-registration curriculum: **Personal invitation International symposium for Compassionate Care, Greenwich 2011**

Making compassionate nursing practice explicit within the pre-registration curriculum: **Two educational practice developments: Enhancing Practice Conference Belfast, 2010**

Book chapter

Adamson, E. & Smith, S. (2014) Can compassionate care be taught? Experiences from the Leadership in Compassionate Care Programme, Edinburgh Napier University & NHS Lothian. In Shea, S., Wynyard, R., & Lionis, C. (Eds.), *Providing Compassionate Health Care Challenges in Policy and Practice*, London: Routledge.

Associated supplementary publications

Smith, S., James, A., Brogan, A., **Adamson, E.** & Gentleman, M., (2016). Reflections about experiences of compassionate care from award winning undergraduate nurses. What, so what.now what?. *Journal of Compassionate Health Care*, *3*(1),6. **6 citations**

Adamson, E. & Smith, S. (2014). Can compassionate care be taught? Experiences from the Leadership in Compassionate Care Programme, Edinburgh Napier University & NHS Lothian. In Shea, S., Wynyard, R., & Lionis, C. (Eds.), *Providing Compassionate Health Care Challenges in Policy and Practice*, London: Routledge. **22 citations**

Dewar, B., **Adamson, E.,** Smith, S., Surfleet, J. & King, L. (2014). Clarifying misconceptions about compassionate care. Journal of advanced nursing, *70*(8),1738-1747**.** **74 citations**

Adamson, E (2013). Lessons in compassion. *Nursing Standard*, *27* (48), 64.

Adamson, E (2013) Compassion into action. *Nursing Standard*, *27* (47), 61.

Edinburgh Napier University& NHS Lothian. (2012). The Leadership in Compassionate Care Programme final report. Contributing author. **12 citations**

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4. Adamson, E., & Dewar, B. (2015). Compassionate Care: Student nurses' learning through reflection and the use of story. *Nurse education in practice*, *15*(3), 155-161.

Journal Double peer reviewed Nurse Education in Practice enables lecturers and practitioners to both share and disseminate evidence that demonstrates the actual practice of education as it is experienced in the realities of their respective work	This paper focuses in on one particular element of the pedagogical intervention central to the action project described in paper 3 above. Narratives gathered in practice were used to initiate reflection. Student data was gathered through a questionnaire and online discussion The research conducted in clinical practice directly informed the educational	LCCP action project lead Contributed to conceptual idea, developed educational materials, facilitated online discussion, gathered and analysed questionnaire data. Contribution to the overall programme final report.

environments, that is both in the University/faculty and clinical settings	development through a strong partnership between practice and education facilitated by the wider ethos of the LCCP	Contributed to all sections of the paper including review and revision. See attached co-authors letter (Professor Belinda Dewar)
Dissemination and impact: Google Scholar -- 78 citations – 4 inclusions in reviews as follows Coffey, A., Saab, M. M., Landers, M., Cornally, N., Hegarty, J., Drennan, J., ... & Savage, E. (2019). The Impact of Compassionate Care Education on Nurses: A Mixed-Method Systematic Review. *Journal of advanced nursing*. Durkin, M., Gurbutt, R., & Carson, J. (2018). Qualities, teaching, and measurement of compassion in nursing: A systematic review. *Nurse education today*, *63*, 50-58. Younas, A., & Maddigan, J. (2019). Proposing a policy framework for nursing education for fostering compassion in nursing students: A critical review. *Journal of advanced nursing*. Sinclair et al (2016). Compassion: a scoping review of the healthcare literature. BMC Palliative Care		

5. Adamson, E., Pow, J., Houston, F., & Redpath, P. (2017). Exploring the experiences of patients attending day hospitals in the rural Scotland: capturing the patient's voice. *Journal of clinical nursing*, *26*(19-20), 3044-3055.		
Journal Double peer reviewed £5,889: Queens Nursing Institute Scotland, 2013 The Journal of Clinical Nursing (JCN) is an international, peer reviewed, scientific journal that seeks to promote the development and exchange of knowledge that is directly relevant to all spheres of nursing practice. The primary aim is to promote a high standard of clinically related scholarship which advances and supports the practice and discipline of nursing	This descriptive qualitative study focuses on the experience of patients cared for in three community hospitals as day patients. Guided by themes identified in the LCCP, narrative interviews using emotional touch points were used to gather data in the patients' homes. Data analysis was through thematic analysis and the findings compared and contrasted with findings form the LCCP. The findings were shared and discussed with nurses involved in direct care delivery with the view to planning and implementing changes in practice and enhanced care in response to patient feedback	Principal investigator. Undertook the study design, development and execution including ethical approval. Undertook interviews and conducted data analysis Responsible for all aspects of the paper including review and revisions. See attached co-authors letters (Dr Janette Pow, Fiona Houston and Pamela Redpath)

<table>
<tr><td colspan="3">Dissemination and Impact: Google Scholar citations 13

Exploring the experiences of patients attending day hospitals in rural Scotland: 5th European Nursing Congress Caring for Older People: How can we do the right things right? De Doelan, Rotterdam, Netherlands, 2016.

Impact on practice: New accelerated discharge project initiated in NHS Borders and lead by co-author staff nurse Pamela Redpath.

Emotional Touch Points methodology used in a follow up study led by a co-author.

Citations 2

See also statement from Fiona Houston Clinical Manager NHS Borders</td></tr>
<tr><td colspan="3">6. Adamson, E., King, L., Foy, L., McLeod, M., Traynor, J., Watson, W., & Gray, M. (2018). Feedback in clinical practice: Enhancing the students' experience through action research. Nurse education in practice, 31, 48-53.</td></tr>
<tr><td>Journal

Double peer reviewed

£5,700: ENU Teaching Fellowship Grant, 2013.

£800, NHS Education for Scotland, 2016

Nurse Education in Practice enables lecturers and practitioners to both share and disseminate evidence that demonstrates the actual practice of education as it is experienced in the realities of their respective work environments, that is both in the University/faculty and clinical settings</td><td>Action research was used to bring about change in student support and learning within practice. Data was gathered using interviews and focus groups and the approach to analysis was thematic.

This study is an example of research gathered in higher education used to directly influence further research and educational practice in the clinical setting.</td><td>Principal investigator

Responsible for conceptual ideas.

Undertook the study design, development and execution of the study including ethical approval.

See attached co-authors letters (Professor Morag Gray, Wendy Watson, Linda King, Jenny Traynor, Margo McLeod and Lynn Foy)</td></tr>
</table>

Dissemination and Impact:- Google Scholar 6 citations Feedback in clinical practice: Enhancing the students experience through action research: **NETNEP, 6th International Nurses Education Conference Brisbane Australia, 2016** Feedback in clinical practice: Enhancing the students experience through action research**. ENTER Edinburgh 2016.** ***Impact on Practice:*** Focus on Feedback introduced to NHS Lothian Mandatory Update for all staff. Citation 1		
7. Adamson, E. (2018). Culture, courage and compassion: exploring the experience of student nurses on placement abroad. *Journal of Compassionate Health Care*, *5*(1), 5.		
Journal Double Peer reviewed £3,616: ENU Teaching Fellowship Grants, 2012 Journal of Compassionate Health Care is the leading journal in a rapidly growing field. By incorporating compassionate healthcare as the core of basic care improves disease management, helps recovery, and alleviates anxiety. The journal brings together multidisciplinary perspectives, research and initiatives regarding compassionate care.	This paper focuses on the emotional elements of compassionate care provision for students working in a diverse country and culture. The study captured the students' feelings, anxieties and subsequent responses as they grappled with a different healthcare system and perceived inequalities in care. They overcame challenges, questioned practice, role modelled person centred care. In addition, they grew personally and professionally through the experience. Narrative interviews using emotional touch points were gathered and data subjected to thematic analysis.	Principal investigator Responsible for conceptual ideas. Undertook the study design, development and execution. Undertook interviews and conducted data analysis Responsible for all aspects of the paper Including review and revision.

Dissemination and impact – Google Scholar 1 citation		
8. Adamson, E. (2018). Helping Student Nurses Learn the Craft of Compassionate Care: A Relational Model. *Journal of Perspectives in Applied Academic Practice*, *6*(3).		
Journal Double Peer reviewed Special issue: Compassionate Pedagogy The Journal of Perspectives in Applied Academic Practice is an open access e-journal of research and practice development in higher and further education. Our peer reviewed Journal promotes evidence-based academic practice through the publication of papers that are theory-based and supported by evidence. The themes of the Journal reflect the breadth of perspectives in academic practice through a wide variety of disciplinary lenses.	The focus of this paper is compassionate craftsmanship. Informed by the findings of my own research and drawing on literature from a range of disciplines where tacit knowledge is commonly a vital underpinning factor. A model for the development of compassionate craftsmanship is presented. The model consists of enablers to the development of craftsmanship, the abilities of a craftsperson and the anticipated outcomes when these are developed.	Responsible for idea, development of a model that articulates nursing craftsmanship. Responsible for all aspects of the paper Including review and revision.

Having presented the papers in tabular from I will now go on to critique the studies using Boyer's four scholarships as a frame of reference.

5.4 Scholarship of Discovery

The scholarship of discovery relates to the creation of new knowledge. In my collection of research and papers The Scholarship of Discovery (Boyer, 1990) is evidenced in the research conducted, which consists of externally and internally funded qualitative research projects from an interpretivist tradition. Each of the studies focuses on illuminating stakeholders' perspectives and experiences.

Study 1 Using syringe drivers in Palliative Care: capturing the experience of patients, carers and community nurses. Papers 1 and 2.

Study 2 Leadership in Compassionate Care Programme. Undergraduate strand. Papers 3 and 4.

Study 3 Exploring the experiences of patients attending day hospitals in the Borders: A pilot study. Paper 5.

Study 4 An international learning experience for Scottish and Australian student nurses: Exploring the student perspective. Paper 6.

Study 5 Feedback in clinical practice: enhancing the student experience through action research. Paper 7.

Overview of research approach

For nurses to provide compassionate care it is important for them to know about the experience (Addo & Eboh, 2014; Parahoo, 2014) as viewed through the lens of those who give and receive it (Willis, 2007). The aim of the work discussed here is to attempt to make sense of the experience by exploring what it means for the individual (Coe, 2012; Tappen, 2016), through interpretative practices (Denzin & Lincoln, 2011) .

Qualitative research is increasingly informing healthcare provision and education as it can shed light on the complex interactions involved which are not simply explained (Anderson, 2010). Nursing practice is relational, responsive and needs to be flexible but those cared for also benefit when care is anticipatory and this is only possible with knowledge.

Conceptual frameworks guide the pursuit of knowledge (Tappen, 2016). They explain the things to be studied and the assumptions, expectations, beliefs and theories that support the research carried out (Maxwell, 2012). With this is mind I now turn to explore this research.

One strong element of coherence in my work lies in the methodological approach that underpins my studies, which is qualitative in nature. In keeping with this approach I see the world through the interpretivist lens, as this view offers opportunities to develop understanding of people living with illness (Bickman & Rog, 2008), and those providing care for them. Qualitative research is person centred (Parahoo, 2014) and reflection is fundamental to the process (Schön, 2017). Strengths include the in-depth nature of the data gathered and the flexibility associated with this approach, which is important when working with patients and families. Furthermore data based on human experience can be captivating and powerfully provocative and therefore forms a useful tool in the education of healthcare professionals. However a potential weakness is that qualitative research rigour is more difficult to demonstrate (Anderson, 2010). Nevertheless, provision of in depth understanding of nursing provided through qualitative research is invaluable to both health practitioners and policy makers (Parahoo, 2014).

Qualitative health research is distinct due to the sometimes life and death nature of care provision and complexities encountered in the context, such as the often

serious condition of the participants (Morse, 2011). Nurse researchers have finely honed transferable skills such as active listening, sensitive probing and responsive empathy. However if participant distress is perceived their caring disposition is likely to evoke a response to pause and to care at the possible expense of data collection (Holloway & Galvin, 2016). Patient comfort is prioritised as nurses uphold the NMC code of professional conduct. The code calls nurses to position themselves as advocate for the vulnerable (Nursing and Midwifery Council, 2018). This was a particular consideration in my first study where participants included terminally ill patients.

This body of research includes an interrelated combination of clinical and educational research. Figure 2 provides a visual depiction of the research journey and associated outputs as a cohesive whole.

I have used colour in the diagram to represent the relationship between my eight selected papers and the studies from which they emanated. The colours mirror those used in the Greek Temple diagram. The curling shape of the diagram depicts progression of my research journey and the arrows highlight the interconnectedness between the eight papers. The text between the boxes indicates the study focus and the multi coloured final shape in the curl represents the contribution that each of the papers and research studies collectively make to the capstone paper.

Red: Study 1 Compassionate care at the end of life

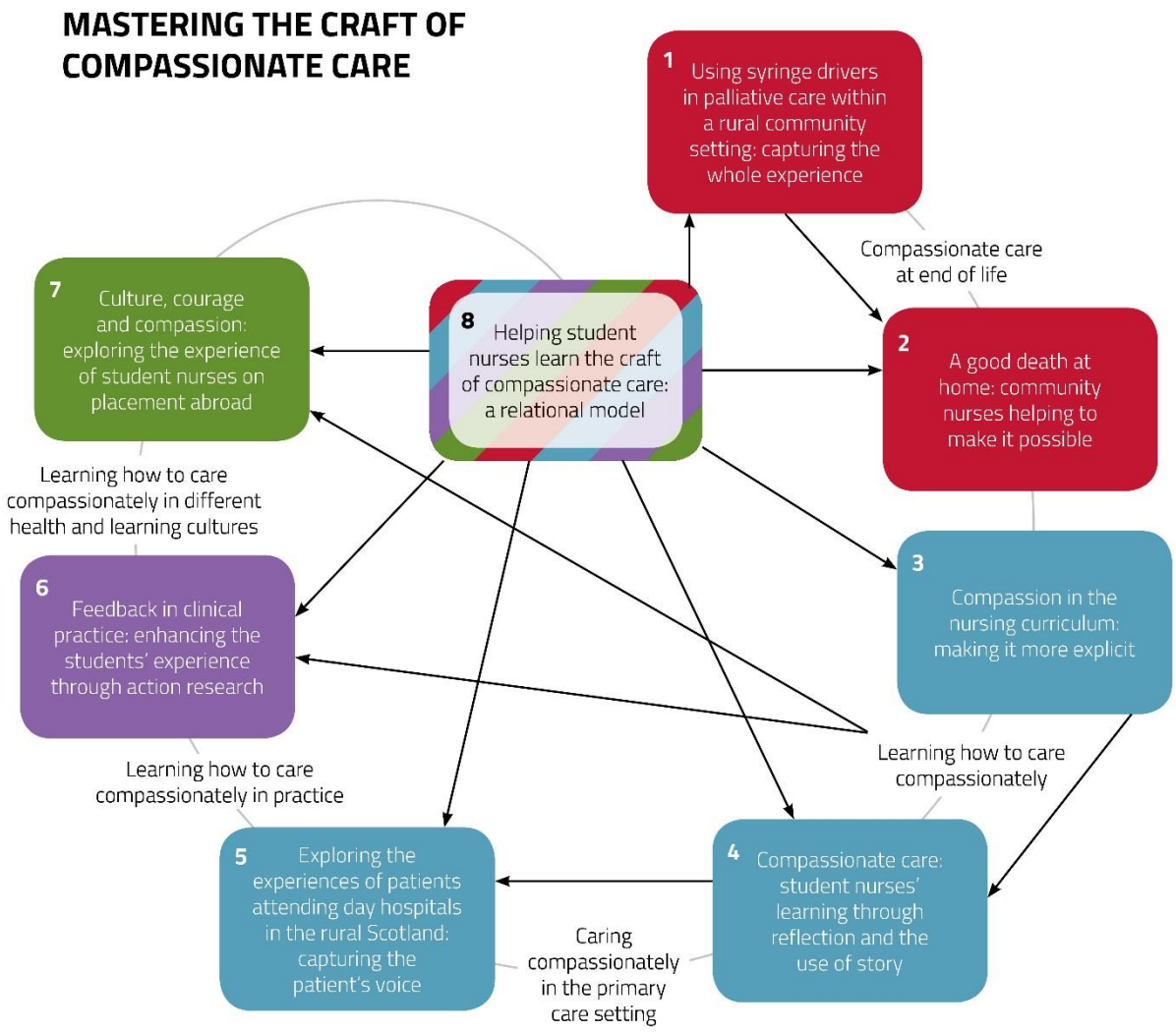
Blue: Study 2 and 3 Learning to care compassionately

Caring compassionately in the primary care setting

Purple: Study 4 Learning how to care compassionately in practice

Green: Study 5 Learning how to care compassionately in different health care cultures

Figure 2 Mastering the Craft of Compassionate Care



5.4.1 My ontological and epistemological premise

The interpretivist paradigm believes in an ontology that is relative, is influenced by context and therefore acknowledges multiple realities. The nature of this knowledge is interwoven and influenced by the personal beliefs and values of each subject involved and also that of the researcher (Cousin, 2009). The nurse encounters this relativist world in healthcare practice on a daily basis.

The aim of all my research was to contribute to knowledge of how it feels to be cared for directly, what makes it compassionate, and how this knowledge could

translate and influence learning and development for student nurses. The unique perceptions and experiences of people were central features of my studies and therefore highly subjectivist in relation to epistemology (Denzin & Lincoln, 2011; Parahoo, 2014).

> "We are shaped by our lived experiences and these can be seen in the data generated through our research" (Denzin & Lincoln, 2011 page 104).

The experience of illness and provision of care whether as one receiving or giving it influences the participants' perspective on life. Understanding the human experience is important to healthcare professionals involved in the relational aspects of caring for patients and their families (Holloway & Galvin, 2016). Context is believed to be as important as the experience of health and illness, the place where people live, the social support and the people with whom they connect all affect recipients of healthcare and should not be ignored.

Healthcare research may therefore focus in on any of these different influences and elements as they can each contribute to the overall experience. Morse identifies different categories of healthcare research. In this body of work three interrelated areas of emphasis are evident a) identification of healthcare need b) the illness experience and b) the education of healthcare professionals (Morse, 2011).

5.4.2 Research focus and methodology

While the focus of my research interest was progressively trained on compassionate caring in practice and education, the methodology underpinning the research studies varied in order to reflect the study aims and research

questions. Phenomenology can be considered a philosophy as well as a methodology (Usher & Jackson, 2019) and Heidegger's philosophy of phenomenology guided the first study as the focus was identification, description and interpretation of the lived experience of the participants while acknowledging the influence of the researchers' preconceptions (Parahoo, 2014; Walker, 2011). A qualitative descriptive approach was adopted in the Day Hospital Study as we wanted to use preselected touch points and to bear in mind the LCCP themes. However, what compassionate care meant to the individuals was explored in relation to their unique experience, which also embraces the philosophy of phenomenology.

Where the research aimed to bring about improvement within clinical practice, action research was the chosen approach (Coghlan & Brannick, 2010). The participatory and inclusive nature of action research was especially apt in the two studies involving colleagues in practice. Here the aim of the enquiry was to bring sustained change, therefore our colleagues in practice needed to share ownership (Whitehead & McNiff, 2006).

5.4.3 Overview of methods for data collection

Where we sought insights into the lived experience through hearing about participants' feelings, thoughts and perceptions, interviews were chosen to gather data (Holloway & Galvin, 2016). Interviews in healthcare research pose their own unique challenge. Illness tends to make a significant and enduring emotional impression on patients and their families, so asking them to recall after the fact is believed to provide better quality data (Morse, 2011). Morse (2011) recommends four strategies to generate high quality data. These are a) conduct interviews retrospectively, b) collect data over shorter periods, c) involve the caregiver and

d) take time. In our programme of research, the interviews were conducted retrospectively where possible.

I was introduced to narrative interviews and the emotional touch points method, which is explained below, during my involvement in the LCCP. This was a significant point in my research journey as I found the stories gathered to be powerful in gaining insights into the lived experience of others, and witnessed first-hand the response that personal accounts of care could provoke in those who heard them (Bate & Robert, 2007). Odell argues that a benefit of emotional touch points is that it allows the participants to describe their experience and feelings at key points in their journey (Odell, 2014). I found that it also provided landmarks for the participant as their story progressed. The touch points act as prompts similar to Riessman's story board approach which is also used in narrative interviewing (Riessman, 2008).Our rationale for using narrative interviews was that they captured not only the experience but what it meant to the participants (Gudmundsdottir, 1995). The method also helps the interviewer to engage emotionally with the participants (Odell, 2014).

Emotional touch points involve the interviewer inviting the participant to select a touchpoint, such as "arriving at the hospital", for them to talk about. A selection of positive and negative words is laid out that can help them describe what happened, how they felt, and words they associate with the experience such as 'anxious' or 'welcome'. The participants are also invited to choose a different touch point or word, and blank cards are available to record this. The participants then use these to describe their experience (Dewar, Mackay, Smith, Pullin, & Tocher, 2010; Edinburgh Napier University & NHS Lothian, 2012).

Focus groups are said to be particularly useful when studying decision making processes where priorities must be weighed (Barbour, 2008), and this is a key

component of caring, and a fundamental part of the nursing role. Where we sought insights into the experience of staff working in teams, we chose to use focus groups, as responsibilities, delivery of care, education and challenges were shared by the participants. However, focus groups were not always achievable due to competing priorities in care practice. Both interviews and focus groups were used accordingly to evaluate the action research interventions.

Data Analysis

I now turn, in this section, to explain my approach to data analysis. Thematic analysis is widely used in healthcare research qualitative descriptive approaches including narrative enquiry (Riessman, 1993), and serves to keep the researcher close to the data (Kim, Sefcik, & Bradway, 2017).

Thematic analysis was used throughout, guided by the work of Braun and Clarke (2012) who advocate

> "an organic approach to coding and theme development, one that is informed by the unique standpoint of the researcher and is fluid flexible and responsive to the researcher's evolving engagement with their data"(Braun & Clarke, 2012, p. 226) .

The analysis was both descriptive (where the data is summarised and patterned meanings described), and interpretative (where there was an attempt to decipher and interpret deeper meaning within the data) (Braun & Clarke, 2012). Six stages were followed, namely:

Familiarization with the data through reading and rereading, identification of patterns through systematically coding, clustering of codes and identification of themes, reviewing themes then defining and naming them.

Rigour

Qualitative research is not designed to be generalised however, standards for good practice should be followed. Rigour in qualitative research is concerned with appropriateness of the method to address the research questions and robustness of the design (Morse, 2011). Checklists have been developed with an aim to help researchers report the important elements of their work (Tong, Sainsbury, & Craig, 2007). Examples are the Consolidated Criteria for Reporting Qualitative Research Excellence in Qualitative Research (COREQ,) and Critical Appraisal Skills Programme (Critical Appraisal Skills Programme, 2019) . Some would argue that checklists can reduce qualitative research to a list of procedures (Barbour, 2001). Never the less they can help guide the researcher at all stages of the research including writing for publication. They can also be used as a useful reflective tool to critique their researcher's own actions.

I have chosen to use the Eight Big-Tent pedagogical model (Tracy, 2010), to appraise my research because it was developed to provide a common language of best practice but with flexibility in mind . The eight markers of qualitative quality within the model are; worth of the topic, rich rigour, sincerity, credibility, resonance, significance, contribution, ethics, and meaningful coherence. I have used the model and markers to critically reflect on my research and have included a summary table of key appraisal points for each study.

In each of the studies, informed consent was obtained and raw data was collected and stored according to ethical practice using recorded transcripts that were then transcribed and uploaded to Computer Assisted Qualitative Data Analysis Software (NVIVO) for coding. Researcher notes were also kept. This included processes for coding and reflections.

Data was coded, themes identified, and interpretations made using an iterative process of initial coding, reflection and discussion between the researchers.

Tappen (2016) also recommends that for the researcher to appreciate and value qualitative research they should engage in appropriate training (Tappen, 2016). I engaged in bespoke training on use of NVIVO prior to analysis of the first study and later completed training in qualitative interviewing at the University of Newcastle and qualitative analysis at Oxford Brookes University.

5.4.5 Appraisal of individual research studies

Research Study 1: Using syringe drivers in palliative care

Study aim

To capture the lived experience of patients, families and nurses at a distinct point in the end of life trajectory when a syringe driver was introduced to deliver medication.

Study design

The rationale for adoption of the phenomenological approach was because study aim was concerned with not only what the respondents experienced but how they experienced and interpreted the introduction of syringe driver (Parahoo, 2014).

Semi structured interviews and focus groups enabled us to collect the data we needed to answer the research questions.

On reflection narrative interviews using emotional touch points could also have achieved this with touch points aligned to priority points in participants' experience (Dewar et al., 2010; Odell, 2014). This method will be discussed more fully in study three below. The nature of the study, which was a stage in end of life care, was itself emotional and this method could have helped capture this aspect of the experience. From a practical perspective, it adds an additional task of choosing

the words and touch points and could therefore have increased fatigue for the patients. This was my first experience of using NVIVO and I found it an effective aid to data analysis (Zamawe, 2015).

Research questions

1. What does it mean to patients and carers, following the introduction of a syringe driver infusion to control distressing symptoms in advanced disease?

2. What are their experiences of the support and information they received?

3. What factors influence the provision of information and support at this time, by the community nurse?

Data collection and analysis

A purposive sample of patients and carers were identified through the palliative care service within the Scottish Borders. The palliative care specialist nurse carried out the patient and carer interviews because she had an established relationship with the family (Wright & Flemons, 2002). This could have introduced a limitation. The number of interviews was smaller than anticipated (n= 4 patients and 8 carers) due to participants' deterioration and recently bereaved carers unable to follow through with their intention to participate. The interviews were shorter than anticipated and believed to be influenced by interviewer inexperience. Concern for patient comfort and compassion can take precedence over the pursuit of rich data (Morse, 2011) and this was compassion in action. Timing was important and though interview experience was limited, skilled anticipation of deterioration was utilised and was key to success of data collection. The relationship between the interviewer and the participants was a possible study limitation however, balanced with the known benefits of a trusting relationship and responsive communication, which can enhance dialogue, we concluded that the

decision was morally appropriate. Ultimately, the glimpses of personal experience shared by patients and families were highly valuable and appreciated.

Two focus group discussions were facilitated with staff. All community and district nurses employed within the NHS trust were invited to participate and both community nurses (n=4) and district nurses (n=8) were included. It was clear that the close knit rurally situated community encouraged mutual appreciation and a sense of working on an equal footing (Barbour, 2008). The participants spoke freely and there was no sense of inhibition exhibited. I was one of two members of the research team who collected the focus group data and we alternated facilitation, field note recording and shared data analysis using Braun and Clarks steps of thematic approach (Braun & Clarke, 2012).

Findings and contribution to knowledge

The findings from this study highlighted the key role that the community and district nurses play in end of life care, and the choice to die at home. Five themes were identified; symptom control, final stages of life, geographical challenges, working in partnership and getting the timing right. The unique contribution made to the field related to the significance of syringe driver introduction. An interesting finding was how care provision encompassed the whole family and this included helpful, skilled and compassionate communication through well-chosen, timely cues by the nurse, around progressive deterioration and impending death.

Attributes of craftsmanship

The findings uncovered the nurses' ability to anticipate care needs, work flexibly and creatively (Gawande & America, 2007; Meal & Timmons, 2012) and to skilfully judge how and when to introduce the device. This was dependent on the nurses' "knowhow" or tacit knowledge (Frayling, 2012; Nonaka & Von Krogh, 2009;

Sennett, 2008) and was instrumental in enhancing patient comfort. The community nurses expressed the satisfaction of a “job well done” (Sennett, 2008). Provision of compassionate care provided meaning and value for the nurses and made the large workload and many challenges worthwhile (Berger, 2003; Mills, 1980; Sennett, 2008). The importance of decision making and taking timely practical action was evident in data gathered from each stake holder as was the nurses’ openness to take a risk and do things differently (Gawande & America, 2007; Kaufman & Schoepflin, 2009) in recognition and response to patient need.

Table 3 Study 1 Key critical appraisal points using the eight quality markers

Criteria	Critique of markers within the research
Worthy topic	Worth of the topic is supported by health care policy at the time (Department of Health, 2008a; Scottish Government, 2008)
Rigour	The approach and methods were outlined in the paper. Interviews and focus groups were appropriate for exploration of lived experience. Use of more than one method of data collection and more than one researcher is thought to open up complex and in depth understanding(Tracy, 2010). Timing of the patient interviews should perhaps have been earlier as some were unable to participate due to deterioration. Other studies recruited participants within 6 months of anticipated death, however syringe drivers tend to be introduced in the last days of life, which made the timing difficult. A weakness of focus group discussions is that they are artificial situations however, when the atmosphere is relaxed and supportive they allow participants to express their opinions openly (Barbour, 2008). A further strength is that they include interaction between the participants, which can be captured in the dialogue and through field notes. The use of thematic analysis provided a framework which enhanced consistency. This method is also believed to be useful where application in practice is important (Braun & Clarke, 2014). NVIVO proved to be a useful tool in the coding process and the research team attended a bespoke training session prior to data collection.

Sincerity	Research quality is dependent on the quality of the researcher (Anderson, 2010). This was a limitation and was reported in paper 1. The rationale for the selected interviewer was her extensive palliative care experience and relationship with the families at a sensitive time (Wright & Flemons, 2002). This relationship of trust was important to encourage openness however it may have influenced the patients' responses.
Credibility	Tacit knowledge applied in practice was apparent in the data and reported in the paper. In observing and taking field notes in the first focus groups I was acutely aware of the benefits of unspoken data but this was not included in the reporting Data were gathered from multiple voices and different stakeholders. Two researchers contributed to the data analysis. A highly valuable contribution to the analysis was reflective discussion between the researchers who analysed the data and agreed naming of the themes No member reflections were sought
Resonance	Difficult to assess except through citations and requests for the papers via Research gate. The International Journal of Palliative Care was selected in order to share the findings with an international audience. The second discussion paper was deliberately published in a journal with a wide community nursing readership and was responsive to then current changes in policy and practice (British Journal of Community Nursing).The focus of this discussion paper is how the findings from the research resonate with new end of life care guidance (Scottish Government, 2011).
Contribution	The study succeeded in contributing to knowledge about lived experience at a specific time in the trajectory of dying not published prior to this. The findings influenced local practice in NHS borders where training and support for staff was introduced. This was led by one of the research team
Ethics	Procedural ethics was through NHS scrutiny and approval. Reflections on situational ethics took place in relation to recruitment of participants so close to death. The team was reliant on the decision making of the palliative care nurse specialist responsible for recruitment and conducting the interviews. As in the study by Wright and Flemons (2002) the needs of the participants was placed before the needs of the study(Wright & Flemons, 2002).

Meaningful coherence	The study purpose was achieved. The aim was to explore lived experience, which best suited to qualitative methods, and aligns to an interpretive paradigm. The background literature was reduced due to limitations of wordage and journal style (Walsh & Downe, 2006). It did however connect with the research questions, methods, findings and interpretation. Paper two was a discussion paper and study detail was limited due to journal style. The priority was to inform practice and the aim of the BJCN is to publish research and clinical papers that are useful to nurses in their day-to-day work.

Research Study 2 Learning how to care compassionately

Context and position within the wider LCCP

The research which is the focus of study two, and papers 3 and 4 formed part of an externally funded three-year collaborative programme of research involving the University and the NHS (Leadership in Compassionate Care programme - LCCP). The overall aim of this research programme was to embed compassionate care in practice and education through action research activities in four programme strands. This included working closely with key NHS leaders to establish a research partnership (Edinburgh Napier University & Lothian, 2012). The early design and development of the project was published in a widely read nursing journal by the team responsible for the early development of the programme including myself (Adamson, King, Moody, & Waugh, 2009). The programme strands taken forward were a) Influencing nurse education by embedding the principles of compassionate care into the curriculum (the undergraduate strand), b) supporting newly qualified nurses, c) facilitating leadership skills development and d) identification of centres of excellence in compassionate care within acute practice (Beacon ward strand).

The LCCP research followed three key theoretical principles: Action Research, Relationship Centred Care and Appreciative Inquiry. The rationale for this as outlined in the programme report was that

> "Building on the principles of Action Research, Appreciative Inquiry and Relationship Centred Care allowed for practitioners to be part of the research process, to develop practice that was meaningful to patients, staff and families, to consider taken for granted assumptions about care, and to understand and celebrate and further develop practice that was already working well." (Edinburgh Napier University & Lothian, 2012, p. 32).

The LCCP was initiated in response to reports of poor patient care in practice. Research that focused on this public concern could have provoked a defensive response from healthcare providers. The appreciative enquiry approach helped staff to focus on positive acts of care and the action research approach encouraged inclusivity. Preserving the dignity of the practitioners providing care was important when working with practice (Peterson & Stevens, 2013), and by utilising a collaborative study design, trust was established and staff engagement maximised.

More can be found about this large scale programme of research at

https://www.napier.ac.uk/research-and-innovation/research-search/outputs/leadership-in-compassionate-care-programme-final-report.

Work with academic staff early in LCCP revealed a belief that compassionate care was implicit within the nursing curriculum.

Study aim

To make compassionate care explicit in teaching and assessment within an acute nursing learning experience

Study design

Action research was the chosen approach as it is concerned with identification of a problem and trying to change it (Lewin, 1946). Our problem was that compassionate care was not explicit within the curriculum.

The project formed part of the second action research cycle of the larger LCCP and was informed by the early findings and themes. The key themes are:

Caring conversations; Flexible person centred risk taking; Feedback: Knowing you knowing me: Involving, valuing and transparency; Creating spaces that work.

Actions for the undergraduate strand of the larger programme were identified as follows:

1. Presenting patient stories gathered in practice throughout the curriculum to enable a developing understanding of compassionate care. It was important to find ways to use this rich data as a learning resource for students.

2. Consider busy clinical area, where there is rapid turnover of patients - how do staff develop relationships and provide compassionate care within this context? Work within the Beacon wards revealed an impression within practice that in busy areas such as the emergency room, care could not be compassionate.

3. Assessing compassion skills. Assessments tended to be focused on technical skill with no marks or feedback offered for compassionate caring. This was perceived to devalue compassionate care and inclusion in the assessment was considered a way that compassion could be given recognition and worth.

Research question

Can compassionate care be made explicit within educational provision and assessed?

Study design

The focus of the action research intervention explores revisions to a blended learning level 9 nursing module that enabled development of systematic patient assessment skills, decision-making and treatment management in an acute emergency setting. Content was delivered face-to-face through simulated patient scenario sessions and online and the module was assessed through a written and practical examination.

We firstly arranged a facilitated action event involving all stakeholders (including student representation academics and colleagues from practice) where discussion of LCCP themes, current module content, and subsequent proposed module revisions agreed.

Academic staff then worked with the experienced actor patients who participated in the simulated patient scenario sessions to identify possible cues that they could use to raise awareness of the anxieties that patients may feel that could prompt the students to reflect in action about practice and respond compassionately (Schön, 2017).

Reflection on action was also encouraged during the facilitated reflective debrief following simulation which was approached in an appreciative way in line with compassionate pedagogy.

Strategies described by Sennett (2008) to enable the development of tacit knowledge associated with craftsmanship as outlined in paper 8 were incorporated into the module (Sennett, 2008).

The first is called “scene narrative” where students are invited through imagination and empathetic engagement to gain understanding of a patient’s experience (Sennett, 2008). Stories gathered in practice which aligned to module content,

were selected, recorded and released as podcasts with accompanying reflective questions (discussed in paper 4). Both the podcasts and the patient scenarios used during the practical teaching sessions provided opportunities for the students to question, imagine and take appropriate action, which are abilities, associated with craftsmanship. A further strategy suggested by Sennett is referred to as “instruction through metaphors” and was used to help the students know what to look out for during patient assessment. When learning for example how to listen to chest sounds, crackles associated with the presence of infection in the lungs (Sennett, 2008) was compared to the sound of cellophane being crumpled or salt dropping into a pan. During the simulation debrief and reflective discussion the lecturers shared their own experiences of difficulties they encountered in practice and overcoming strategies which aligns to Sennett’s third teaching approach, “sympathetic illustration” (Sennett, 2008).

Data collection and analysis

Step four of the action research cycle involved feedback from all stakeholders (Coghlan & Brannick, 2010). This was accomplished through two focus group interviews with staff and actor patients and a student online survey. The sample was purposive and actor patients and three lecturers involved were invited to share their views and experiences. The survey gathered qualitative and qualitative student data. Follow up focus groups would have enriched the survey data but this was prohibited by immediate commencement of a final practice learning placement.

Findings and contribution to knowledge

All students demonstrated compassionate practice during practical assessment and in the online discussion. In particular, this related to enhanced insights into

the patient's point of view and decisions to change practice in response to hearing first-hand accounts of care experience. The findings showed that the simulated practice enhanced student confidence and self-efficacy and prepared them to care compassionately in emergency (Fry, MacGregor, Hyland, Payne, & Chenoweth, 2015). The students also self-reported changes in their thinking and realisation of what matters to patients and intension to change practice in response.

Three themes were identified in the focus group data. These were

1) Demonstrating compassionate care. Staff and actors mentioned careful attention to how they fed back to students that would role model compassion. 2) Paving the way. This related to the benefits to students of reflecting on patient stories through the timely release of podcasts and online theoretical content, and also preparation of the actors before attending the face-to-face session, which paved the way for discussion and dialogue. An example of a cue used by the actor patients that aligned to the LCCP theme "Knowing you Knowing me " and subtheme of "making a connection" was by wearing something that would indicate a preferred hobby (such as football team scarf) that if noticed, could initiate a personal conversation between the patient and nurse. 3) The patient as a person. Students who treated the manikin as a "dummy" were encouraged to use their imagination to transport themselves into clinical practice and provide care that was compassionate. Changes were perceived by the actors who alluded to being treated as a person rather than a "heavy dummy" as they had experienced in past delivery of the module.

Attributes of craftsmanship

The students demonstrated the construction of both explicit and tacit knowledge gained from previous caring experiences in practice, either given by them or observed in others, and applied during simulated practice and reflective sessions.

Increasingly during the module and in the assessment the students demonstrated increased sensitivity to those cared for (Goodman, 2013), attention to detail (Harper, 1987; Sennett, 2008), creative thinking (Gawande & America, 2007; Meal & Timmons, 2012; Taylor, 2012) and taking practical action (Sennett, 2008; Thorlindsson et al., 2018). Notably these resonate strongly with attributes of craftsmanship.

Table 4 Study 2 Key critical appraisal points using the eight quality markers

Criteria	**Critique of markers within the research**
Worthy topic	Worth of the topic is supported by crisis accounts, disciplinary priority and gap in the literature on teaching and assessing compassion (Patients Association, 2011). It also contributes to the debate concerning whether compassion can be taught (Dewar et al., 2014).
Rigour	Action research met the study aim which was to change practice (Coghlan David & Brannic, 2014). The study was a case study pilot and could have progressed to a larger study Questions posed to students could have been crafted differently, and discussion enriched to open up the dialogue to other LCCP themes in paper 4. Students could also have been invited to be co researchers throughout. The method would have been reported in paper 4 more comprehensively if the paper had been written for a different journal. Journal style restricted reporting of study detail. This can be a problem for qualitative researchers publishing their work (Morrow, 2005; Treloar, Champness, Simpson, & Higginbotham, 2000). The rationale for the choice to publish in this edition was the timely focus on a special compassionate care focused edition.

Sincerity	Self-reflexivity was minimal in the reporting. Limitations were discussed in both papers but made more explicit in the second of the two papers. Although the background literature was limited, reference to the full LCCP final report offered the reader opportunity to read more about the methodology and background. Data analysis was not make explicit in terms of coding and theme development.
Credibility	The purposive sample was appropriate for this pilot. Crystallisation encourages comparisons between multiple types of data. This was not made explicit and was a limitation Multiple voices from different stakeholders were included in the evaluation stage and two researchers contributed to reflective discussion and data analysis. No member reflections were sought
Resonance	Student self -reporting indicated that the intervention changed practice
Significant contribution	Locally compassionate care was introduced as an educational theme throughout the nursing study programmes. The intervention described was established in the module.
Ethics	Procedural ethics was through University scrutiny and approval.
Meaningful coherence	The purpose of the study was to change educational practice and this was achieved. Action research allowed for inclusivity. The literature was more explicitly connected in the second paper both within the background and discussion sections. The background literature was not as comprehensive as it could have been in paper one due to limitations of wordage and journal style (Walsh & Downe, 2006).

Research study 3 Exploring the experiences of patients attending a day hospital in the Borders

Study aim

To explore compassionate caring in a community care setting informed by the LCCP themes, and gain understanding of the meaning of compassionate care for people attending day hospitals in rural Scotland.

Study Design

A descriptive qualitative approach was adopted in order to use the LCCP themes and pre-selected emotional touch points (Kim et al., 2017; Sandelowski, 2000). The rationale was to build on the findings from the LCCP and find out about the care experience in the community setting.

Research questions

1. What is the experience of patients attending a day hospital and their families?
2. What matters most to patients and families in relation to the care that they receive at the day hospital?
3. What elements of care do patients and their families consider important contributors to compassionate care?

Data collection and analysis

The purposive sample included patients who had attended one of three day hospitals within three months of commencement of the study. Those with a diagnosis of dementia were excluded from the study.

As principal investigator, I firstly established the research team, which included an academic with community nursing experience, a nurse manager from the NHS Trust and a community staff nurse. I then visited each hospital to meet the lead nurses and explain the study in advance of recruitment. The nurses identified a list of possible participants, explained the study to them using written and verbal information, and sought their agreement to participate. Many of the patients were older adults and having a trusted practitioner explain the study to them was considered good practice (Wright & Flemons, 2002).

Numbers of potential participants who met the inclusion criteria varied across the three sites. Five from each list were selected based on gender, reason for attendance and duration of attendance. The rationale for this was to gain insights across a range of patients (Tongco, 2007).

A possible bias in recruitment was that the nurses might have selected patients whom they thought would express satisfaction with the service. The aim was to avert the possible risk of alarming participants by cold calling.

The rationale for using emotional touch points was to invite the patients to share how they felt as part of telling their experiential story. The touch points were associated with key points on the participant's journey such as arriving at the day hospital. Positive and negative emotional words were offered to help participants describe how they felt (Dewar et al., 2010; Odell, 2014). Emergent themes and findings from the leadership in Compassionate Care Programme (LCCP) gathered in acute care settings informed the touch points. For example, "Being kept in the loop" was an LCCP theme and so participants were offered "Getting information" as a touch point.

The interviews took place in the patients' homes within a variety of towns and villages across the rural location. Two researchers predominantly conducted the interviews. However, the community staff nurse was invited to join the team as a development opportunity and also co facilitated two interviews.

The data were analysed by the two main interviewers using Braun and Clerks thematic analysis.

Findings and contribution to knowledge

The findings resonated with those found in acute care (LCCP) though continuity of care was found to have a greater emphasis in community care. Like

compassionate care, continuity of care is often identified through its absence. The participants made comparisons between regular attendance at the GP and the joined up care they received through the day hospital. It was interesting that compassionate care was identified as reciprocal. The patients valued helping others and taking an interest in the nurses as it gave them a sense of purpose and significance (Nolan, Brown, Davies, Nolan, & Keady, 2006).

Attributes of Craftsmanship

Within the patient stories, tacit knowledge was implicit as a key contributor to provision of compassionate care by the day hospital nurses. The care provided was considered to be a demonstration of compassion in action by the patients and important learning and encouragement for the nursing teams that the researchers fed back the findings on completion of the study. This turned the spotlight on feedback for learning and development of the craft of nursing. Emergent outcomes of compassionate craftsmanship were seen in the apparent job satisfaction, doing a good job for its own sake and shaping clinical practice (Sennett, 2008; Shaffer & Zikmund-Fisher, 2013; Thorlindsson et al., 2018).

Table 5 Study 3 Key critical appraisal points using the eight quality markers

Criteria	Critique of markers within the research
Worthy topic	Increase in care within community settings (Local Government Association, 2012). Ten years since pervious research on day hospital care (Nolan, 1987).
Rigour	The study design and methods were explained in the paper. The sample was purposive. The use of emotional touch points did provide prompts for the participants to share their story however some participants were clear in what they wanted to focus on during the interview and it is likely that this would have been so without the touch points. It was important to be flexible and accommodating. Thematic analysis was considered most suited to this study where research is applied and where the results can be accessible to those out with academia (Braun & Clarke, 2014). The wordage restriction was a challenge as this reduced the number of quotes included in in order to allocated space to an explanation of the less familiar emotional touch points method (Morrow, 2005; Treloar et al., 2000). Detail included such as the words selected by patients in their interview helped to convey additional insights for the reader.
Sincerity	Self-reflections on the credibility and dependability of the study were reported in the paper. Transparency could have been enhanced by inclusion of greater detail such as challenges associated with individual participant agendas during the interviews, achieving engagement between researchers and the staff at one of the three hospitals and geographical challenges in reaching the participants.
Credibility	Greater detail could have been included and researcher reflections on variation in quantity and quality of data. Relationship between the participants was touched on in the paper but could have been discussed in more detail. Patient data only was reported as nurses were not formally interviewed No member reflections were sought
Resonance	Staff indicated intension to make changes to practice during the debrief sessions where the data was shared and discussed. The community staff nurse who contributed to the study utilised the same method in her own research. It is important in reporting qualitative research that a balance is struck between inclusion of direct quotes and interpretation of the finding(Morrow, 2005). Feedback from peer reviewers resulted in

	the number of original quotes being reduced and subthemes removed from the text which was disappointing.
Significant contribution	Emotional touch points had not been reported elsewhere in a study of patient experience of compassionate care in the community setting. Examples of changes to practice as a result of the study were 1. Review of the “invitation to attend the day hospital” letter and development of an information leaflet to enclose with this. 2. Review of process for greeting patients on their first visit so that they received a deliberate welcome. 3. The emotional touch points method was used to evaluate a new discharge service in NHS and led by the community nurse involved in the study.
Ethics	Procedural ethics were through University scrutiny and approval Reflections on situational ethics took place in relation to recruitment of participants. The team was reliant on participant information communicated to potential participants by the day hospital staff. Participants were invited to suggest a suitable time for interview and we went to them. Interviewing the participants on their own homes helped them to feel relaxed and able to be open in sharing their experiences (Koch & Hudson, 2000). As in the study by Wright and Flemons (2002) the needs of the participants was placed before the needs of the study
Meaningful coherence	The purpose of the study was achieved. The gap in the literature was made clear in the paper and the link to the LCCP themes and Senses framework helped to increase connectivity.

Research study 4 Feedback within clinical Practice

Study aim

To respond to the student voice and enhance feedback experience within clinical practice

Context

In the UK, student nurses experience 50% of their learning on clinical work based placement where they are supervised and assessed by nurse experts (mentors). Feedback is known to be central to provision of a supportive and effective learning environment for student nurses (Gray & Brown, 2016; Vinales, 2015). It enhances the mentor student relationship, however it is known to be complex. Feedback is important in provision of compassionate care as it enhances understanding of what matters to people and also enhances learning (Edinburgh Napier University & Lothian, 2012). An audit of assessment and feedback practice carried out in the nursing school revealed that 68% of a cohort of 476 students felt that they received insufficient feedback. In particular the findings raised questions about mentors' provision of feedback to students during clinical placement and the inclusive nature of action research was important in achieving a change in practice (Edinburgh Napier University & NHS Lothian, 2012). Clinical educators who support both mentors and students in practice were important contributors to the action research team as they had established working relationships with the mentors. The inclusive nature of action research offered the opportunity for trained researchers to work with knowledgeable local stakeholders to address this problem (Denzin & Lincoln, 2011).

Study Design

The action research approach was guided by Coglan and Brannick's (2010) action research cycle . In the planning action the research team developed an evidence based face to face training resource for mentors. The study took place in three sites within a large hospital and bespoke information about the project was shared with mentors, students and NHS managers.

The action research process mirrors elements of professional nursing practice, which helped to make the process meaningful for practitioners. The iterative process of patient assessment, identification of need, intervention and review is routine to nurses providing care and this resonates with the action research the cycle of enquiry, intervention and evaluation (Hart & Bond, 1995).

A second benefit of the participatory nature of action research was the opportunity to influence, as the practice-learning environment does not lie within the academics' sphere of control. By working with colleagues who support student learning on placement, practice can be improved (Myall, Levett-Jones, & Lathlean, 2008).

An interactive evidence based training session for mentors was developed with a predominant focus on practical application. The content focused on exploring the nature and purpose of feedback provided in practice and reinforced the importance of explicit feedback provision to students every day. The findings from data gathered in the pre-step audit of feedback experience detailed above was used to initiate discussion. The sessions provided mentors with space to share experiences, reflect on current practice and explore how this could be enhanced.

Pocket sized flash cards informed by literature were developed for mentors to carry with them and provided top tips for feedback and sample sentences to help start a dialogue. Flashcards have proved to be a useful prompt resource in other healthcare professions (Seymour & Watt, 2015). A template for personal reflection on interaction with students was also developed. This acted as an incentive to mentors as UK registered nurses UK must revalidate every three years in order to maintain professional registration and the reflections would contribution to their portfolio of development evidence (Nursing and Midwifery Council UK, 2018).

Academics supporting students in practice explained the rationale for the project to them. As feedback in placement was known to be a concern for students they also explored different types of feedback and how students might seek this out and act on it. This fulfilled the taking acting phase of the action research cycle. The final phase is evaluation. Findings are discussed below.

Research questions

What does feedback mean to student nurses and their mentors?

How can educational providers work with practice to enhance feedback on placement?

Data collection and analysis

The sample was purposive. Students and mentors who had experienced the intervention were invited to participate. Evaluation was accomplished through focus groups and interviews with all stakeholders and Braun and Clarke's thematic analysis used to identify key themes and subthemes, which would inform the second cycle.

Findings and contribution to knowledge

The findings reinforced the vital part that feedback plays in student nurses' learning about caring. The data also confirmed the unique position that mentors hold as experts in practice, role models and facilitators of learning and development. Three themes were identified from the data. 1.) Shared responsibility. All stakeholders emphasised that responsibility for feedback rested with mentors and student alike. 2.) Feedback process in action. Mentors were surprised that students felt reluctant to ask for feedback and of the impact that their feedback had on the students. Dialogue about the nature and purpose of feedback revealed the benefits of explicit as opposed to generic feedback. 3)

Project impact. In response to fresh insights into how students felt, the mentors expressed greater empathy towards them. Some mentors believed that provision of generic feedback such as " you are getting on well" was enough while students were looking for explicit guidance on how to improve. The action research approach supported development of a collaborative, respectful and supportive intervention that initiated reflection on practice and behaviour change amongst mentors, which ultimately reshaped feedback practice (Myall et al., 2008). In cycle two a focus on feedback was introduced to mandatory training for all NHS Lothian employees, including all student mentors.

Attributes of craftsmanship

Feedback is known to play a significant part in the nurses' growth and development of expertise (Benner & Tanner, 2009). Provision of constructive feedback requires compassion and insight (Aston, Aston, & Hallam, 2014) and the emergent elements of compassionate craftsmanship were apparent in this study through the apprentice master relationship. The mentors demonstrated commitment to do a good job in supporting students. During the feedback sessions, they were questioning and open to do things differently and the focus group data showed self-reported practical action through changes in their supervision practice. These abilities are also identified in craftsmen (Gawande & America, 2007; Harper, 1987; Kaufman & Schoepflin, 2009; Mills, 1980; Sennett, 2008).

Table 6 Study 4 Key critical appraisal points using the eight quality markers

Criteria	Critique of markers within the research
Worthy topic	The topic of Feedback for learning was highlighted in the literature as an area for development (Gray, 2014; Vinales, 2015).
Rigour	Although action research proved effective in this study the process and setting was complex. Using Peters' (2017) definition of "difficult to resolve", the problem of feedback in practice could be considered wicked. The qualitative data collected was rich and informative however meeting with mentors proved challenging due to competing clinical pressures (Peters, 2017). Methods were explained in the paper.
Sincerity	Limitations associated with recruitment were reported in the paper. The large research team posed challenges however this allowed for maximum inclusivity. An element of trust was required in terms of delivery of the educational sessions as the practice educators delivered these and success was reliant on their skilled facilitation. The process was outlined and the methodological framework explained
Credibility	Feedback from the journal reviewers initiated discussion and debrief amongst the team which was highly valuable. Triangulation and crystallisation were not possible as only one source of data Multiple voices were included from staff, students academics and educators in practice No member reflections were gathered formally or reported but took place in the team debrief
Resonance	The student direct quotes were provocative and emotional captivating such as those that communicated resignation that their learning was perceived to be a low priority in practice. The study started a dialogue amongst mentors concerning provision of explicit constructive feedback to students.

Significant contribution	The study influenced changes in the curriculum to include feedback literacy Feedback sessions introduced to mandatory training sessions for all NHS staff of how to give and receive feedback. This is not yet complete so the impact is uncertain. Led to a further project: Co-creation of a student feedback tool
Ethics	Procedural ethics was through University scrutiny and approval
Meaningful coherence	The purpose to enhance feedback for nursing students in the practice learning environment was accomplished. The action research approach succeeded in bringing all stakeholders together with a shared aim. The literature made clear connections with the research aim both within the background and discussion

Research study 5 An international learning experience for Scottish and Australian student nurses: Exploring the student perspective

Study Aim

To explore the experience of student nurses on overseas placement including responses to cultural differences.

Study design

A descriptive qualitative approach was used to capture the experience of student nurses on clinical placement overseas. The placement was offered as part of an agreement between my University and one in Western Australia. Narrative interviews were undertaken using emotional touch points.

Research questions

What are the views and feelings of nursing students who undertake a clinical placement abroad?

How do nursing students on overseas placement respond to cultural differences?

Data collection and analysis

The sample was purposive (n-10). All students who took part in the overseas placement were invited to participate. Recruitment was problematic as a result of partnership agreement restricted to a maximum of two students engaging in the experience at any one time due to restricted placement availability. Four additional participants agreed to participate but did not follow through with the interview due to timing and competing priorities.

Findings and contribution to knowledge

Development of cultural awareness is vital to compassionate caring (Papadopoulos, 2006). Expectations and evidence of readiness for independent work as a registered nurse is increasingly required to be demonstrated by graduate nurses (Diamond, Walkley, Forbes, Hughes, & Sheen, 2011). Participants in the study expressed the challenges and anxieties of the experience in the telling of their stories and their coping mechanisms. Professional and personal development was apparent in all of the participants as was confirmation of career choice and increased self-efficacy which is also associated with craftsmanship (Berger, 2003; Gawande & America, 2007).

Attributes of craftsmanship

The students became acutely aware of cultural differences between their own and the country visited and associated knowledge deficits which they corrected in order to increase understanding (Carmel, 2013; Meal & Timmons, 2012), and problem solve to improve care. Students exhibited flexibility and openness to do things differently (Gawande & America, 2007; Kaufman & Schoepflin, 2009). They also demonstrated compassionate craftsmanship through shaping practice (Gawande & America, 2007) and role modelling compassionate care.

Table 7 Study 5 Key critical appraisal points using the eight quality markers

Criteria	Critique of markers within the research
Worthy topic	Topic was supported by literature. Need for development of cultural sensitivity and competence in multidisciplinary literature (Long, 2012; Papadopoulos, 2006). The European University Association as part of the Bologna process agreed that by 2020 20% of students should engage in a mobility experience
Rigour	Emotional touch points method was appropriate for exploring the emotional aspects of the student lived experience. Recruitment was challenging and the sample size could have been larger although nothing new emerged in the later interviews. The study duration was prolonged due to recruitment. Thematic analysis was considered useful for this study where research is applied and where the results can be accessible to those out with academia (Braun & Clarke, 2014).
Sincerity	Self-reflection could have been more explicit in the reporting. One researcher may have brought personal bias
Credibility	The methodology focused on emotions therefore the narratives were emotional. The participants shared their depth of feeling Triangulation and crystallisation were not possible as one source of data. Member reflections were obtained by sending the participants the interview transcriptions. One participant responded to agree with the content and meaning
Resonance	The direct quotes spoke for themselves and were moving to read
Significant contribution	Value of student mobility opportunities continues to be highlighted in the literature.
Ethics	Procedural ethics was through University scrutiny and approval
Meaningful coherence	The method fitted with the goals. There is meaningful connection between literature, research questions and findings

Capstone paper

This paper amalgamates my research findings with literature, and presents an original recombinant innovation in the concept of compassionate craftsmanship. The concept brings together what may at first glance appear to be disparate endeavours, combining caring practice with the work of the craftsman. However, on closer examination the craftsman's ability to carefully sense their way in skilful application of embodied knowledge is mirrored in the complex and dynamic work compassionate nursing.

The paper and model was briefly introduced in chapter 3 in relation to its position within the Greek temple metaphor.

In "Helping Student Nurses Learn the Craft of Compassionate Care: A Relational Model" I proposed a model of compassionate craftsmanship informed by my own research. The article presents this model with a discussion of multidisciplinary literature. Findings from my own research emphasised the key part that the often hidden tacit knowledge, closely associated with craftsmanship, plays in compassionate nursing practice. Surfacing the invisible through glimpses of momentary yet significant acts of care was an important outcome of the research. These were complex, personalised to the situation and to the recipient of care, yet often considered incidental by the nurse craftsman (Dewar & Nolan, 2013). Sennett's seminal work The Craftsman (Sennett, 2008) was a significant influence in helping me identify what was illuminated in my research and which I propose is key in compassionate caring. This apparent link with craftsmanship drove me to a review of cross-disciplinary literature on craftsmanship and the subsequent development of a model to be used as heuristic device for nurse educators and others with an interest in better understanding and developing compassionate pedagogies. The model can be seen in the image below and features attributes of

compassionate craftsmanship, enablers to their development, and anticipated outcomes that influence care practice. It represents a drawing together of the findings of my previous studies in order to crystallise and communicate key features as a starting point for discussion and debate in relation to nurse education.

Figure 3 Learning the Development of Compassionate Craftsmanship

The model places the learner at the centre. The purple ring represents enablers to development of compassionate craftsmanship informed by the findings from my own body of work and that of other disciplines (Gane & Back, 2012; Gawande & America, 2007; Nonaka & Von Krogh, 2009; Taylor, 2012; Thorlindsson et al., 2018). These enablers are development of knowledge both tacit and explicit (Nonaka & Von Krogh, 2009), opportunities to think creatively (Ingold, 2011) and take appropriate practical action (Thorlindsson et al., 2018). In a ripple effect the

rings grow larger and the arrow depicts progression outward. Nurse educationalists can offer pedagogical approaches and learning environments where students grow in knowledge, are given the scope and opportunity to think creatively and put their knowledge into practical action in provision of compassionate care.

I see these enablers leading to the development of abilities associated with craftsmanship which include a questioning curious attitude (Kaufman & Schoepflin, 2009; Mills, 1980; Sennett, 2008), willingness and ability to localise or zoom in on the situation at hand to problem find and problem solve (Harper, 1987; Thorlindsson et al., 2018) accompanied by flexibility in attitude and openness to do things differently (Gawande & America, 2007; Kaufman & Schoepflin, 2009). The projected long term outcomes seen in the outer ring are firstly the hallmark of a craftsperson which is to be resolved to consistently do a good job for its own sake (Harper, 1987; Sennett, 2008) and to shape practice (Gawande & America, 2007; Meal & Timmons, 2012). In addition, self-efficacy (Gawande & America, 2007), job satisfaction and a sense of meaningfulness are experienced (Coeckelbergh, 2013). Self-efficacy is associated with an ability to see difficulties as challenges rather than hindrances and is known to reduce risk of burnout which is associated with compassion fatigue and poor care (Ventura, Salanova, & Llorens, 2015). The outer ring has no border, conveying the lifelong learning experience of the compassionate craftsman.

The model presented in this paper is evidence based and designed to be of interest to nurse educators and mentors supporting and developing student nurses. Application will be discussed further in the section to follow.

5.5 The Scholarship of Teaching

In the previous section my focus was the scholarship of discovery however on reflection the eclectic nature of my work has been motivated and inspired by each of the four scholarships which I believe represent a fully rounded academic. In this section my focus will be the Scholarship of Teaching and how my work relates to this domain. The scholarship of teaching involves bringing disparate information together and presenting it to students in a creative, applied and intelligible way (Miller, 2014). It is enhanced by active involvement in educational research (Elsen, Visser-Wijnveen, Van der Rijst, & Van Driel, 2009) and is essential for teachers who are committed to immersion in the knowledge of their field (Boyer, 1990). The work of the nurse educator goes beyond knowledge conveyed and skills taught. The development of learning opportunities and environments where learners thrive and develop is vital and this includes challenging their existing values, beliefs and practice (Starck, 1996).

I believe that teachers as scholars must also be learners and how better to gain insights into caring practice than through research activity? This is strongly represented in papers 3 and 4 where, through action research, innovative teaching and learning strategies involving personal stories are used to help students gain insights into the lived experiences of others and to make connections between what people need and want and current practice. Students were also exposed to real time patient scenarios with simulated patients who were primed to question and role-play the anxious patient. In a simulated care environment of fast pace and high patient turnover, students were encouraged to reflect in action or “think on their feet” (Schön, 2017). They learned “by doing” that care could be compassionate in any care setting. Using prior experience and tacit knowledge, they engaged in knowing-in-action as they responded to the patient’s

need. They then reflected on action where peers, simulated patients and lecturers provided feedback (Schön, 2017).

The approach to teaching compassionate care through simulated practice and use of real life stories was introduced at a time when the focus was almost exclusively on honing technical skill. Therefore, the new emphasis in learning through reflection on the softer aspects of care was ground breaking. I was personally invited to share these pedagogical interventions with colleagues through contribution to an international Compassionate Care Symposium and through publication in a special issue of the Journal of Holistic Healthcare (Adamson, 2018).

Educational practice described in paper 3 was also innovative as podcasts focused on caring were brought to life by use of recorded stories of care experience, which were shared by those who owned them. Here the novelty lies in creatively aligning the real live narratives to acute nursing care contexts and releasing them as podcasts which initiated reflection on these and the student's own experiences, which brought about transformational learning (Mezirow, 1991).

The scholarship of teaching also underpins the Feedback in Clinical Practice project which features in paper 6. Action research is especially amenable to educational interventions and scholarship (Norton, 2018). Bespoke educational resources informed by prior 'scholarship of discovery' activities were developed for nurse mentors. This project also demonstrates teaching in its broadest sense, in that it provided a mechanism for collaborative practice, which drew in colleagues from clinical practice in order to develop their skills in educational research and writing for publication. Reflective practice is a key theoretical influence in the scholarship of teaching as the academic ponders all elements of the learning

experience, imagines how this might be different and plans and implements appropriate change (Schön, 2017).

One output from the project was the suite of flashcards mentioned previously. This was subsequently inspired further work with students as partners. Senior students worked with academics to develop a similar student learning resource for junior students focused on how to seek, receive and act on feedback in practice.

I was keen to develop fresh learning experiences for final year students and opportunities to develop cultural sensitivity, which is important in compassionate care, I set up a study abroad opportunity in Western Australia. This catapulted the students into an unfamiliar environment and disorientating dilemmas similar to the experience of that person who becomes a patient and provoke transformative learning (Mezirow, 1991).They are plunged into an unfamiliar world which can cause anxiety and feelings of vulnerability. In paper 7, the experiences, challenges and ability to adapt, develop and question custom and practice in caring are explored. The paper is focused on the emotional aspects of the student learning experience. The participants demonstrated a variety of attributes that relate to learning compassionate craftsmanship, including the resolve to do a good job for its own sake.

The relational model central to paper 8 made a contribution to curriculum development for undergraduate nurses. Guided by the Nursing and Midwifery Council all pre-registration nursing programmes are reviewed, revised and formally approved every five years. The model became an influence in the dialogue, planning and development of a new programme to be implement in 2020/21. In accordance with the updated Standards for Pre-Registration Nursing educational providers must ensuring that students are able to provide and promote person-centred and sensitive care, taking into account people’s values

and beliefs, diverse backgrounds and cultures, needs and preferences while adapting to and adjusting when circumstances needs change. The concept of compassionate craftsmanship aligns to this.

I will now go on to discuss my contribution to the scholarship of application.

5.6 The Scholarship of Application

The Scholarship of application is the “interaction of knowledge and its practical use” (Honig, Smolowitz, & Larson, 2013) page 359. This underpinned my work in so far as the nurse educator is well positioned to apply the knowledge ‘discovered’ through their own research activity and that of others, within educational practice. This is known to be beneficial for healthcare students who benefit when educators remain connected with patients, and active involvement in research helps to achieve this. Perceived advantages include increased awareness amongst students that research leads to knowledge creation in the discipline (Elken & Wollscheid, 2016). This is also found to correlate with students’ perception that their course is current when lecturers incorporate their research into teaching. It also sparks curiosity and interest in research for students as future registered nurses and aligns to vision and expectations of the profession.

> “faculty committed to academic nursing demonstrate a commitment to inquiry generation of new knowledge for the discipline connect practice with education and lead scholarly pursuits that improve health and healthcare” (American Association of Colleges of Nursing, 2016, p. 1).

Next I will turn to how papers 2, 3, 4, 5 and 6 relate strongly to the scholarship of application.

Firstly, research findings generated through activities undertaken within the Beacon ward strand of the Leadership in Compassionate Care Programme were applied in an action project which contributed to the educational strand of the programme. The key themes, and also stories from patients, families, staff and students were subsequently woven into curriculum content. Here they acted as a catalyst for the development of empathy, compassion, caring knowledge and skill (papers 3 and 4) (Adamson & Dewar, 2011, 2015).

The scholarship of application is also evident in the syringe driver project (described in paper 1) where in paper 2 findings from the research are discussed, compared and contrasted with new national guidance on end of life care for “A good death at home”(Adamson & Cruickshank, 2013). This scholarship is further evident in paper 6 as data gathered through audit of the student experience of assessment and feedback were used to initiate an action research project aimed at enhancing feedback practice.

The Scholarship of application is also evidenced in the day hospital study which is the focus of paper 5 (Adamson et al., 2017). Key themes from the LCCP and undertaken in acute care are applied to an exploration of care in the community. In addition, the impact of this applied work is evident in the development of clinical colleagues and which initiated further work to enhance care in the community (Starck, 1996). In practice based learning and development it is beneficial to make findings available to practitioners immediately (Peterson & Stevens, 2013). Sharing the findings of this study stimulated dialogue with the nurses at the point of care, so that changes and actions could be agreed and implemented to enhance compassionate care (Burgener, 2001). I will turn to discuss my contribution to the scholarship of integration.

5.7 The Scholarship of Integration

The scholarship of integration is concerned with making connections across disciplines (Bartunek, 2007) and integrating what can be isolated facts into something greater (Fisher, 1984). Knowledge is gathered and amalgamated, then presented in a different way to make greater sense of it (Barbato, 2000 page 214; Miller, 2014). Boyer emphasises a significant advantage of the scholarship of integration is that it situates specialities in broader contexts which can be make it more meaningful for those out with the disciplines themselves (Boyer 1990 p18). In my case, the disciplines of Nursing and Education are a significant area of integration within work.

My capstone paper further evidences integration of a range of literature and empirical work and culminates in visualising the multidisciplinary recombinant innovation of compassionate craftsmanship. Here I combine the practice of compassionate caring with the expertise and attributes of craftsmanship identified in other disciplines (Eddy, Hoeksel, Fitzgerald, & Doutrich, 2018).

5.8 Conclusion to this chapter

This chapter has presented and critiqued my core papers and related research studies. Using Boyer's four scholarships as a framework, I have demonstrated how my work, taken as a whole, makes a contribution to all four domains of scholarship. Theories that influenced the work will now be discussed.

6.0 Chapter 6 Theoretical influences

6.1 Chapter introduction

The last chapter presented and critiqued the core papers and associated research in relation to the contribution they make to Boyer's four scholarships.

This chapter focuses on the underpinning theoretical influences on my research and my incrementally developing concept. Growth and development of a discipline is dependent on accumulation of knowledge, and theories contribute to this by connecting knowledge with practice (Parahoo, 2014).

The chapter outlines range of conceptual platforms, which underpin my research trajectory. Firstly, I discuss the theory of craftsmanship and the key attributes and abilities of the craftsman which my own research in nursing practice revealed. The influence of experiential learning theory in my pedagogical studies through students' application of theory in direct care practice, and provision of feedback from nurse experts is also discussed. Narrative and transformative learning theories also influenced my research as I adopted a pragmatic problem solving approach to the apparent compassionate care deficit alluded to earlier. Stories gathered in practice, which conveyed care experiences were personally transformational for me, and this prompted me to use them as a learning tool within my pedagogical approaches. My own learning prompted personal reflections about the powerful arresting nature of stories and the underpinning influence of both narrative and transformational learning theory on my work. Finally, reflective learning is an essential interwoven element within each of these.

I will now go on to discuss these influences on my work, thinking and ongoing development as a researcher.

6.2 Theory of craftsmanship

The concept of craftsmanship has a longevity which began with Aristotle and relates to possession of the practical knowledge to know what is right and good in a given situation and make wise judgements (Coeckelbergh, 2013). This practical knowledge is often invisible and can be difficult to articulate (Polanyi), and yet is discernible in its application. Harper describes this as engaging in knowing beyond the here and now (Harper, 1987). This tacit knowledge, or knowhow is stored up in the mind of the worker and is an important distinct marker of the craftsman (Harper, 1987; Sennett, 2008; Thorlindsson et al., 2018). MacEachren describes this expertise in terms of collectively activating affective, cognitive and psychomotor faculties integral to the craftsperson (MacEachren, 2004), while Goodman alludes to imaginative, intuitive thinking (Goodman, 2013 page 89). In practical application this is about looking for cues and identifying patterns which could also be described as artistic insight leading to effective reasoning and appropriate decision making (Rogers, 1983) . This expertise was what I observed in the work of the nurse experts who participated in my research.

It is important to draw attention to a further and important marker of the craftsman which is the internal motivation to doing a good job for its own sake (Thorlindsson et al., 2018), and this according to Sennett makes the craftsman distinctive (Sennett, 2008). He goes on to identify three foundational abilities of the craftsman, which are to localise or zoom in on the matter at hand, to question and consider what action to take, and to be open to doing things differently in order to achieve the best result. He uses the skilled and detailed work of the surgeon to illustrate how this might be worked out in healthcare practice. This precision and mental agility has long been associated with craft mastery by the early theorists such as Becker and Harper who alludes to being willing to take risks while at the

same time acting with caution (Becker, 1978). Gawande and America (2007) also focus on the work of surgeons. They describe the importance of three key motivations. The first is diligence, where good enough isn't good enough. A good job requires going the extra mile to provide excellent care. The second is a resolve to do what is right and the third is ingenuity which might also be described as resourcefulness (Gawande & America, 2007). This resourcefulness and going beyond the task at hand was also alluded to by early writers (Harper, 1987, p. 21). This usefully positions craftsmanship with the work of the compassionate nurse who must be willing to work with uncertainty and take risks in order to provide the care required (Dewar and Nolan). I view this as important for my work as these attributes were evident in the nursing practice of community nurses caring for dying patient and their families and in the day hospital nurses coordinating patient care.

The work of the craftsman is also social and relational as the craftsman of old was immersed in and served the community (Becker, 1978; Harper, 1987). This active engagement with those around them is shared by the compassionate carer (Cole-King & Gilbert, 2014).

The outcome of the craftsman's work is determined by the expectation of the patron (Barker & Buchanan-Barker, 2004), and in the same way the patient is central in compassionate care. The craftsperson needs to know how to go about their work in order to meet the expectations of the recipient, or negotiate what is possible. The compassionate nurse sets out to discover what the person they are caring for needs and wants. In dignified compassionate nursing this entails caring with, as well as caring for the person. The precision and diligence applied to the task is often invisible but can also be transformative (Barker & Buchanan-Barker, 2004, p. 18).

As a nurse educator at a time when poor care was reported, nursing practice questioned and professional standards perceived to be lost, reclaiming craftsmanship in nursing resonated strongly with me. Sennett's application of craftsmanship to nursing caused me to reflect on the care practice uncovered in my research, and also the cross over between craftsmanship and intuitive compassionate care.

6.3 Theory of experiential learning

Experience shapes who we are and learners enter programmes of study with their own life story. In nursing the learners are adults and bring with them their existing attitudes, values and beliefs which may impede their ability to care compassionately. Compassionate care must therefore be learned. Learning involves growth, and experiential learning is said to be the transformation of experience into knowledge, skills, attitudes and values (Jarvis, 1999).

In his early work, Dewey described experience as a "moving force" and points out that not all experiences are educative. The quality of the experience is judged on where it leads the learner and for the educator this may be introducing them to a new way of thinking, to arouse curiosity and reflection. The aim is to increase initiative and intensify purpose. He proposes two principles fundamental to experience. These are firstly continuity, which relates to the belief that every experience absorbs something of previous experience and influences that which is still to come. Secondly, the principle of interaction, whether that be with others as human experiences are generally social, or with the environment (Dewey, 1986). In the shifting landscape of healthcare, the nurse must embrace the concept of lifelong learning and much is practice based whether it be the student on clinical placement or the nurse with a community caseload.

The challenge for the nurse educator is the creation of learning environments which provide experiential learning opportunities and trigger enquiry and a quest for knowledge and expertise. A key contributor to this is reflective practice (Jarvis, 1999), which can be both retrospective reflection on action where one weighs up the things that went well and what could have been different, and reflection in action where the situation at the time is problematized and solutions in the moment sought (Schon & DeSanctis, 1986). This is also referred to as thinking on one's feet, can be described as creative and is often in closely associated with application of tacit knowledge (Jarvis, 1999). Although half of the nursing students' learning takes place in clinical placement, the busy environment does not always allow for questions to be posed and answered at the time, while in simulated practice these queries can be expressed and reflected on with peers and academics. Using Kolb's experimental learning cycle care experiences are discussed, concerns and queries expressed and solutions formulated (Jarvis, 1999). These can then be tested in a safe environment and feedback used to initiate reflection and development of knowledge and skill to be applied in real time clinical placement. These learning experiences shape, form and reform the developing nurse and are noticed and self-reported throughout the data gathered as part of my body of research. This was fundamental in the simulated practice, debrief and online reflective activities introduced in papers 3 and 4. Experiential learning and reflective practice is also central to student learning and development through study abroad in paper 7.

6.4 Theory of Transformative learning

Mezirow's work has influenced my thinking because my own research and also published accounts written by health practitioners revealed transformed thinking and care practice (MacArthur, 2014; Mezirow, 1991; Youngson, 2011). Nurses

and students described how specific care encounters or hearing real life narratives disorientated and challenged their thinking and beliefs which lead to transformation. Transformative learning

> "seeks to explain the way adult learning is structured and to determine by what processes the frames of reference through which we view and interpret our experience are changed or transformed" (Mezirow, 1991 page xiii).

This is what I wanted to achieve in the students. By entering into the experiences of others through listening to narratives, transformation could occur in their thinking, values and practice. I knew that this was possible because I experienced it for myself as I listened to and reflected on the accounts of illness and of care.

Transformative learning comes about through deep questioning and reshaped thinking (Merriam, 2004). McAllister (2015) suggests that transformative learning in nursing assumes that learners enter a situation with preconceived values and biases (McAllister, 2015). The theory centres on becoming critically aware of this and one's own perceptions, understandings and feelings about our world (Hoggan, Mälkki, & Finnegan, 2017).

In transformational learning perspectives are transformed through critical reflection on what Mezirow refers to as unexpected events or circumstances. This critical reflection challenges prior thinking and beliefs and brings about altered perspective (Morris & Faulk, 2012). The transformation tends to be social as the event or dilemma that initiates the transformation is often triggered by other people (Mezirow, 1991).

This resonates strongly with my body of research where nurses and students were confronted by real life care encounters and transformative care narratives which

challenged their knowledge and beliefs. One example expressed by a participant was the perception that their role in palliative care was confined to the care of patients with a diagnosis of cancer until they were asked to provide end of life care for someone with AIDS. This experience challenged their attitude and beliefs about sufferers of HIV and transformed their thinking. The experience of caring was also highly satisfying.

A second example was provision of feedback to the nurses providing day hospital care. Patients conveyed that they felt apprehensive prior to their first visit due to lack of information. The nurses responded with a critical reflection and review of existing communication methods and resources and adoption of creative ways to prepare patients.

Effective reflection is essential to effective learning (Merriam, 2004), and this continues to be emphasised in transformational learning through content, process and premise reflection. These forms of reflection are discerned in practitioners and students involved in the body of research presented here. For example, content reflection could be identified in a community nurse who reflected on the decision to introduce a syringe driver for symptom relief. In relation to process reflection, they might further reflect on the timing of the introduction, the complexity of making contact with the GP and sourcing the drugs during pharmacy half day closing in rural settings. Premise might involve consideration of national guidelines that inform decision making and why and how they are applied. The learning from the experience with reference to clinical outcomes such as successful symptom management and increased patent comfort can be stored up in the mind of the nurse as tacit knowledge to enrich future caring practice.

In my pedagogical research learners were encouraged to reflect in and on action as described by Schon (2017). Reflective discourse with fellow students both face

to face and online, known to encourage examination of alternative perspectives and help the individual to pause before judging (Mezirow, 1991) was also actively facilitated. Students described challenged assumptions and application of learning in future practice through expressions such as “note to self”. In the overseas placement study students expressed culture shock that lead to transformational learning. Helping learners to look critically at their attitudes, beliefs and behaviours is the responsibility of educators (Mezirow, 1991) and particularly important in sensitising students to a particular need or issue which in this body of work was the need for compassionate care.

One catalyst used in my research was narrative theory through reflection on patients’ healthcare stories.

6.5 Narrative theory

Narrative theory has been an important conceptual platform for my research as it is focused on exploration of the nature of stories and how they help people make sense of their world (Casey, Proudfoot, & Corbally, 2016; Lee, Fawcett, & DeMarco, 2016). I found hearing and reading the stories gathered in clinical practice as part of the LCCP transformative, and reflected on the power they could have on the listener to question, challenge and amend their practice.

Narrative theory involves transportation, where the listener or reader becomes absorbed in the story and is strongly correlated with changes in knowledge, beliefs and attitudes (Murphy, Frank, Chatterjee, & Baezconde-Garbanati, 2013). It also evokes an emotional response (Van Laer, De Ruyter, Visconti, & Wetzels, 2013). It also involves identification where the listener gains insights into the views and perspectives of the story teller (Casey et al., 2016; Green & Brock, 2000). Thirdly, it involves realism where a judgement is made regarding the authenticity of the story. Through these three concepts story telling can bring about behaviour

attitude and motivational change in the listener and is therefore important in the development of compassionate nursing practice (Liehr & Smith, 2014).

Narrative theory is influenced by a number of philosophies. Firstly, phenomenology as is focused on the meaning of the lived experience so often conveying in a story. Cognitive psychology is said to influence as it involves configuration of complex experiences of life and thirdly social constructivism as the story is constructed by the teller and influenced by context (Casey et al., 2016).

Medical narratives are powerful. They help the practitioner self-reflect as well as reflecting on practice (Borkan, Reis, & Medalie, 2001). They not only increase knowledge of illness but help imagine future health states (Shaffer & Zikmund-Fisher, 2013). They are empowering for those who tell their story of illness but also effectively facilitate transformative learning in the listener (Gidman, 2013).

Some make a distinction between narrative and story where narrative is said to contain the story and the telling of the story through discourse. The story involves merely the events, characters and setting and make up the narrative content. Narratives can be considered to ascribe meaning to an event as it is a natural way to convey an experience (Gudmundsdottir, 1995). For others narrative and storytelling are terms used interchangeably (Riessman, 2008).

In the research discussed here not only the experience but what it meant to those giving and receiving care was important to capture and therefore narrative theory was an important influence. The educational purpose of storytelling relates to what we want students to be like. This includes the attributes we want them to have and the knowledge we want them to possess (Jackson, 1995). Narratives are known to increase not only insight but empathy (Gidman, 2013), and provide a strong persuasive influence (Gidman, 2013). They are transformative as they activate the

imagination and self-consciousness of the reader or listener and cause them to identify with the subject or experience which can be transformative (Gudmundsdottir, 1995; Jackson, 1995).

In healthcare it is by patients telling their story that what they need and want can be identified (Guaspari, 1998; Petersson, Springett, & Blomqvist, 2009). Stories are useful in describing the human side of the nurses patient interaction (Petersson et al., 2009; Van Manen, 2016). Narratives are said to

> "enter empathetically into another's life" (Witherell, Tan, & Othus, 1995 page 41). Stories let us imagine and feel the experience of another and change stereotypes when we listen to diverse cultural narratives first hand (Witherell et al., 1995).

Stories can also motivate people to particular action and behaviour (Lee et al., 2016), which resonates with craftsmanship and development of a disposition to do a good job for its own sake. The compassionate nurse who has developed this disposition is resolved to care, to respond to need and to act.

Exploration of these theories helped me to make sense of my thinking around the growing concept of compassionate craftsmanship and how as an educator I could help students to develop attributes associated with this for themselves. This led to the formulation of a relational model containing the enablers, attributes and anticipated outcomes of compassionate craftsmanship together. The model is central to paper 8.

6.6 Conclusion to this chapter

This chapter discussed theories that have influenced the research and scholarly activity presented here. The theories of craftsmanship, experiential and

transformative learning and narrative theory are discussed. The role and influence of reflective practice is also emphasised as the foundation for my work. In summary, my research is influenced by the work of key learning theorists and multidisciplinary scholars spanning three decades.

Next I will discuss the key theme of compassionate craftsmanship and coherence of the work will now be discussed.

7.0 Chapter 7 Coherence and evidence of the key theme

7.1 Chapter introduction

In the last chapter, the theoretical influences on my work were presented and discussed. This chapter presents the incrementally developing concept of compassionate craftsmanship as a key theme running throughout my research and papers.

7.2 Emergence of the Compassionate Craftsmanship concept

My research journey is depicted as an interconnected whole of empirical research which informed the emergent concept of compassionate craftsmanship. Development of the concept was gradual and not explicitly named until my final paper, though abilities and attributes that I relate to compassionate craftsmanship were discernible in the data gathered in study 1. I selected my 8 papers because of the collective and ongoing contribution they make to the progression of my research journey and their gradual contribution to the overall coherence of my work through the ongoing development of the key theme.

Coherence across this body of work is demonstrated firstly through a common topic emphasis on compassionate care, and abilities associated with craftsmanship.

The first study raised questions for me about mastery in nursing and the subtle application of tacit knowledge to sensitively question, to find and solve the problem and to care compassionately (Harper, 1987; Sennett, 2008).

These abilities can be seen in nursing practice central to papers 1, 2 and 5 (studies 1 and 3), as can the commitment to go the extra mile to do a good job which is the hallmark of craftsmanship. Care accounts gathered in acute care settings through the LCCP shed further light on what makes care compassionate.

In order to use what we learned, we wove the findings into pedagogical approaches aimed at facilitating student learning in compassionate care. Compassionate care and development of abilities that enable nurses to provide this is the focus of papers 3, 4 and 7. Paper 6 relates to enhancing the effectiveness of the learning process through explicit feedback. This focus on giving and receiving feedback through facilitated reflection further demonstrates coherence as it also forms part of the pedagogical initiative central to papers 3 and 4. In addition feedback is a key LCCP theme, and highlighted as an important contributor to compassionate caring (Edinburgh Napier University & NHS Lothian, 2012).

A second cohesion in this body of research relates to methodology. The relational nature of qualitative approaches mirrors the relational aspects of caring for patients and their families and growth in understanding about the human experience (Holloway & Galvin, 2016) so necessary in compassionate care.

Stories are gathered throughout, used to enhance emotional connection with patients (Coffey et al., 2019) and to engage the senses in unexpected ways of knowing.

The use of the emotional touch points method to capture these lived experiences was introduced through the LCCP was used in study 3 and 5 and use of story as an aid to reflective learning study 2 and discussed in papers 3 and 4.

Stories can be strongly persuasive and prompt practical action (Gidman, 2013). They not only increase insight and knowledge of illness but help the listener to imagine future health states (Shaffer & Zikmund-Fisher, 2013) which are each important abilities of the compassionate craftsman and feature in the relational model presented in paper 8.

Participatory action research used to bring about pedagogical changes in practice is a further common link in papers 3, 4 and 7. This method resonates with the golden thread of compassionate craftsmanship through the shared aim of problem finding and problem solving, being open to do things differently and of shaping caring practice. These each contribute to the relational model and golden thread running through my research, compassionate craftsmanship. There also exists a strong analytical coherence in the use of thematic analysis across the research.

The relational model presented in paper 8 further demonstrates coherence through synthesis of multidisciplinary concepts with findings of my own research to present an original recombinant innovation.

Underpinning my work overall is reflective practice (Schon, 1987) which is apparent in the data gathered in clinical practice and plays a significant role in the pedagogical interventions introduced. It is additionally a foundational cornerstone of nursing practice and necessarily underpins my personal and professional outlook.

Overall, my collective publications contribute to a greater understanding of specific attributes that enable the health practitioner to provide compassionate care and shed light on how elements of the nursing curriculum could offer environments and opportunities for students to develop this.

7.3 Conclusion to this chapter

This chapter builds on chapter 2 where the work central to this thesis is presented in pictorial form. The chapter has focused on coherence of the work and development of the emergent concept of compassionate craftsmanship. Originality of the work will now be presented.

8.0 Chapter 8 Originality of the work

8.1 Chapter Introduction

The last chapter focused on development of the key theme and coherence of the work. This is closely related to the originality of the work. A case for this will now be presented and discussed. What follows is evidence of new knowledge highlighted within each of the main areas of focus of the empirical studies presented within the core papers.

8.2 Compassionate care in practice

1.) The Leadership in Compassionate Care Programme was trailblazing work. It is reported to be “One of the earliest focused interventions that took a systematic approach to investigating the complex issue of compassionate care” (MacArthur, Wilkinson, Gray, & Matthews-Smith, 2017 page 44).

The programme was a unique development at the time of inception, as was the recording of experiential stories with involvement of those who owned them in the process as a strategy to bring the narratives to life. Furthermore, utilisation of these as a teaching aid to facilitate reflective learning in compassionate care was novel and, as far as could be determined, not reported anywhere else at the time. Narratives are now considered a valuable way to help the development of compassionate care (Terry et al., 2017).

The term compassionate care was infrequent in published literature at the beginning of the LCCP. In patient feedback it was implicit and often marked by its absence, however it gradually became explicit, began to pervade policy documents and started to appear more commonly in literature about care and caring after the launch of the LCCP (Davin, Thistlethwaite, & Bartle, 2018;

Department of Health, 2012; Dewar & Mackay, 2010; Firth-Cozens & Cornwell, 2009; Tierney, Seers, Tutton, et al., 2017).

As part of this rising tide of change, the day hospital study brought together three interwoven and timely elements, which made an original contribution. These filled a gap in relation to 1.) Compassionate care 2.) Community setting and 3.) Intermediate day hospital care.

In tandem with the growing emphasis worldwide on compassionate care (Department of Health, 2012; Grimley, 2017; Lown & Manning, 2010; Tadd et al., 2011) was a shift in care provision focus from hospital to care nearer to home (Department of Health, 2012; Local Government Association et al., 2012). Research relating to care provided in particular through community day hospitals had not been explored for a decade and data was gathered here using the emotional touch points methodology, which helped patients tell their story (Brocklehurst, 1970; Cousins A & Hale S, 1985; Martin & Millard, 1976; Nolan, 1987). Fresh value has been placed on the voice of the patient in studies that capture the lived experience of those cared for, seek insights into what patients believe compassionate care to be in practice (Albarran et al., 2014; Bramley & Matiti, 2014; Straughair, 2019; Straughair, Clarke, & Machin, 2019). The unique contribution in this study was in combining the three elements outlined above, by inviting a group of people who had not been heard before to tell their story, and in testing out the findings for the LCCP in a different care setting. In addition provision of direct feedback to colleagues in practice delivering this care proved to be a powerful catalyst to forge positive and immediate change (Whitehouse, 2018). Collectively this work offers an original contribution to knowledge and to caring practice.

In the earlier study, where my qualitative research journey began, care at the end of life was the focus and in particular, when a syringe driver was introduced. Other studies were published that focused on the use of the device but these in contrast, were focused on evaluation of training (Hayes et al., 2005; Irving, Irving, & Sutherland, 2007) and development of guidelines (Kain et al., 2006). One study mentions patient opinion but does not share my spotlight on lived experience and provides no information about how patient views were invited (Smith, 1997). The aim of my study was to capture the whole experience and it succeeded in shedding light on caring compassionately in rural settings at the end of life at a particular point in the illness trajectory. The findings made an original contribution by illuminating expertise, dedication and adaptability displayed by community nurses that make dying at home possible. The study revealed a hidden dimension to the introduction of a small piece of equipment for symptom management. The act conveyed a change in circumstances and required wise judgement in terms of timing and using the silent message conveyed to the informal carer that it was time to prepare for the impending death of their loved one. Compassion was a motivator to go the extra mile both geographically and in caring practice and had not been reported before.

The work was also timely politically as questions about the suitability of a best practice clinical framework used widely to guide end of life care (The Liverpool Care Pathway) had been raised, and the two new policy documents published (Department of Health, 2008b; Scottish Government, 2008) to guide future care. This opened up an opportunity to not only share the findings in a discipline specific international journal but to follow this up by publishing in a widely read community nursing peer reviewed journal. This allowed us to highlight the findings within the end of life care context and contribute to the debate.

8.3 Nurse education

In the student study abroad project, focus on the emotional aspects of the experience was original, as was use of the emotional touchpoints method. This made the study and paper distinguishable from others. Increasingly cultural sensitivity amongst nurses is under discussion due to increased global migration (Alharbi & Al Hadid, 2019; Archer, 2017; Singh, King-Shier, & Sinclair, 2018) and the NMC include development of cultural sensitivity in their standards for nurses education.

The final and most original contribution evident in this body of work is the recombinant innovation that I developed and named compassionate craftsmanship, which culminates in presentation of a relational model in paper 8. This innovative approach of utilising and integrating knowledge from other disciplines with nurse research to inform the practice of compassionate nursing and nurse education is original. The presentation of this concept took courage, as the notion of craftsmanship has historically been limited to perception of working with one's hands, skilled labour and in nursing, the doctors' handmaiden. Nursing theorists have strived for recognition of nursing as a science and art in order to attain professional status and distance the profession from such limited understanding (Fawcett, 2000).

The model of compassionate craftsmanship extends an invitation to nurses and nurse educationalists to think more broadly and view craftsmanship through a different lens in keeping with Sennett's definition.

It is interesting that the idea of craft is gathering momentum in other healthcare professions such as that of surgery where experts recognise the synergy between medicine and other disciplines associated with craftsmanship (Kneebone 2019).

8.4 Conclusion to this chapter

Presented within this chapter is evidence of original knowledge generation. How this contributes to the fields of nursing and nurse education will now be discussed.

9.0 Chapter 9 Contribution to the field

9.1 Chapter introduction

The last chapter discussed originality of the work presented here. This chapter will build on the interrelated fields of nursing practice and nurse education.

9.2 Significance and contribution

My work sheds light on how nurses care compassionately and how nurse educators can facilitate development of this in student nurses as they progress from novice to expert in the craft of compassionate caring.

9.2.1 The field of nursing

LCCP

A sizeable and significant contribution to the field of nursing was achieved through the three year externally funded Leadership in Compassionate Care Programme (LCCP). The project ran from 2009, however planning began in 2006 when I with a small group of academics, recognised that things most important to patients had been lost. Negotiation with an external funder resulted in securement of one million pounds to support the project.

Although the project was a collaboration between the University and NHS Lothian, funding was held and managed by the University. The work was unique at the time of inception and I was one of four people who contributed to identification of priorities that would best influence healthcare provision and which led to formulation of the four LCCP stands. I contributed to forging a strong connection with key practitioners in NHS Lothian and progressed the early work which focussed on defining what we meant by compassionate care and development of a process for identification of the four Beacon wards who would showcase excellence compassionate care (Adamson et al., 2009) and within which stories of

care were gathered that I then used in innovative ways within educational practice (Core papers 3 & 4). It was important to share the aim and aspirations of the LCCP with healthcare practitioners, and in particular, nurses, therefore I published this early work in a journal widely read by nurses in clinical practice (Adamson, E., King, L., Moody, J., & Waugh, A. (2009).

The day hospital study (Study 3) built on this work and contributed to knowledge of compassionate care experience within the primary care setting. The study confirmed that many of the same elements of care apparent in acute settings (LCCP) were highlighted by those involved in care within the community setting. The findings emphasised the importance to patients of care near to and at home and the role of the nurse as care coordinator. This is an important finding for integration of health and social care.

9.2.2 Support for older people - evaluation and measurement practice

My work has importantly influenced practitioners whom I involved as co-researchers. The community staff nurse invited to contribute to the study as a novice researcher gained experience of data collection and writing for publication. She is now leading an accelerated hospital discharge project in NHS Borders, which provides support for older people ready for discharge home who would otherwise be forced to spend longer in acute care. She contacted me to ask for advice in use of the emotional touchpoints method to evaluate the project with staff and patients.

9.2.3 The field of education

Development of new knowledge was accomplished through the diverse and innovative approaches to learning teaching and assessment described below.

Using simulated practice

At the time of development and implementation my work, using simulated practice to facilitate learning and assessment of compassionate care was new. In recognition of this, I received a personal invitation to present the work at an international symposium in Greenwich in 2011. I was also invited to share the work with academic colleagues from Curtin University Perth Western Australia with the aim to start a dialogue about to the delivery of their curriculum and inclusion of compassionate care.

9.2.4 Stimulating reflective practice through recorded narratives

The use of stories in learning and teaching within the curriculum, recording the narrative and releasing them as podcasts to bring these stories to life acted as a catalyst to embed this teaching and learning approach within the future Edinburgh Napier University undergraduate nursing and midwifery curriculum (See http://www.knowledge.scot.nhs.uk/compassion.aspx . My work in this area also features in five systematic reviews (Coffey et al., 2019; Durkin et al., 2019; Feo et al., 2018; Sinclair et al., 2016b; Younas & Maddigan, 2019).

9.2.5 Enhancing feedback in clinical practice

The feedback in practice project has progressed to second cycle which involved teaching and awareness raising about feedback in practice for all NHS staff as part of the 2018-2019 mandatory update. A second project focused on students as partners has led to development of a set of feedback flashcards to help new students receive and use feedback effectively. The aim of the new project is to help students to take ownership of feedback on their clinical placement.

9.2.6 Role of the future nurse

Nurse education is regulated and guided by the Nursing and Midwifery Council's standards for pre-registration education. During the decade of this work, revision of these standards has included a growing focus on the importance for new registrants to have the ability to provide compassionate and culturally sensitive care. The nurse of the future is required

> "To provide expert, evidence-based, safe compassionate direct care to people of all cultures and beliefs." (Nursing and Midwifery Council, 2018, p. 3).

This programme of research has contributed new knowledge and insights into how nurse educators might facilitate the development of such skills and attributes that enable this in the future nurse.

9.3 Conclusion to this chapter

This chapter has presented a discussion on how within this body of work new knowledge has been created that already has and will continue to impact nursing and nurse educational practice. Reflexivity in relation to the research journey and proposed future work is the focus of the next chapter.

10.0 Chapter 10 Reflexivity and next steps

10.1 Chapter introduction

In the last chapter, I discussed my contribution to the fields of nursing and nurse education. In this chapter, I will focus on researcher reflexivity and future work. Reflective practice lies at the heart of nursing, nurses education and the scholarship of teaching and learning (Boyer, 1990; Schon & DeSanctis, 1986). Understanding my research journey has transformed by own thinking.

10.2 Transformation of the researcher

The journey reinforced my belief in the transformative power of narrative as a learning tool (Egan & McEwan, 1995). My journey has also illuminated the complex and mysterious nature of compassionate caring. I have learned a great deal from fellow researchers and the participants who shared their experiences with me. Two things in particular stand out. The first is the wealth of knowledge the compassionate craftsperson has stored up applied in practice, which can be taken for granted and considered just part of the job.

The second is experiential learning in relation to qualitative interviewing that can open up dialogue and enrich data. I would describe this as the ability to capture the participant's imagination

One example was the older lady who had little to say of her experience of care except that she was satisfied with it. No prompt could entice her to say more, to elaborate or expand on her experience but when given the opportunity to speak of her life as a shepherd's wife she was transformed and became animated. Reflection on this raised questions for me about investment in the participants and caused me to reframe my thinking and approach. Finding what sparks the participant's imagination and interest first could serve to 1) make them and their

experience feel valued 2.) Create an atmosphere of ease and trust 3.) Offer possible connections between that discussed in the early dialogue and the topic researched. All of this needs to be balanced with keeping the participant on topic and bringing the conversation back around to the focus of the research.

10.3 Transformation as an educator

The journey has encouraged me to take a risk. Working in partnership with students in their learning brings with it vulnerability as students can ask you the unexpected in the simulation learning environment. I believe that the benefits are multiple 1.) It build relationship and trust (Sennett's sympathetic illustration) (Sennett, 2008) 2.) Dialogue and feedback can spark imagination and vision for future practice 3.) The lecturer is also the learner and has the opportunity to role model vulnerability and compassionate craftsmanship.

To work with students as partners in learning takes a deliberate decision and is more than an approach, it is an attitude. The true master craftsman has a social edge to their work and takes pleasure in sharing what they possess through knowledge transfer and celebrates the success of the apprentice (Sennett, 2008).

10.4 Future work

My first area of future work is in developing the model of compassionate craftsmanship further, using it to influence educational practice. This could be achieved by, for example, embedding compassionate craftsmanship within the overall curriculum, including the assessment of craftsmanship abilities. This programmatic approach would benefit from following the principles of the PASS project, helping students to develop incrementally in compassionate craftsmanship, with a view to making the overall learning and assessment journey more meaningful (Hartley & Whitfield, 2011; Jessop & Tomas, 2017; Whitfield &

Hartley, 2019). Possibilities include, exploration of how these abilities could be demonstrated in practical assessment, reflected on in online peer discussion and included in practice assessment within clinical placement. However, it is important that the assessment strategy is designed holistically to enable assessment for learning rather than merely assessment of learning, in order to avoid what may be regarded as a tick box exercise. The overall aim is development of a deep-seated disposition of craftsmanship through doing a good job for its own sake in keeping with the ethos of the craftsman.

Evaluation of this work will also be conducted through formal and informal student, staff and service user feedback in University and clinical practice. The findings will be shared through publication in a peer reviewed journal.

A second focus of future work and complimentary to that discussed above is to further develop students as partners,building on a recent feedback in practice project (Sambell, Brown and Adamson, in press), in which a group of nursing students were invited to co create a feedback resource for fellow students in the form of a set of flash cards.

The students were encouraged to reflect on their dialogic relationship with practice mentors. As facilitators, we created conditions for development of compassionate craftsmanship. From literature and student narratives, discussion topic sentences were developed and the student team developed statements to help junior students to seek, receive and act on feedback. The team were encouraged to recount their own experiences, and share and reorganise their thinking through dialogue. Through this they identified challenges and discussed solutions, they thought imaginatively and ultimately created a practical resource. The students then reflected on the experience. They spoke altruistically of helping fellow

students who would follow them and demonstrated compassionate craftsmanship in practice through doing a good job for its own sake.

The work was shared by one of the student co-creators at the RAISE conference in 2019 http://www.raise-network.com/events/conference-2019/ and will be presented to an international audience in Spain in 2020 https://www.elsevier.com/events/conferences/international-nurse-education-conference. A paper has now been published in the Student Engagement in Higher Education Journal.

In addition and in keeping with the scholarship of integration, compassionate care has taken a new turn for me in the form of a multidisciplinary programme of research and innovative practice, which is focused on finding practical solutions to healthcare problems. The aim is to provide patients with assistive equipment, which is what they need, and want, and will enhance dignity and independence.

Engineering, design and healthcare graduate interns were offered the opportunity to work with patients in the development of equipment that is user centred in development. This provide invaluable opportunities for the graduates to converse with patients and the public, which increase their confidence, and their understanding of living with illness.

Through use of props and existing equipment, the interns engaged in problem finding and problem solving. They zoomed in on the problems with existing equipment and imagined what could be different. They took practical action to design and develop a solution. Compassionate craftsmanship should not be confined to healthcare practitioners as the associated abilities can be developed in other disciplines and impact healthcare in different ways. For example, through design and development of user centred products intended to positively influence

quality of life for patients, increase product adoption and reduce NHS costs. Involvement in the project has already influenced graduate employability.

These projects were accepted for presentation at an international design conference in New York in March 2020.

Titles “Making a Difference” and “Patients as Partners”

The Fourteenth International Conference on Design Principles & Practices, at Pratt Institute, Brooklyn Campus, New York USA.

https://designprinciplesandpractices.com/2020-conference

10.5 Conclusion to this chapter

My scholarly journey has been transformative. My learning has been as valuable as the outcomes and impact of the work. The journey has brought me to the introduction of compassionate craftsmanship as a recombinant innovation, which will evolve further and influence care practice and the profession.

11.0 Conclusion to the thesis

The purpose of this thesis was to present ten years of research and scholarly activity represented by eight selected peer reviewed papers with an associated critical appraisal. The appraisal provided an opportunity for reflection on the body of work as a coherent whole and discussed theoretical influences, relevant literature and the original contribution that it makes collectively to the field of nursing and nurse education.

In the thesis, I drew upon the broader craftsmanship literature to illuminate the developed concept of compassionate craftsmanship in practice-related contexts, and then explained how it was employed as a critical lens through which to view my subsequent educationally focused papers. Pedagogical interventions that enable the development of compassionate caring and the capabilities of craftsmanship in student nurses were the focus of these papers, which culminates in a capstone paper. This paper proposed and presented an indicative model of compassionate craftsmanship as a recombinant innovation and offered it as a heuristic device for nurse educators and others with an interest in better understanding and developing compassionate pedagogies.

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Appendix 1 CV

Elizabeth Adamson

♦ Edinburgh Napier University, Sighthill Court, Edinburgh EH11 4BN ♦ 01314 555696 ♦ l.adamson@napier.ac.uk

PERSONAL PROFILE

I am a nurse and midwife with twenty years of experience in education in both clinical practice and higher education. I am passionate about healthcare improvement and provision of authentic and engaging learning environments for students. I have extensive experience of teaching learning and assessment in patient assessment, compassionate care, clinical decision-making and older people's care within in the UK and overseas. As lead for the SOLUTION multidisciplinary development project which is focused on finding practical solutions to healthcare problems, I have forged links with the NHS, industry and higher education providers nationally and internationally. A key outcomes of the SOLUTION project is the development of medical devices to increase independence and mobility amongst patients living with long term conditions. A particular focus of my research is exploring the experience of patients, families, nurses and students in relation to compassionate care. Educational research interests include assessment and feedback in clinical practice and working in partnership with students.

QUALIFICATIONS

Working towards PhD by Publication	Anticipated completion	2020
MSc in Professional Education, Queen Margaret University College		2006
BSc (Hons) in Health Studies, Queen Margaret University College		1998
State Certified Midwife		1980
Registered Nurse		1978

CAREER & ACHIEVEMENTS TO DATE

Current role

Associate Professor School of Health & Social Care, (SH&SC)
Edinburgh Napier University August 2018-date

KEY ACHIEVEMENTS

- Invited secondee to the University Department of Learning and Teaching Enhancement
- Lead for University wide Personal Development Tutor (PDT) project
- Development of PDT toolkit to support academic staff
- Students as partners work to develop a learning resource on feedback for student nurses
- Programme lead for Global Online (GO) Nursing Studies
- Nursing Studies (GO) programme growth by two thirds
- Introduction of bespoke support for global online students to enhance learning experience

- Lead for the SOLUTION project
- Multidisciplinary working
- Supporting staff through application for senior fellowship with Advanced HE and PG Cert LTA

Associate Professor and School Academic Lead Student Experience School of Health & Social Care, (SH&SC)

Edinburgh Napier University August 2015-2018

KEY ACHIEVEMENTS

- Strategic role within the SH&SC Senior Leadership Team and School Regional Lead for Australia
- Lead for student support, widening access and employability within SH&SC
- Contributes to the University's student experience/LTA, student retention and induction committees
- Initiated and lead for SH&SC students experience steering group
- Enabled leadership opportunities for staff in student experience enhancement
- Initiated staff development in PDT role and consistency in feedback through use of GradeMark
- Developed and implemented guidance on assessment practice within SH&SC
- Increased response rate in all student satisfaction national surveys
- Led on initiative to enhance feedback for students in practice funded by NHS Education Scotland
- Spearheaded a multidisciplinary programme for development of medical devices
- Established NHS collaboration to develop technologies and enhance healthcare
- Raised £76,720 to develop an alternative eye dropper for patients
- Led research on two projects that support assisted independent living for patients
- Contributed to AHP/ social work programme development and management group

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Senior Lecturer/Senior Teaching Fellow School of Nursing Midwifery & Social Care,

Edinburgh Napier University 2012-2015

KEY ACHIEVEMENTS

- Developed and led teaching in compassionate care, clinical decision-making using patient simulations
- Led a project to Transform the Experience of Students Through Assessment (TESTA) funding £5.7k
- Led on Learning, Teaching & Assessment (LTA) enhancement, chair of committee
- Key player in Leadership in Compassionate Care involving the University and NHS Lothian
- Serves as link lecturer for students in 2 major hospitals ophthalmology, surgical and medical
- Major contributor to LTA for home students and registered nurses in Singapore
- Established and coordinated a student exchange programme for students in UK and Perth, Australia
- As regional lead for Australia initiated a collaborative agreements with Perth and Sydney
- Invited to share best practice in compassionate care with Curtin University Perth Australia
- Helped develop an authentic international experience for students unable to travel overseas
- Conducted educational research on global citizenship and assessment and feedback practice
- Helped raise £1m in funds for research into compassionate care & £76,000 for other projects

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Lecturer in Adult Nursing Edinburgh Napier University 2004-2012

KEY ACHIEVEMENTS

- Taught, assessed and supported nursing students on a wide range of adult modules
- Taught, assessed and supported international MSc clinical research students
- Supported and assessed BSc honours students completing their final dissertation
- Used a variety of learning, teaching and assessment strategies: face-to-face, blended, and online
- Successfully managed the BSc conversion programme within Singapore from 2010 to 2012
- Served as cohort lead & personal development teacher for students 2004-date
- Module lead for an acute nursing module in Scotland and Singapore
- Led on action research projects designed to embed compassionate care within the curriculum

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Clinical Skills Coordinator | Shared Governance Coordinator | Intravenous Therapy Facilitator

Lothian University Hospitals Trust 1999-2004

KEY ACHIEVEMENTS

- Appointed as clinical skills coordinator to teach & assess clinical skills (2000-04)
- Supervised and supported nurses and taught the safe management of infusion devices
- Audited practice and drug administration to ensure teaching covered relevant drugs and calculations
- Influenced the design and implementation of government policy and national standards, clinical skills
- Served as part-time shared governance coordinator to encourage staff governance (2001-04)
- Set up 3 shared-governance councils in general surgery, peri-operative care & ambulatory care
- Supported the council chair and council in all aspects of the role and influencing practice
- Supervised & supported nursing staff in IV therapy within the clinical environment (1999-2000)

Research Nurse Inveresk Clinical Research Riccarton Edinburgh 1993-1999

KEY ACHIEVEMENTS

- Screened volunteers for recruitment into clinical drug trials, and implemented clinical procedures
- Contributed to the work of the research team within Good Clinical Practice Guidelines for Research

ADDITIONAL ROLES

- Peer reviewer of NEP,NET, Journal of British General Practice, JAN
- Member of British Gerontology Society Scottish Group
- Member of advisory board for the Medical Device Manufacturing Centre Herriot Watt University Edinburgh.

AWARDS

- Edinburgh Napier University Above and Beyond award for building effective partnerships 2019
- Converge Challenge Finalist; Project: The Development of an Alternative Eye Dropper 2014

- Lothian Health Case Innovation Award, First Prize 2009

SKILLS & KEY COMPETENCIES

- Expertise in teaching adult nursing, clinical skills and patient simulation, academic skills
- Expertise in supporting and developing colleagues
- Innovative and engaging teaching skills
- Programme and module board convenor
- Extensive international HE network
- Research experience
- Secured research grants & funding
- Notable change & performance management
- Excellent organisational & administration skills
- Proven leadership, training and team building
- Building effective partnerships
- Charismatic, innovative & influential leader
- First-class communication & presentation
- Mentor and assessor for Advance HE fellowship
- Insightful decision-maker/problem-solver
- Professional, diplomatic and trustworthy
- Dedicated, proactive and versatile
- Able to identify and capitalise on opportunities
- Strategic & tactical in thinking; commercial vision
- Highly committed to student-centred teaching
- Inherent drive and readiness for challenge
- Natural ability to engage across all levels/cultures
- Multidisciplinary collaborative working

RECENT RESEARCH

- Making connections with feedback: working with students to co-create a feedback literacy toolkit 2019
- Qualitative study exploring the experiences of patients attending a day hospital in the Scottish Borders region - funded by QNIS - completed 2014
- Qualitative research project using interviews and emotional touch points to explore the experience of student nurses who have undertaken an international clinical placement - funded by a Teaching Fellowship grant – completed 2014
- Quantitative study using a questionnaire to explore the patient experience of self-administration of eye-drop medication - completed 2013
- Qualitative study using focus groups and interviews to explore learning through simulation and the application of learning in practice 2007

RESEARCH TEAM FUNDING

- Feedback in clinical practice: enhancing the student experience through action research £800, NHS Education for Scotland, 2016
- Development of an alternative eye-dropper £76,720, Edinburgh and Lothians Health Foundation, reference 141-556, 2015
- Innovation in Healthcare Technologies: a collaborative project between SNM&S, School of Engineering and Creative Industries, £45,000, £15,000 contribution: Edinburgh Napier University Opportunities Fund, 2015, 2016

- Exploring the experiences of patients attending a day hospital, £5,889: Queens Nursing Institute Scotland, 2013
- Staff Development through a research away-day a writing retreat, £1,500:Development Grant, 2013
- TESTA project: £5,700: ENU Teaching Fellowship Grants, 2013
- International Exchange evaluation, £3,616: ENU Teaching Fellowship Grants, 2012
- International module development, £2,265: ENU Teaching Fellowship Grants, 2011
- Self-administration of eye drops: The patient experience, £4,270: Research Excellence Grants, 2011
- Pod cast project, £2,747: ENU Teaching Fellowship Grants, 2010
- A virtual international experience for student nurses, £1939: ENU Teaching Fellowship Grants, 2010
- Providing Healthcare support workers with the knowledge skills and confidence to provide compassionate caring conversations, £5,000: NHH Education for Scotland 2010
- Using syringe drivers in palliative care the experience of patients, carers and community nurses, £14,985: Centre for Integrated Healthcare Research Pump Priming fund 2010
- Learning through simulation: Application in practice £4,950: ENU Teaching Fellowship Grants, 2009
- Communication and Human Relationships LTC and Palliative Care £4800 NHS Education for Scotland
- Leadership in Compassionate Care Programme, £1,000, 000 over three years: External benefactor, 2007-2010

PUBLICATIONS

Adamson, E., 2018. Helping Student Nurses Learn the Craft of Compassionate Care: A Relational Model. *Journal of perspectives in applied academic practice*. doi.org/10.14297/jpaap.v6i3.376

Adamson, E., 2018. Culture, Courage and Compassion: Exploring the experience of student nurses on placement abroad. *Journal of Compassionate Healthcare*. https://doi.org/10.1186/s40639-018-0048-4

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Adamson, E. and Kendall, G., 2016. Difficulty in eye drop administration for people with rheumatoid arthritis. *British Journal of Occupational Therapy*, *79*(9), pp.550-556.

Adamson, E. and Dewar, B., 2015. Compassionate Care: Student nurses' learning through reflection and the use of story. *Nurse education in practice*, *15*(3), pp.155-161.

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Adamson, E (2014) Caring behaviour of nurses in Malaysia is influenced by spiritual and emotional intelligence, psychological ownership and burnout: Commentary. *Evidence Based Nursing*

Dewar, B., **Adamson**, E., Smith, S., Surfleet, J. and King, L., 2014. Clarifying misconceptions about compassionate care. *Journal of advanced nursing*, *70*(8), pp.1738-1747.

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Metcalfe, S., McInally, W., Strickland, Karen., **Adamson, E.,** Tiittanen, T. (2012) International collaboration: Developing an international nursing module through the use of Wiki technology. *SEDA Educational Developments*

Contributing author for the Leadership in Compassionate Care Programme Final report (2012)

Holland, A., Smith, F., McCrossan, G., **Adamson, E**., Watt, S., Penny, K. (2012) Online video in clinical skills education for undergraduate student nurses: A mixed methods prospective cohort study. *Nurse Education Today*

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Amoore, J., **Adamson, L.,** (2003) Infusion devices: characteristics, limitations and risk management. *Nursing Standard*, 17, 28, 45-52

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TESTA in Scotland: Impact and Enhancements (Symposium) University of Dundee, 2019

Making Connections with feedback: working with students to co-create a feedback literacy toolkit

Making Connections with Feedback: working with students to co-create a feedback literacy toolkit: RAISE Newcastle, 2019

Exploring the experiences of patients attending day hospitals in rural Scotland: 5thEuropean Nursing Congress Caring for Older People: How can we do the right things right? De Doelan, Rotterdam, Netherlands, 2016

Feedback in clinical practice: Enhancing the students experience through action research: NETNEP, 6th International Nurses Education Conference Brisbane Australia, 2016

Enhancing assessment and feedback: Using TESTA (Transforming the Experience of Student through Assessment) as a catalyst for change: SEDA Spring Teaching Learning and Assessment Conference 2015

Innovation in assessment and feedback: Enhancing the student experience International Conference on Research Education and Science Turkey 2015

Enhancing the student experience through innovation in assessment and feedback: Core paper: NET Conference Churchill Collage Cambridge, 2014

Round Table discussion: Enhancing communication through Rapid Feedback and Action: NHS Lothian and Edinburgh Napier University Inaugural International Conference on Compassionate Care, 2012

Developing global citizenship in nursing nurses: HEREN conference, 2012

Scottish Clinical Skills Network Edinburgh 2012: NHS Lothian and Edinburgh Napier University Inaugural International Conference on Compassionate, 2012

Workshop: Patient stories: NHS Lothian and Edinburgh Napier University Inaugural International Conference on Compassionate, 2012

Embedding compassionate caring elements into an UG nursing module: International symposium for Compassionate Greenwich Care, 2011

Learning through simulation: Is this applied in practice? Clinical Skills Network Edinburgh, 2010

Making compassionate nursing practice explicit within the pre-registration curriculum: Two educational practice developments: Enhancing Practice Conference Belfast, 2010

Simulation in Nurse Education: contextualisation improves confidence: University Staff conference, 2009

Using syringe drivers in palliative care: capturing the experience of patients, carers and community nurses: 15th International Cancer Care Nurse Conference Singapore, 2008

To teach or not to teach: Should pre-registration nursing students be taught intravenous (IV) therapy? RCN Intravenous therapy conference London, 2007

Simulation as a Learning Tool: The Student Nurse Perspective: Clinical Skills Network Edinburgh, 2006

DEVELOPMENTS IN CLINICAL & EDUCATIONAL PRACTICE

Facilitation of training for NHS staff funded by NHS Education for Scotland: Using Feedback, 2014

Contributed to the initiation and development of Leadership in Compassionate Care Project: a joint venture between Napier University and NHS Lothian, 2005 and ongoing

Contributed to the development of an online training resource 'Setting up a syringe driver': a joint venture between Queen Margaret University College and Lothian Universities Hospitals Trust which was purchased by NHS Education Scotland and made available to every NHS Trust in Scotland, 2003

Contributed to the NHS Education for Scotland; Transferring the Skills: A Quality Assurance Framework for Venepuncture, Cannulation, and Intravenous Therapy, 2004

Provided credit rating and guidance to health professionals seeking accredit for: Good Manufacturing Practice for Hospital Blood Banks, 2019, 2012; WCSM Certificate in Optical Care, 2009, 2012; Ophthalmic skills training course: Nursing management of acute eye conditions, 2009; Professional Practice in Ophthalmology: Developing evidence based practice for ophthalmology nurses.

Appendix II Table of Co-authors

(Co-authors were asked to confirm my contribution to the conceptual idea for the study, design and position (e.g. PI), data collection, data analysis, report to funders, paper development and revision)

Papers	Author	Affiliation	Letter
Cruickshank, S., Adamson, E., Logan, J., Brackenridge, K. (2010) Using syringe drivers in palliative care within a rural, community setting: capturing the whole experience. International Journal of Palliative Care, 16, 3, pp 126-132	Professor Suzanne Cruickshank	University of Stirling	Yes
	Janice Logan	St Columbus Hospice	Yes
	Katie Brackenridge	N/A Retired and unavailable	No
Adamson, E., Cruickshank, S. (2013) A 'good death' at home: community nurses helping to make it possible. British Journal of Community Nursing, 18, 1, pp 40-42	Professor Suzanne Cruickshank	University of Stirling	Yes
Adamson, E., Dewar, B. (2011) Compassion in the nursing curriculum: making it more explicit. Journal of Holistic Healthcare, 8, 3, pp 42-45	Professor Belinda Dewar	University West of Scotland	Yes
Adamson, E. and Dewar, B., 2015. Compassionate Care: Student nurses' learning through reflection and the use of story. Nurse education in practice, 15(3), pp.155-161.	Professor Belinda Dewar	University West of Scotland	Yes
Adamson, E., Pow, J., Houston, F. and Redpath, P., 2017. Exploring the experiences of patients attending day hospitals in the rural Scotland: capturing the patient's voice. Journal of clinical nursing. 26 3004-3055	Dr Janette Pow	Edinburgh Napier University	Yes
	Fiona Houston	NHS Borders	Yes
	Pamela Redpath	NHS Borders	Yes

Papers	Author	Affiliation	Letter
Adamson, E., King, L., Foy, L., McLeod, M., Traynor, J., Watson, W., Gray, G. 2018. Feedback in clinical practice: Enhancing the students' experience through action research. Nurses Education in Practice. 31. 48-53	Linda King	Edinburgh Napier University	Yes
	Wendy Watson	Edinburgh Napier University	Yes
	Jennifer Traynor	NHS Lothian	Yes
	Lynn Foy	NHS Lothian	Yes
	Margo McLeod	NHS Lothian	Yes
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Adamson, E., Cruickshank, S. (2013) A ' good death' at home: community nurses helping to make it possible. *British Journal of Community Nursing*,18**, 1,** pp.40-42.

The papers are co-authored by myself (Elizabeth Adamson) and Sue Cruickshank. I contributed to development of the study reported in these papers, application for ethical approval, collection and analysis of the data. The structure, writing and revision of the papers was shared between the authors. Dr Cruickshank is willing to be contacted to address any concerns and has signed the letter to as a sign of agreement.

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The paper is co-authored by myself (Elizabeth Adamson) and Janis Logan. I contributed to development of the study reported in this paper, application for ethical approval, collection and analysis of the data. The structure, writing and revision of the paper was shared between the authors. Ms Logan is willing to be contacted to address any concerns and has signed the letter to as a sign of agreement.

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Adamson, E. and Dewar, B., 2015. Compassionate Care: Student nurses' learning through reflection and the use of story. Nurse education in practice, 15(3), pp.155-161.

The papers are co-authored by myself (Elizabeth Adamson) and Professor Belinda Dewar. I led the action research stream "Assessing compassion skills" as part of the Undergraduate Strand of the action research Leadership in Comapssionate Care Programme and as a consequence led the action project which is the focus of these papers. The conceptual idea for the project was shared. I designed the teaching and assessment materials, implemented the intervension and collected and analysed the evaluation data. The structure, writing and revision of the paper was shared between the two authors. Professor Dewar is willing to be contacted to address any concerns and has signed the letter to as a sign of agreement.

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This paper is co-authored by myself (Elizabeth Adamson) and Dr Janette Pow. I am responsible for the conceptual idea for the project and study design. I acted as PI for the overall study and led the application for funding. I contributed to data collection and analysis, feedback to the clinical teams and coordinated development of the paper. The structure, writing and revision of the paper was shared by all the authors. Dr Pow is willing to be contacted to address any concerns and has signed the letter to as a sign of agreement.

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This paper is co-authored by myself (Elizabeth Adamson) and Professor Morag GrayI am responsible for the conceptual idea for the project and study design. I acted as PI for the overall study and led the application for funding. I contributed to design of the training materials and data collection and analysis of the evaluation data. I also wrote the end of study report. The structure, writing and revision of the paper was shared by all the authors. Professor Gray is willing to be contacted to address any concerns and has signed the letter to as a sign of agreement.

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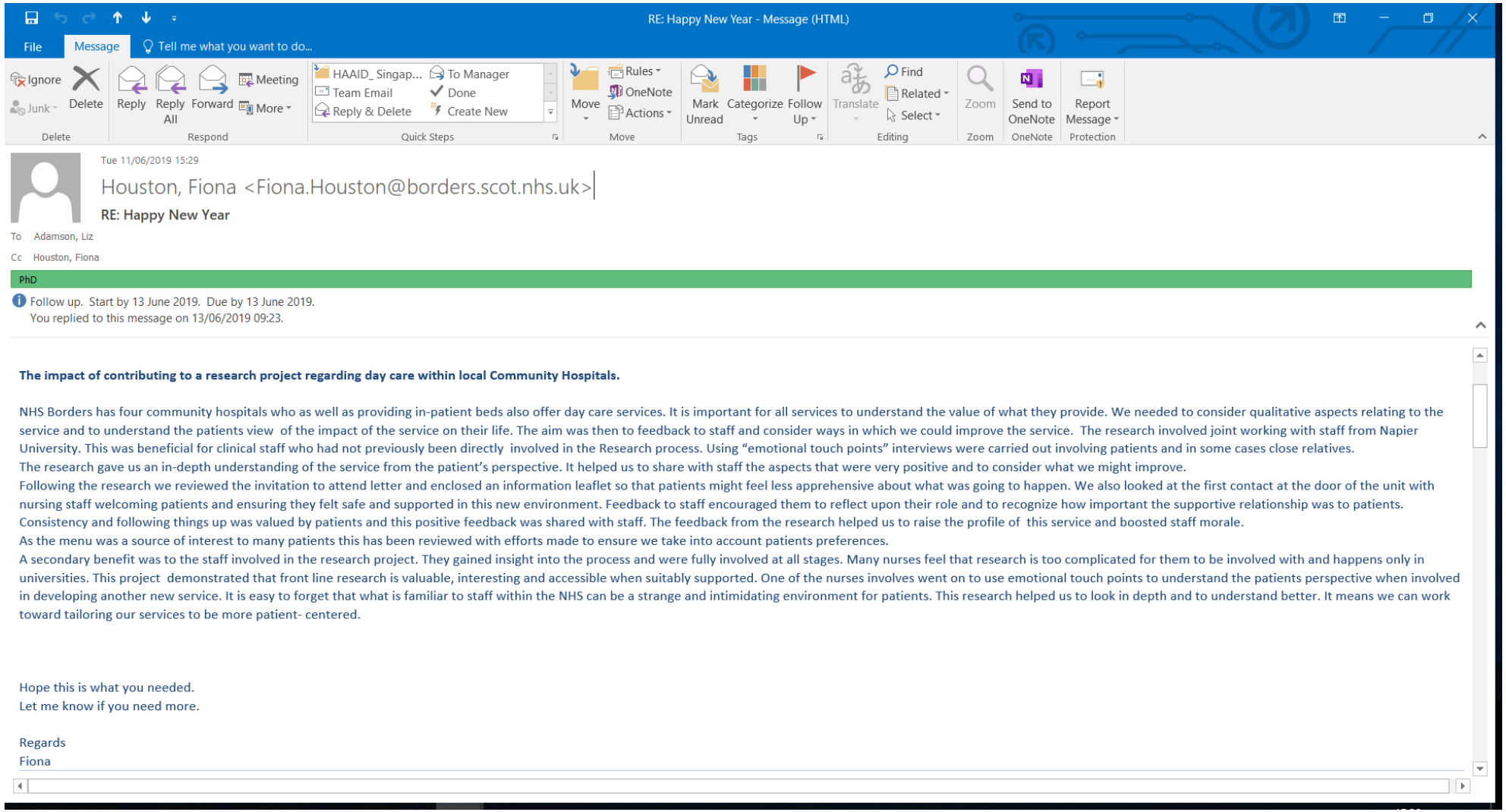
Appendix III Supporting evidence

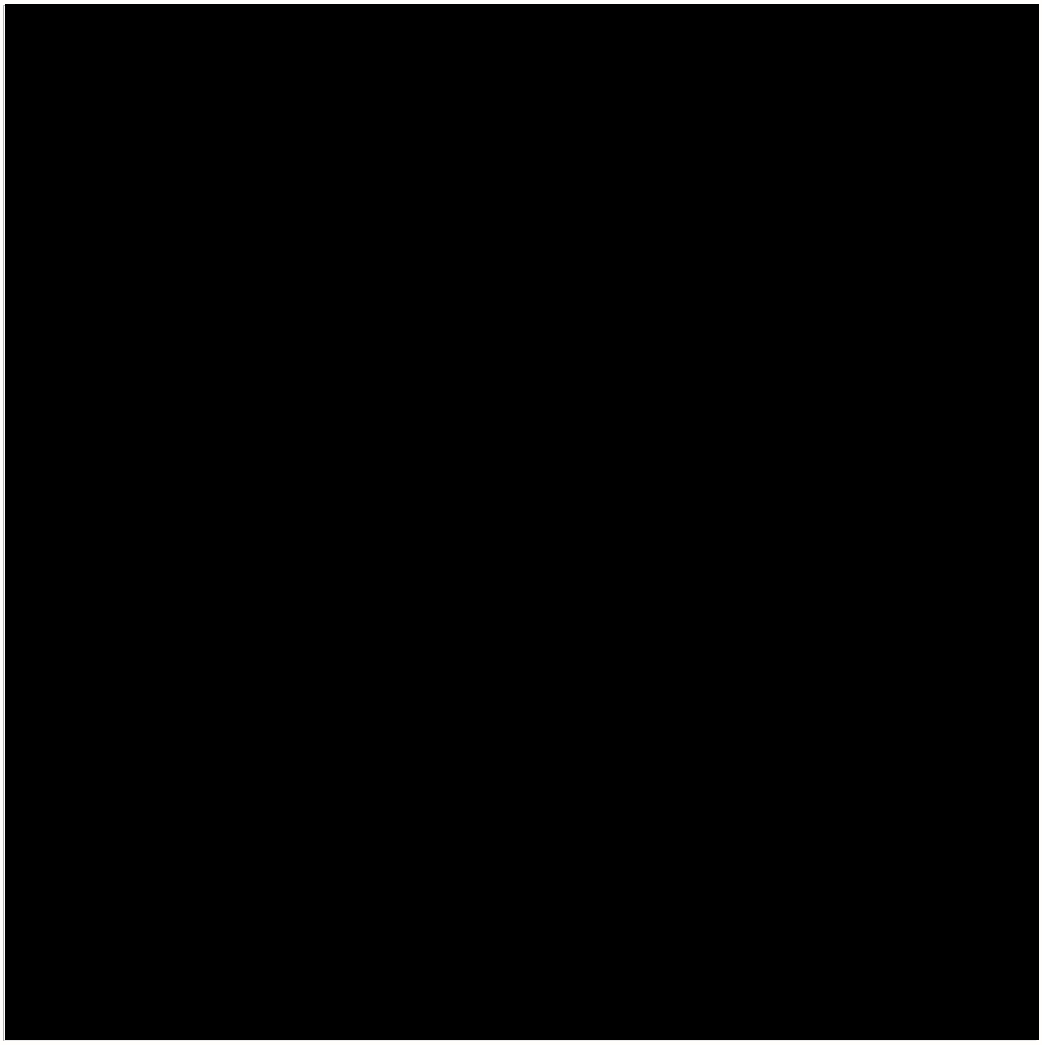


Appendix IV Core papers

Research

Using syringe drivers in palliative care within a rural, community setting: capturing the whole experience

Susanne Cruickshank, Elizabeth Adamson, Janice Logan, Katie Brackenridge



A 'good death' at home: community nurses helping to make it possible

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Compassion in the nursing curriculum: making it more explicit

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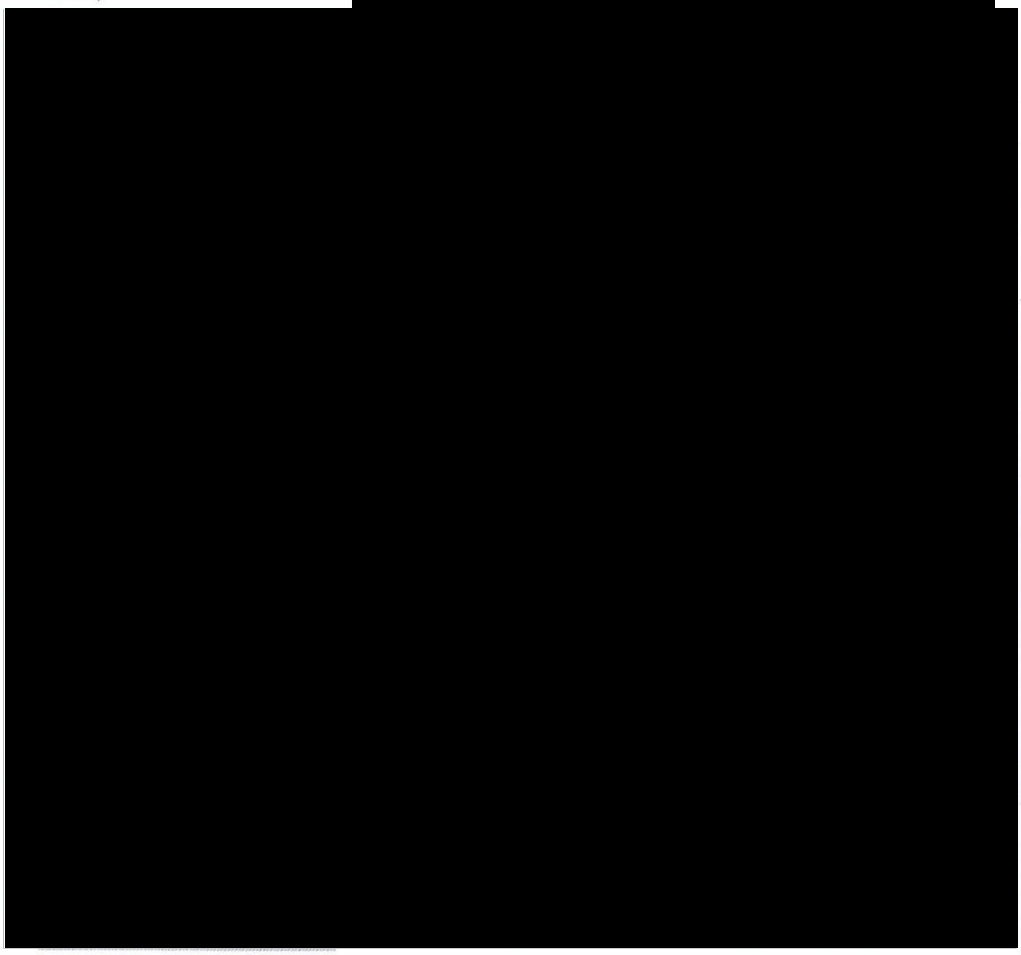

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Compassionate Care: Student nurses' learning through reflection and the use of story

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ORIGINAL ARTICLE

Exploring the experiences of patients attending day hospitals in the rural Scotland: capturing the patient's voice

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Clinical education

Feedback in clinical practice: Enhancing the students' experience through action research

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ORIGINAL RESEARCH Open Access

Culture, courage and compassion: exploring the experience of student nurses on placement abroad

Elizabeth Adamson

Abstract

Background: Nursing is emotional work and learning how to manage their emotions is a valuable part of nurse education. As the workforce becomes increasingly mobile nurses will care for people from diverse cultures and backgrounds. The development of cultural competence and a global mind-set is therefore a valuable asset and engagement in study abroad through overseas clinical placement can help to facilitate this. This study set out to explore the experience of student nurses involved in an exchange programme between Scotland and Western Australia. A particular focus was on the emotional aspects of the experience, responding to challenges and provision of care in a different healthcare setting.

Methods: A descriptive qualitative strategy of enquiry was used and semi structured interviews undertaken with a sample of 10 student nurses using emotional touch points. The interviews were recorded, transcribed verbatim and subjected to thematic analysis using NVIVO 11.

Results: Five main themes were identified. Making it happen, connections, feeling vulnerable, culture and assertiveness and affirmation.

Conclusions: This study makes a unique contribution to the nursing student experience of overseas placement as it focuses on the emotional elements. The study shows that the experience of care delivery in an overseas placement has many benefits but also challenges. Management of emotion is required and transition to a different healthcare system can be stressful. Cultural differences were more marked than anticipated but when students responded by questioning, respectful assertiveness and provision of compassionate care there were clear rewards. These manifested as a sense that caring is a privilege and affirmation of career choice.

Keywords: Student nurses, International exchange, Culture, Compassionate care, Emotional labour

Background

The workforce worldwide is becoming increasingly mobile and this includes within healthcare [1]. As a consequence nurses and midwives throughout the world are increasingly likely to encounter patients, families and colleagues from diverse cultures and backgrounds. There is an expectation amongst patients and families that the care they receive should be not only compassionate but sensitive to their cultural needs [2]. Papadopoulos and associates suggest a model for the development of cultural competence that outlines the progress from awareness through acquisition of cultural knowledge, to the development of cultural sensitivity and eventual cultural competence [2]. Cultural awareness relates to reflection on personal values and beliefs, cultural knowledge considers the impact culture has on health and illness, while cultural sensitivity embraces relationship and how health professionals view the people in their care. Together these enable appropriate interaction and care. One way for nursing students to advance in this journey of growing insight is to spend time in a different healthcare environment working with and caring for people from a culture other than their own. The experience has been found to help students to develop personally and professionally [3–5], including in terms of cultural

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sensitivity [6] and cultural competence [7]. These benefits are recognised by employers across many professions. Time spent overseas is associated with the acquisition of the attributes of a global mind set which is believed to be demonstrated in understanding and respect for other cultures.

Diamond and associates [8] asked employers what they rated most in prospective employees. The participants ranked global competencies, and the highest were found to be excellent communication skills and the ability to work with people from a range of backgrounds and countries. Drive and resilience were also highly rated, as was the ability to embrace multiple perspectives and challenge thinking. Self-awareness which is linked to cultural awareness was also highly rated.

The healthcare landscape worldwide is constantly changing with a shift from acute to primary care, and increasing numbers of people living for longer with complex physiological multi morbidities and psychosocial needs. Nurses and midwives provide care for patients within stressful environments that are short staffed and where acute settings experience high patient turnover [9]. The high expectations and fast pace of nursing can lead to burnout and associated reduction in quality of care [10]. Educators are faced with the dilemma of how best to equip students with the skills they need for professional registration while inspiring commitment to high quality equitable care, and this includes confidence to challenge practice. Study abroad opportunities can contribute to this, and this is actively encouraged as a way to enhance curriculum content [11]. The perceived advantages for students are well reported but study abroad can also be challenging, and for nursing students engaging in emotional work, it can evoke an emotional response.

In the current study students who engaged in an overseas exchange programme between Scotland and Western Australia (WA) were invited to share their experience. The study differs from others in that emotional touch points were used during the interviews to help students to reflect on and discuss not only their personal experience and perceived learning, but also how they felt and responded to difficulties they encountered. The findings uncover not only the challenges associated with clinical placement in a different healthcare setting, but the satisfaction and affirmation experienced in caring compassionately for people of diverse cultures.

Methods

Research questions

What are the views and feelings of nursing students who undertake a clinical placement abroad?

How do nursing students on overseas placement respond to cultural differences?

Design

A descriptive qualitative strategy of inquiry was used to understand the experience of student nurses on clinical placement overseas. Semi-structured interviews using emotional touch points were conducted to gather data on the phenomena of interest [12]. A study information sheet explaining the rationale for the research, who it would benefit and how the data would be used was sent to the students in advance of the placement, and informed consent obtained before commencing each interview. A method called Emotional Touch Points was used [13] which allows participants to describe their emotional experiences at particular points in time using words or pictures [14]. This method is known to help the interviewer engage emotionally with participants and to understand their experience at a deep level. It has also been found to uncover the needs of the participant [15], and to help them to see the positive and negative aspects of their experience in a balanced way [16]. Participants are invited by the interviewer to select a touch point such as "caring for patients and families" for them to talk about. A selection of words is laid out in front of them and participants are invited to choose words that help describe what happened and how they felt. This includes both positive and negative words which the participant may associate with the experience such as "safe" or "worried". The participants may also suggest a different touch point or descriptive word other than the pre-prepared ones. These are written on blank cards. The participants then use the touch points and words to describe their experience [15].

The interviews were conducted in the same way in that participants were invited to choose the touch-points they wanted to discuss and the emotional words that helped them encaptulate what the experience meant for them.

An interview schedule comprising additional questions was also prepared in advance and used as a check list at the end of the interview to ensure that the principle phases and landmarks of the experience were included. In each case the students talked with ease about their experiences using the touch points and the resulting collection of rich data did not require prompting through additional questions.

The students were invited to choose where the interview would take place and the first one was conducted in a hotel as the participant had completed their programme of study and commenced a nursing post some distance from the University. The others were conducted within University or the National Health Service on completion of the Australian students' placement. The interviews lasted between 30 and 75 min in duration.

The interviews were recorded and transcribed verbatim and sent to the participants to check accuracy of content. Field notes were also taken and the touch

points and emotional words selected during the interviews recorded.

Sample

Data was collected from 2011 to 2017. The exchange agreement between the Universities allowed 1–2 under graduate nursing students from each University to participate per year and this recruitment limitation prolonged the period of data collection. The sample was purposive and composed of students from Australian ($n = 6$ second year) and Scottish Universities ($n = 4$ third year). Three of the students enrolled in the Australian programme held EU passports as they had lived in the United Kingdom (UK) and immigrated to WA. Four of the Australian students travelled in pairs while the remaining participants were alone but had a contact within the country of international placement. Four other students were also invited to participate and although they agreed, this was not followed through to interview due to competing demands on their time.

Students were interviewed by their University tutors to determine suitability for inclusion within the programme. Motivation, expectations and previous experience were explored during the interview. During the course of the placement the students were expected to meet the requirements of the practice module assessment which included demonstration of competence in specific skills such as those that related to compassionate care. On return to their home country students developed a presentation for peers and the module team as part of the module assessment which focused on their experience, personal reflection and perceived learning.

Data analysis

Data was organised and coded using NVIVO 11 and analysis employed thematic analysis guided by Braun and Clerk's [17] six phases of analysis. The data was read repeatedly in order to become familiar with the breadth and depth of it. The data were then coded for initial codes. Initial themes and subthemes were identified and then reviewed and revised. The final themes were then named and a thematic map developed to demonstrate how they fit together (Table 1).

Results

Table 2 contains the emotional touch points offered to the participants and the words they selected to help describe their experience and tell their story.

The findings showed that overall the students felt there were many benefits to engaging in the exchange opportunities but also challenges and surprises. They were able to identify personal and professional growth and how this would influence their subsequent nursing practice. The themes and subthemes will be discussed in turn with supporting quotes interspersed within the text. The participants have been given a number to preserve confidentiality. SS refers to a Scottish student and AS to an Australian student.

Table 1 Thematic map

Theme	Subtheme
Making it happen	Determination to succeed
	Pushing the boundaries
Connections	Friends and relatives
	Support and mentorship
Feeling vulnerable	Out of my depth
	Managing emotions
Culture	Healthcare systems
	Attitudes and behaviours
Assertiveness and affirmation	Challenging practice
	Little things that matter
	Confirmation of career choice

Making it happen

The students spoke of the need for determination. Part of the intended learning experience was for students to take responsibility for preparation such as finding accommodation and securing a visa, while simultaneously

Table 2 Emotional touch points

Touch points	Positive words	Negative words
Preparation for placement	Encouraged	Misunderstood
Expectations	On top of the world	Tense
Culture	Fortunate	Pressured out of control
First impressions in placement	Competent	Embarrassed
Caring for patients and families	Heard	Confused
Relationship with mentor	Wonderful	Determined
Working with the ward team	Relieved	Lost
New skills and knowledge	Safe	Grumpy
Living overseas	Sense of belonging	Bored
Learning about myself	Included	Helpless
	Surprised	Worried
	Happy	Anxious
	Appreciated	
	Others added by students	**Others added by students**
	Significant	Disinterested
	Doing something different	Scared
	Taking opportunity to travel	

managing other demands such as attendance at clinical placements within their home country and completing theory module assignments. They recognised that they needed to make sure this happened but found this to be stressful.

I was absolutely determined that this was my placement (SS 1)

I felt like I was quite determined to learn a lot (SS2)

The stress came from trying to do things in the right order like visas, and medicals and insurance and things like that was probably the biggest amount of effort (AS2)

We still had assessments to complete and course work to hand in while we were preparing and that was stressful (AS 6)

Pushing the boundaries

Students also spoke of choosing to travel to an international placement as a personal challenge as this was for some out of character.

I am quite an unconfident person and I just thought if I could go out there and cope with working in a totally different hospital, in a different country that would really boost my confidence (SS 1)

I wanted a different challenge.....going out there and sort of putting myself out with my comfort zone and learning different clinical procedures and knowledge from a different culture (SS 2)

Feeling vulnerable

Out of my depth

The students described feeling lost and out of their depth and yet did not allow this to hinder their learning

I was a bit like lost just because I was unaware of things and a lot of people they didn't even realise that I wasn't a student from Perth at first so they just expected me to know everything you know all these small things make like massive differences (AS1)

I did feel quite lost, what if people didn't like me what if I didn't have the skills they expected (SS2)

I have never wanted to work in A&E (Accident and Emergency) and I was really really scared and I thought I was going to be totally out of my depth (SS1)

Managing emotions

The students described feelings and expressions of emotion they experienced in response the new and different environment and yet also determination to cope and find a solution.

On placement was quite challenging but in fact you had to bring in your own decision making skills, even after that panic and sitting crying, to decide well no I'm going to get help and actually out of it came a solution (SS3)

I was scared about how big the hospital was and frightened of finding my way around and being orientated to it and I was also scared that I may not perform at my best and not be a good model for the University, or say something stupid. I didn't want to let anybody down either. But after the first day there I felt very relieved and surprised at how much I did know (AS2)

I never had much experience in coronary care and I absolutely loved it after my first day on my lunch break I burst out crying (SS2)

Connections

Friends and relatives

It was important for the students to be connected. Most had a relative or friend in the host country.

My friend had found out where I needed to go to register at the University to become a student with them, so I was quite lucky that I had a lot of support (SS1)

I was helpless because I was on the other side of the world, I didn't have anyone (SS 4)

Support and mentorship

The Students spoke highly of the welcome and support they received from their mentors and the staff in general, and looked to them for guidance and reassurance. They also appreciated support given by the University in the host country.

The university over there were very supportive (SS 2)

My mentor immediately took me under her wing and she was absolutely brilliant (SS1)

I did have a patient who was an old gentleman... he had a bleed from his rectum. A Doctor did a rectal examination some time later and he found no

abnormalities....I told my preceptor about it and she had a look as well and told me to document it so I did. It did happen again and taught me the value of documentation because that patient's blood pressure dropped and it was an emergency (AS1)

You could take it to your clinical educator and say can you show me this and she was quite happy to spend hours with me and she would get all the kit out and show you how to do it until you understood it (SS3)

There was a sense of disappointment for some students when the staff were unfriendly but they found ways of coping and remaining positive

...I made the most of it, kept my enthusiasm up, made sure that I kind of went and got on with it.... and it paid of (SS2)

Culture

Healthcare system

There were clear differences in the healthcare system and learning environment. Australian students struggled with understanding the different staff uniforms, different names for medication and documentation. Scottish students placed in private hospitals found the system very different such as a greater focus on cost in comparison to their experience of working within the National Health Service.

I just thought it was going to a hotter version of the UK. I generally thought the attitudes and that would be very similar but they weren't. They were very conscious of the price of everything down to a pair of ted stockings which was charged to the patient's bill. Everything little thing that was used was noted down and they were billed for the whole lot so that was very interesting. They were paying privately and they thought they could demand a lot so it was almost like working in a hotel (SS2)

Attitudes and behaviours

The students found the cultural differences marked and surprising.

Coming from the environment that we have here where we treat everyone the same I was embarrassed about the way they treated their Aboriginals because they didn't give them the time of day like they would the white Australians (SS 1)

I was quite surprised when I went in and realised the way the nurses treated them (SS2)

I had to do quite a bit of study myself on Aboriginal culture....., it's very difficult unless you know that but I soon sort of studied it myself and got quite used to that and found it easier to care for the patients and the families (SS 1)

Assertiveness and affirmation

Challenging practice

The students questioned staff and patient attitudes and behaviours, sought out information and chose to role model what they believed to be best practice in caring for patients even when it was contrary to custom and practice in their placement.

Different attitudes towards the different cultures was quite shocking I was embarrassed about the way they treated their Aboriginals. I would get a chat with them I (Indigenous people) and get the kids some, ice-lollies 'cos they had ice-lollies ... they might say thank you but they will never make eye contact, but that is a part of their culture and you just get used to it, you just pick it up. I had to do quite a bit of study myself on Aboriginal culture and stuff. I did speak to my mentor about it and she just said that they don't get many Aboriginals. That was her answer. They didn't have any information and my clinical educator seemed embarrassed and said that they would have to do something about it (SS1)*

I had a gentleman who called me, Scotsboy, and would ring his buzzer and shout, haw Scotsboy get me this and get me that, and eventually I just said to him 'my name is .... and I am willing to help you but I would appreciate if you wouldn't call me Scotsboy' (SS 2)

The little things that matter

The students discussed the value of caring for vulnerable people. They were able to identify specific events with their patients that resulted in therapeutic and compassionate care. The students voiced altruistic outcomes from their interactions. There was a sense that the students regarded provision of care as a privilege.

I remember there was this eight day baby that came in I held him while the doctor put an IV cannula in a little tiny wee arm. I just felt awful ...the mum had to walk out so I went and sort of comforted the mum and just talked her through the process...I felt very fortunate. I find the whole experience of nursing very humbling, to be able to take care of people when they are at their lowest (AS3)

I suppose the little things. I felt happy when I had one patient I offered him a cup of tea… I didn't really do much for him he thanked me for taking care of him. That is one of the good things I took away from it. If someone is thirsty just get them a drink…(AS4)

Care here is different. You provide personal care so you get the chance to build a therapeutic relationship with your patients (AS6)

I work in aged care and I find it very humbling to be able to take care of somebody. They are the most vulnerable and they are scared. For them to talk to me, trust in me….(AS4)

Confirmation of career choice.

The students could see for themselves how they had grown in autonomy, and gained a fresh awareness of their capability as nurses.

When you are training you always have your doubts, like I don't know, am I really cut out for this and you know I really want to go ahead now (SS2)

I had to be always following the group…. I know I am capable now of setting things up and doing it (SS 1)

I am a little different now. And determined to get where I want to go in nursing (AS 4)

Discussion

Relationships and interaction are central to nursing and sharing a personal experience or story has been found to be an effective way to describe an experience and how the story teller felt at that time [18]. In this study student experience of international clinical placement was explored with a specific emphasis on the emotional aspects, the highs and lows of the overall experience and how the students responded. Despite apparent challenges all the students involved in the exchange completed their placement.

The main themes will be discussed in relation to relevant literature.

The students found preparation for travel to and work within an overseas placement stressful and anxiety provoking which is consistent with previous findings [19]. In order to follow through, a deliberate choice and determination to make it happen was required. Responsibility for applying for a visa, booking travel etc. lay with the students. It was interesting that some students chose to embark on the placement as a way of moving out of their comfort zone and challenging themselves. The ongoing demands of study and assessment required managing, as preparation for the overseas placement manifested itself as additional work.

Levels of preparation provided by Universities who engage in overseas placements vary. Some students experience a "sink or swim" approach to study abroad with little preparation. In this case an onus of responsibility was placed on the students to research the placement and people in advance. It has been suggested that anxiety could be reduced and students would benefit from greater formal preparation and connectedness [20]. Strickland and associates [21] connected student groups in the UK, Finland and the USA as part of an international learning experience using a Wiki where students learned about and discussed their differing healthcare systems. This model offers an alternative approach to an international experience where students can build relationships prior to travel. If utilised as a preparation activity prior to commencement of the placement this model could ensure that students are better informed and equipped to care for diverse cultures. It could also soften the reality shock apparent in this study, where students were faced with the realisation that the decision to go was enormous as expressed in the question "what have I done?"

Clinical environments can be stressful for students [22]. The Australian students were at an earlier stage in their programme of study than the Scottish students and had not yet experienced work in a large hospital. Familiarisation and adjustment was necessary and connection with others was important to the students. Most travelled alone and valued having a friend or relative to connect with.

The relationship with their mentor or preceptor was also important. The students looked to them for reassurance and spoke of the value they placed on this support. Allan, Smith and Lorentzon (2008) go further to say that "mentors provide access to cultural knowledge and practices of the clinical team" page 552 [23] . The relationship that students have with their mentor is known to be fundamental to their learning and perceived emotional aspects and fear of the impact on mentor-student relationships can influence their actions [24]. When a registered nurse's behaviour is in conflict with what the students believe to be right they face a dilemma. Bradbury-Jones and associates found that students are reluctant to speak out [25]. In this study, though it was clearly challenging, with skilled communication and a respectful manner the students found themselves able to question practice and received a positive response which encouraged them as learners. Working in diverse cultures brings additional challenges but provision of support for students to exercise a strong voice could in turn influence them to encourage patients to speak out and question decisions of care [25].

Transition to the new healthcare environment and the many differences was challenging and the students felt vulnerable, lost and out of their depth. The depth of feeling the experience evoked could be seen in the show of emotion described. The students demonstrated a resilient response however, with a determined decision to manage their emotions, solve problems and move forward. Kramer and associates explored transition from student to registrant for newly qualified nurses and introduce the notion of environmental reality shock [26]. Duchscher (2009) suggests a similar adjustment process in response to transition shock [27]. Other studies that focus on transition required during student placement acknowledge similar challenges and advocate greater preparation and support prior to and during placement [20]. Thomas, Jinks and Jack (2015) suggest that resilience, determination to be professional and student personal values in terms of care for those in need, helps student to transition within clinical placement [28].

In Greatrex-White's study (2008) of the experience of students on an overseas placement participants described a sense of foreignness and feeling on the outside [29]. The participants spoke of everything feeling twice as hard in the foreign environment. This experience of foreignness could however help students to identify with minority groups and associated empathy could in turn be translated to practice within their home country. Increased understanding for patients and families who also feel foreign, excluded and lost could be developed as a consequence. The students in the current study were sensitised to the little things that mattered to those in their care and expressed a wish to help. They also described feelings of humility as they engaged in helping others and how changed they felt after the experience of the overseas placement.

Differences in Culture were discovered to be more marked than the students anticipated. It was interesting that the students experienced this despite placement in what could be regarded as a similar Western culture where English is predominantly spoken. It was also noteworthy that the Scottish students used words such as surprised, confused and embarrassed to describe cultural differences that related to staff interaction with indigenous people. Other research refers to culture shock [3]. Despite having concerns about perceived inequalities in care, students responded respectfully to staff, asked questions and took the initiative to seek out information about how to provide care within this new environment. They also took risks in testing out connecting with Indigenous patients and their families with what was perceived by them to have encouraging results in providing person centred compassionate care.

Taking risks to connect with people mirrors findings from the Leadership in Compassionate Care Programme [15] where flexible person centred risk taking was found to be, in particular circumstances, a characteristic of compassionate relational care. The students though themselves emotionally challenged chose to take a risk and connect with patients and families. It took courage especially in a different culture and where they felt alone. This was however clearly satisfying and affirming. They further demonstrated courage in challenging behaviours in a respectful way. Courage is one of the six 'C' s of Compassion in Practice outlined in the Department of Health's Strategy for Nursing Midwifery and Care Staff [30]. Pam Smith and associates [31] introduce the notion of emotional labour where "what one feels can be in conflict with what one thinks they should feel" (page 12) and this can happen in clinical practice when a nurse or student is confronted by challenging behaviours. It was interesting in this study that when a patient persistently addressed the student in what was perceived to be an insulting and derogatory way he chose to respectfully ask him to stop while reassuring him that he was willing to provide the help and care that the patient was requesting.

It was noteworthy that at the end of the placement the students believed that they had not only grown in confidence but expressed a sense of overcoming and accomplishment similar to passing a test, they also gained assurance and affirmation that they had the capability to join the nursing profession. The students all found the international placement a worthwhile learning experience. Australian students experience significantly less hours working in clinical practice during their programme of study that those in the UK and are known to want more [32]. Provision of an international learning experience within an acute clinical setting is therefore particularly valuable.

Overall the students expressed the high value they placed on participating in the exchange and a determined resolve to apply their learning in practice on return home.

Recommendations for practice

Provision of opportunities for students to make contact with fellow students in the host country and explore and discuss different Healthcare Systems prior to overseas placement.

Improvement of support systems for all students whilst aboard. In particular for those without family or friends in the visiting country.

Active encouragement and facilitation of a structured debrief for students.

Limitations

The study sample was small and data collection carried out over an extended period. This limitation was a

consequence of student numbers dictated by the exchange agreement and unexpected personal circumstances that caused some students to drop out prior to commencement of travel. The short notice did not allow for the opportunity to be offered to others and meant that where four students per year could have participated in the exchange the numbers were sometimes reduced. The study results cannot be generalized however, the researcher believes that the findings are applicable to similar contexts.

Conclusions

This study demonstrates that overseas placements can provide a valuable learning experience for nursing students but it is not without its challenges. These relate to cultural and healthcare differences and adaptation to the new care environment. Students are required to acknowledge and manage their own emotions while responding sensitively to the needs of others. Judgements about how best to respect cultural differences without compromising care must be made and followed through, but through executing this successfully the experience can be rewarding. Perceived benefits included personal and professional development and confirmation of career choice, however greater preparation would have reduced stress and increased cultural awareness in advance of the placement.

Abbreviations

AS: Australian student; NVIVO: A qualitative data analysis (QDA) computer software package produced by QSR International; SS: Scottish student; UK: United Kingdom; WA: Western Australia

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Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available as the participants were not informed that the data would be shared verbatim but as anonymised quotations. The data are available from the corresponding author on reasonable request.

Author's contributions

The author made substantial contributions to conception and design, the acquisition of data. The author has been involved in drafting and revising the manuscript critically. The author has given final approval of the final version to be published. The author has agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Authors' information

Elizabeth Adamson is an Associate Professor within the School of Health and Social Care at Napier University Edinburgh, Scotland. She has 17 years of experience in education both within clinical practice and university. Her current strategic role as Academic Lead for Student Experience within the School provides an opportunity to actively promote and facilitate excellence in student learning. Her pedagogical research interests are assessment and feedback and student mobility. Her clinical research interests are enabling patient with long term conditions to live independently and compassionate person centred care.

Ethical approval and consent to participate

The research was approved by the Edinburgh Napier University Faculty of Health, Life & Social Sciences Research Ethics and Governance Committee. The Australian students were matriculated as Edinburgh Napier University students for the duration of their stay in the UK and clinical placement. Participants gave written consent to participate in the study and for publication of the study findings.

Consent for publication

Not applicable.

Competing interests

The author declares that they have no competing interests EA.

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Helping Student Nurses Learn the Craft of Compassionate Care: A Relational Model

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ABSTRACT

This on the horizon article proposes a relational model for enabling the development of skills and attributes associated with 'compassionate craftsmanship' in the developing nurse. This pedagogic model was informed by findings from the author's research with patients, nurses and students, all of which focused on aspects of care and compassion. While the studies were located in varying contexts and involved diverse stakeholders, findings consistently revealed a connection between the provision of compassionate person-centred care and the development of tacit knowledge in the nursing profession. These will be teased out and explicated in a future paper; this article focuses on the proposed model.

The proposed model was developed by drawing on the literature of craftsmanship in a range of disciplines, where tacit knowledge is commonly regarded as a vital underpinning factor. In consequence, the compassionate craftsmanship model emphasises the importance of tacit knowledge in the design of appropriate pedagogic approaches to foster an ethos of compassionate craftsmanship in nursing. The very nature of tacit knowledge, however, means it is a challenging educational area to address. Hence the model, which illuminates a series of inter-related enabling factors that underpin the development of key abilities associated with compassionate craftsmanship. It also highlights anticipated long-term outcomes for those who develop and apply these in clinical practice.

The model will be of particular interest to healthcare practitioners, nurse leaders and those working in higher education. While the underpinning abilities and associated outcomes are specific to nursing, they are likely to be relevant to different disciplines where effective interaction with others is essential.

Keywords: craftsmanship, compassionate pedagogy, nursing, tacit knowledge, craft mastery

Introduction

Healthcare provision is under increasing pressure as people are living for longer and many with long term conditions who require ongoing treatment and care (Stucki, Bickenbach, Gutenbrunner, & Melvin, 2018). Compassion continues to be central to the provision of excellent care (McSherry, Timmins, de Vries, & McSherry, 2018) and how patients are cared for is as important to them as the nature of the care itself (Dewar & Nolan, 2013; Edinburgh Napier University & NHS Lothian, 2012). Despite this realisation and associated increased emphasis on provision of compassionate care globally (Dewar & Nolan, 2013; MacArthur, Wilkinson, Gray, & Matthews-Smith, 2017), even the most vulnerable people do not always experience this (McSherry et al., 2018; Parliamentary Health Service Ombudsman, 2011). Reports of poor care have featured in the press (Sinclair et al., 2016), resulting in calls for action such as careful screening of student nurse candidates for a compassionate disposition (Timmins & de Vries, 2015). Research shows that health professionals enter the profession with the intension to care (Mackintosh, 2006). Unfortunately, not all care environments are conducive to this and through the sociocultural influences in practice nurses can become desensitised to patient need (McSherry et al., 2018). Students may be encouraged to keep their distance from those for whom they care in order to protect themselves (Dewar, Adamson, Smith, Surfleet, & King, 2014). Although nurse educators are rarely able directly to ameliorate the significant practical challenges their students will encounter in healthcare environments, they can do much to prepare developing practitioners to work effectively within them.

Patients associate quality care with connectedness, attentiveness to patient comfort and kindness (Grimley, 2017). They value nurses detecting and attending to the little things that matter most to them and treating them as a person not a number (Adamson, Pow, Houston, & Redpath, 2017). Nurses need to identify and work adaptively with the constantly arising variations in circumstances, conditions and the people for whom they care and students need explicit and sustained support to learn how to do this. This paper suggests that one way to help nursing students is to support them develop an ethic of craftsmanship, underpinned by the key abilities and characteristics associated with this. This ethic involves a commitment to work that is excellent (Berger, 2003; Coeckelbergh, 2014).

Background

In the widening access agenda and broad entry gate to education, student nurses embark on their programme of study with a range of life experience, differing values and beliefs and varying degrees of sensitivity to the needs and feelings of others. It is unwise to assume that students are naturally caring and that compassion is entirely innate. Research shows that curriculum can emphasise knowledge-based competencies which can dominate students' attention, to the detriment of compassionate caring (Sinclair et al., 2016). Therefore, a key challenge for educators is to explicitly and sympathetically provide the tools, opportunities and environment for students to develop not only compassionate caring skills but attributes of craftsmanship, such as development of tacit knowledge and a commitment to do a good job for its own sake regardless of circumstances.

Prompted by Sennett's (2008) seminal work on craftsmanship, Meal and Timmons (2012) call for Craftsmanship in nursing to be 'Reclaimed'. The notion of the Art and Craft of nursing in general has been widely debated (Edwards, 1998; Jenner, 1997; LeVasseur, 1999) but not explicitly applied to the aspect of compassionate caring, much of which I argue resides in tacit knowledge and is a key feature of my model.

Tacit knowledge is closely associated with craftsmanship. Sennet's work is founded on educational approaches that enable students to develop this for themselves (Sennett, 2008). From this viewpoint effective pedagogies focus on development of tacit knowledge and can help students understand and engage in care that is more than technically correct. It is also concerned with the 'how' of caring (Frayling, 2012). Tacit knowledge is rooted in action and an individual's commitment to their profession. This can be 'more than the experienced practitioner can tell' (Polanyi, 2009) and associated with expertise and mastery. The inexperienced practitioner

Whereas explicit knowledge is articulated and captured in text or drawing, tacit is not voiced, involves the senses, physical experiences and intuition. It consists of both cognitive (ability to perceive and define in the context of one's world) and technical (know how) elements (Nonaka, 1994; Nonaka & Von Krogh, 2009).

It is this tacit knowledge that gives a practitioner the edge and helps them to advance in growing expertise but it can be difficult to uncover in others and to develop for oneself. There is an expectation that the learner picks this up in the course of work experience but it can seem mystical and unattainable to the learner (Frayling, 2012). Benner and associates (2012) in her skills acquisition model from novice to expert suggests that a mark of expertise is the ability to have an intuitive grasp on a situation which enables the nurse to know what must be done and how. She also advocates the use of pedagogical strategies that facilitate this development (Benner, Tanner, & Chelsa, 2012). Use of educational approaches as represented in the following model aim to help the student to recognise, 'see' and develop tacit knowledge which should help achieve this.

It is important to recognise that the proposed model was heavily influenced by a programme of research focused on uncovering what matters to patients and families. The specific details of the ways in which the model emerged from my work will become the subject of a future paper, so here I briefly indicate them to place my model in context. They included two studies set in the community care setting (Adamson et al., 2017; Cruickshank, Adamson, Logan, & Brackenridge, 2010) and the Leadership in Compassionate Care Programme (LCCP) (Edinburgh Napier University & NHS Lothian, 2012).The aim of the three year action research LCCP was to embed compassionate care in practice and education. The importance of tacit knowledge to enable and enhance person centered compassionate care was evident in all three studies The findings resonated with abilities of craftsmanship included in the model such as being curious, questioning, being open to do things differently, compassionate listening and connecting with the person as an individual (Dewar & Nolan, 2013; Edinburgh Napier University & NHS Lothian, 2012).

The different dimensions of the model

The first or inner ring within the model represents the learner; for whom the development of an ethos of compassionate craftsmanship via the overlapping surrounding elements is central. The second represents the enablers to the development of compassionate craftsmanship. The third circle represents the abilities that learners need to develop and apply in practice. The outer ring represents the anticipated beneficial outcomes that will influence care practice into the future. The arrows indicate progression.

Figure 1: Model of Nursing Craftsmanship

Enablers to development of craftsmanship

The enablers are interrelated. The craft person engages in creative thinking through adoption of a creative mindset and continually seeks out and gains knowledge that is applied in practical action. The craftsperson attempts to make sense of a situation while allowing that sense making to be questioned and reshaped (Taylor, 2012). Therefore, pedagogical activities that encourage and enable the development and application of this mindset help the learner to keep an open mind, to consider alternatives and to imagine how things might be. As nurses they are seeking out and finding underlying problems and solutions through assessment and questioning (Sennett, 2008). The work of the nurse is social and Sennet suggests that the same capacity to influence is required for this as for the craftsperson working with physical materials (Meal & Timmons, 2012; Sennett, 2008). For this they require knowledge both explicit and tacit as well as flexibility to adapt to ever changing circumstances and each person as an individual.

> *The craftsperson uses knowledge to understand and overcome the constantly arising difficulties that grow out of variation in tools, materials and conditions in which they work.* (Frayling, 2012, p. 78).

Sennet suggests three approaches to help students to develop the more difficult to attain tacit knowledge. The first approach he calls **sympathetic Illustration** which is focused on the needs of the learner. The lecturer shows empathy by sharing difficulties that they experienced as a novice including strategies to overcome these. These useful problem-solving techniques help the students develop their own strategies. This requires the expert retracing their practice step by step to the place before the activity became routine (Sennett, 2008). Use of loose analogies help the learner to feel that a new procedure/task is roughly like something they have done before and gain confidence to try to attempt the new. The student is encouraged to think creatively and imagine what engaging in a care activity or process might be like.

Secondly **scene narrative** acts as a vehicle for consideration of the 'how' of care by relating a story. It conveys the student to a scene clear in detail but puzzling in significance and meaning (Sennett, 2008). This is used to trigger curiosity and contemplation of what to do and how to do it. It encourages the learner to enter into the context and imagine what it would be like to be there. This is used to initiate independent thinking in the student, to help them understand the patient perspective and facilitates the development of creative thinking about care (Meal & Timmons, 2012; Sennett, 2008). One way to accomplish this is through sharing and reflecting

on patient unique stories gathered in clinical practice (Adamson & Dewar, 2015), which can help students "stand in the patient's shoes" (Browning, Meyer, Truog, & Solomon, 2007).

A third approach is **instruction through metaphor** which helps the student to consider the effect of an action, intervention or communication on person in their care. The student is encouraged to imagine for example the impact that a diagnosis may have on a person. One possible approach which could facilitate this and is through simulated practice in the classroom setting using simulated (actor) patients. Simulated practice environments are set up to mimic a real care setting and known to help students identify and even challenge their tacit values (Green & Bull, 2014). Students work in teams and are given a patient to care for or assess and provided with limited information about the person.

The aim is to encourage the learner to engage creative thinking in their situational problem finding and problem solving (Taylor, 2012). Opportunities for problem finding and problem solving which are closely connected in craftsmanship are woven into the learning experience.

The learner must uncover the often hidden problem and decide on and undertake appropriate care practices (take practical action), while observed by facilitators and peers (Carmel, 2013) who then feedback and initiate reflection and dialogue facilitated by the lecturer. Feedback from simulated patients is also valuable (Adamson & Dewar, 2011). In medical education this approach was found to help doctors reconnect with their humanness (Browning et al., 2007).

Abilities of a craft person

As learners are exposed to pedagogical approaches such as those described above it is anticipated that they will develop key abilities which are also interrelated. Those included in the second circle of the model are identified as foundational to craftsmanship (Sennett, 2008). These are firstly localising or zooming in on what is important; secondly the ability to question, to dwell on and ponder the situation or problem and seek solutions; and thirdly the ability to open up and unravel the situation or problem further. This is closely aligned with being open to act differently.

The practice of craftsmanship in nursing is mostly social (Coeckelbergh, 2014), as it requires connection and relationship with those with whom they work and with those for whom they care.

Localising relates to identifying the focal point and requires engagement of all of one's senses (visual, auditory, tactile) in assessing, sensitive probing, compassionate listening and attending to clues so that key concerns can be identified and priorities decided. This relates to the nursing vigilance, awareness and attention to the needs of the patient (Grimley, 2017; Raingruber & Wolf, 2015).

Questioning draws on the tacit and requires the ability to think creatively. The craftsperson tries to make sense of the situation, is influenced by past experience but keeps an open mind. Sense making is questioned, reshaped and transformed (Taylor, 2012).

Opening up involves the craftsperson being open to do things differently, They apply fresh thinking and imagine an alternative way (Taylor, 2012). They are open to new ways of working and the views and suggestions of others. This may be patients and families as well as colleagues.

Anticipated outcomes associated with craftsmanship

The ultimate aim is that the learner will grow in compassionate caring expertise and will experience the long term anticipated outcomes that feature in the outer circle of the model. These are also interlinked. The compassionate craftsperson needs to believe in their ability to provide compassionate care. Research shows that high self-efficacy is correlated with greater motivation and courage to attempt new and difficult tasks. Self-efficacious people also recover better from setbacks so important with increasing demands of healthcare provision. Research also shows that healthcare practitioners with low self-efficacy have been found to be less likely to exhibit compassion (Davin, Thistlethwaite, & Bartle, 2018). The craftsperson is committed to do a good job for its own sake (Sennett, 2008; Thorlindsson, Halldorsson, & Sigfusdottir, 2018), and take pride in their work (Frayling, 2012). Provision of compassionate person centred care is known to bring satisfaction and meaning for nurses (Dewar et al., 2014) and job satisfaction has been found to be closely linked to meaningfulness (Thorlindsson et al., 2018). Nurses who have this sense of meaningfulness of the work they do enjoy greater job satisfaction (Janssen, De Jonge, & Bakker, 1999; Raingruber & Wolf, 2015). The craft person who experiences these outcomes is well placed to influence and shape current and future practice. These links suggest that the anticipated outcomes could be seen as an interwoven whole.

Conclusion

In conclusion this model draws on the work of Sennett and others to present key dimensions of the development of nursing craftsmanship (Sennett, 2008). The interrelated elements of the model can prompt key questions and scaffold dialogue amongst educators and learners, about learning environments that inspire and engage learners in the pursuit of excellence and the invisible craftsmanship of compassionate caring. Its strengths are that it is student-centred and emphasises the importance of relational approaches to teaching and learning which can help students to begin to develop tacit knowledge so vital to the 'how' of caring practice.

Biographies

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