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Embedding compassionate care in local NHS practice

Embedding compassionate care in local NHS practice: developing a conceptual model through realistic evaluation

Introduction

Concern about the delivery of compassionate care in the UK National Health Service (NHS) has become a focus of debate (Patients Association, 2011; Holmes, 2013) and internationally there has been similar alarm about patient experience in hospitals and care homes (Clarfield et al., 2001; Youngson, 2008; Lown et al., 2011). The failures in care highlighted in the Francis Report (2013) raised major questions about leadership and organisational culture and how these impact on the quality of care.

The aims of this paper are to present a critical analysis of the 'Leadership in Compassionate Care Programme' (LCC Programme) and offer a conceptual model of factors that can enhance organisational capacity to develop and sustain a culture of compassionate care. The LCC Programme was a three-year initiative developed in partnership between a health board in Scotland and one higher education institution and was designed to embed compassionate care in practice and pre-registration education. Adopting Pawson and Tilley's (1997) realistic evaluation approach, this longitudinal qualitative study analysed the experiences and outcomes of eight wards participating in the programme 2008-2011. Despite its local focus the study has implications for wider policy and practice through recognition of the reality of delivering of compassionate care in contemporary health care environments.

Background

At the inception of the LCC Programme in 2007 the term 'compassion' was not strongly linked to patient experience, although 'dignity' was a key concept for the expression of concern about the care of older people (Agnew, 2007; Reed and McCormack, 2007) and the focus of a number of initiatives (Healthcare Commission, 2007; Department of Health, 2009). Related work underway in the UK included development of the 'Person-Centred Nursing Framework' (McCormack and McCance, 2010), the implementation of the 'Point of Care Programme' (Firth-Cozens and Cornwell, 2009) and Patterson et al's (2010) longitudinal study examining the cultural context of care in acute hospital settings. Compassion was later identified as a key component of NHS quality strategy (Scottish Government, 2010) and a 'core NHS value' (Department of Health, 2009).

Furthermore in the UK it was at the centre of national nursing strategy (Department of Health, 2012) and a commission on the future of nurse education (Royal College of Nursing, 2012).

Youngson (2014) defines compassion as 'the humane quality of understanding suffering in others and wanting to do something about it'. One of its central characteristics is being an active emotion that demands a response rather than simply an awareness of the plight of another. Other definitions emphasise the importance of relationships, values and how people perceive their care (Department of Health, 2012). More recent research has sought to define compassionate care from the perspectives of patients, staff and students (Van der Cingel, 2011; Curtis, Horton and Smith, 2012; Bramley and Matiti, 2014), develop a conceptual model for compassionate relationship-centred care (Dewar and Nolan, 2013) and identify educational approaches to enhance compassionate interactions with patients (Betcher, 2010; Sheild et al., 2011; Adamson and Dewar, 2015).

There is international evidence demonstrating the connection between hospital environments and quality of care (Aiken et al., 2012)., Patterson et al. (2010) recognised the pressures within acute hospitals and discussed the tension between 'pace' and 'complexity' (Williams et al., 2009), which they found made 'often conflicting and paradoxical demands' on those delivering care (Patterson et al., 2010: 48). Firth-Cozen and Cornwell (2009) similarly argued that the emphasis on targets (i.e. pace) as opposed to the totality of patient experience (i.e. complexity) had the potential to exert a profoundly negative effect on the culture of care and staff morale. In an international meta-ethnographic study Bridges et al. (2013) found little understanding of the conditions in which high quality, compassionate in-patient care is delivered within acute care settings. There has been little research addressing what is required to embed and sustain a culture of compassionate care within the reality of modern health care environments.
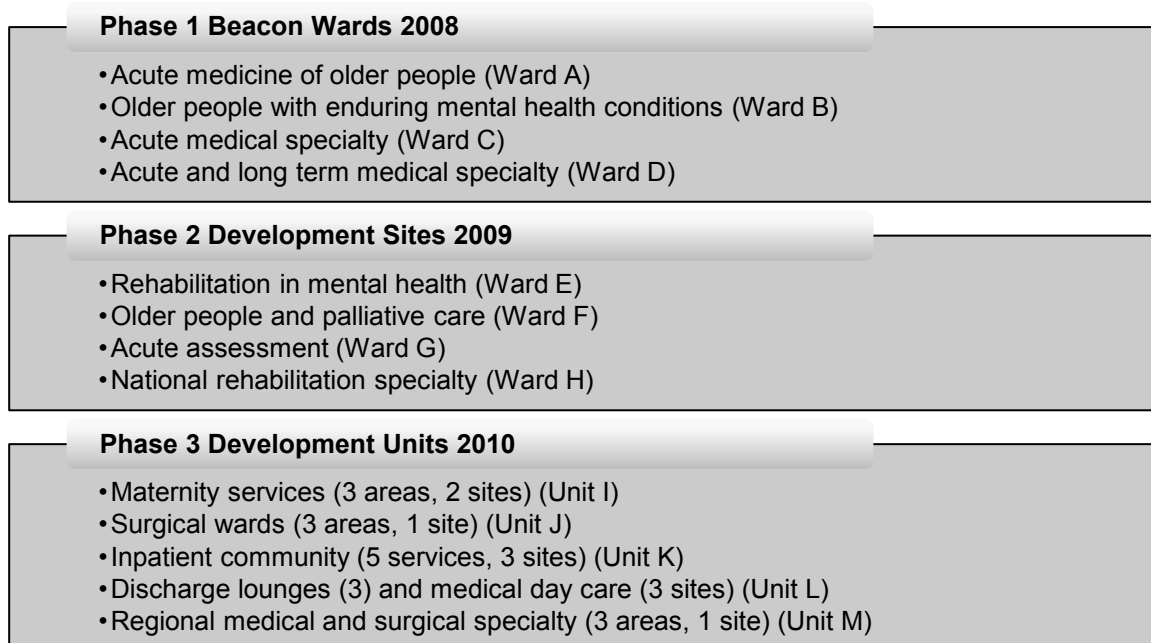
Leadership in Compassionate Care Programme
The LCC Programme, which was funded by a benefactor, aimed 'to embed compassionate care as an integral aspect of all nursing practice and education' (Edinburgh Napier University & NHS Lothian, 2012:14) and included establishing

'Beacon Wards' to showcase excellence in compassionate care. It was conducted as a three-year research study underpinned by the theoretical principles of action research (Meyer, 2000), relationship-centred care (Nolan et al., 2006) and appreciative inquiry (Cooperrider et al., 2008). The Programme involved engagement with a wide range of participants including patients, relatives, NHS staff, lecturers and student nurses (Smith et al., 2010; Dewar, 2011a; Edinburgh Napier University and NHS Lothian, 2012). A total of 33 clinical settings were involved (Figure 1), with direct participation of 106 individuals.

Figure 1.

Phases and Clinical Settings involved in the LCC Programme.

Phase 1 Beacon Wards 2008

- Acute medicine of older people (Ward A)
- Older people with enduring mental health conditions (Ward B)
- Acute medical specialty (Ward C)
- Acute and long term medical specialty (Ward D)

Phase 2 Development Sites 2009

- Rehabilitation in mental health (Ward E)
- Older people and palliative care (Ward F)
- Acute assessment (Ward G)
- National rehabilitation specialty (Ward H)

Phase 3 Development Units 2010

- Maternity services (3 areas, 2 sites) (Unit I)
- Surgical wards (3 areas, 1 site) (Unit J)
- Inpatient community (5 services, 3 sites) (Unit K)
- Discharge lounges (3) and medical day care (3 sites) (Unit L)
- Regional medical and surgical specialty (3 areas, 1 site) (Unit M)

The study reported in this paper, which was a separate entity to the LCC Programme action research study, aimed to critically analyse the impact of the complex interventions undertaken by the LCC team in order to understand factors that had the potential to embed and sustain compassionate care. It focussed primarily on Beacon Wards (A-D) and Development Sites (E-H). The purpose and selection methods of these wards within the LCC Programme are outlined in Box 1.

Box 1.

Purpose and selection methods of Beacon Wards and Development Sites

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Beacon Wards

Expected to demonstrate excellence in compassionate caring, with a view to sharing and spreading effective practice to other areas. Wards were selected through submission of a portfolio and a visit for demonstration of i) the caring environment ii) evidence of collaborative and effective team working: and iii) evidence of staff development.

Development Sites

Purpose was to help the LCC team test out the methods and processes understood from the Beacon phase and assist staff to develop their relationship centred, compassionate care practice. Wards were selected on the basis of demonstrating a commitment to supporting change and developing practice both at senior level and within the multidisciplinary team.

Four senior nurses and a lead nurse delivered the LCC Programme; their role was to work alongside staff in each ward/unit for 7-9 months conducting the action research and to facilitate innovative practice development approaches, including:

a) Emotional touchpoints (Dewar et al. 2011b) - eliciting stories based on an individual's emotional experience of a number of 'touchpoints' during their healthcare journey.

b) Beliefs and values clarification (Edinburgh Napier University and NHS Lothian, 2012:38) - facilitation of staff groups to develop a common shared purpose/vision and understand how these influence practice and culture.

c) Photo elicitation (Dewar, 2012) - using photographs to prompt staff and patients to discuss the meaning of compassionate care, with statements subsequently being displayed as 'positive care practices'.

Research questions

The research questions addressed in this paper were:

1. What are the views, experiences and perceptions of participating stakeholders of the impact of the LCC Programme?

2. How are the mechanisms used in the LCC Programme seen to influence the outcomes in different clinical settings?

3. What are the early signs of sustainability of the LCC Programme?

Methods

Methodology

The study was based on realistic evaluation (Pawson and Tilley, 1997), a theory-driven research approach that places emphasis on understanding the context within which an intervention takes place. Rather than seeking to answer whether a programme has 'worked' (or not), realistic evaluation is designed to provide detailed answers to the question of '*why* a programme works, for *whom* and in *what* circumstances?' The theoretical underpinning of realistic evaluation is founded on the link between the context (C) within which the programme is being delivered and the ideas and opportunities known as mechanisms (M) that the programme brings, which in turn lead to the programme outcomes (O). Pawson and Tilley (1997) describe these as CMO configurations.

Consideration of the insider-outsider perspective

A key feature of the study was that of the investigator (JM) being an insider-outsider researcher (Corbin-Dwyer and Buckle, 2009); being an insider to the organisation through employment in a lead research role, having a close working relationship to the LCC Team but with no specific role in Programme delivery. Being an insider gave opportunity to engage with a wide range of stakeholders and possess an in-depth knowledge of the organisational context. Remaining an outsider to the Programme, along with a systematic approach to the inquiry and regular supervision, maintained an independent perspective on impact.

Research design

A qualitative, longitudinal research design was adopted, with data collection being undertaken in three time points with a time lag of approximately 6 months to the implementation of the LCC Programme: phase 1 - 2008-9; phase 2 - 2009-10; and phase 3 - 2010-11. Table 1 outlines the data collection methods and outputs, all of which were obtained in the field, giving opportunity to observe the clinical environments and review tangible signs of the implementation of the LCC Programme: informal observations of care practices; 'Compassionate Care' notice boards with evidence of outputs from 'beliefs and values clarification'; folders containing patient, relative and staff stories; and 'positive care practices' displayed in digital photo frames. Other

opportunities to record field notes took place during meetings, seminars and conferences related to the LCC Programme.

Table 1.

Data collection methods and research outputs

Data collection method	Research output
Semi structured interviews with key stakeholders	• Views, experiences and perceptions of LCC Programme • Understanding of practice development tools in action • Outcomes for patients, relatives, staff and charge nurse
Informal observation of practice in clinical settings	• Outputs from engagement with LCC team – patient stories, photo-elicitation • Developments in practice
Attendance at LCC meetings	• View and experiences of LCC team • Emerging themes on compassionate care from action research
Review of research outputs from LCC team	• Emergent understanding of compassionate care in practice • Development of practice development methods that have impact on embedding compassionate care
Attendance at LCC conferences	• Outcomes for clinical teams of participation in LCC Programme • Developments in practice

The combination of data collection methods were focussed on building up a picture of the context of each ward, the mechanisms utilised by the LCC team and the outcomes for patients, relatives, ward staff and the charge nurse as leader of the ward. Patients and relatives were not included as direct research participants in this study since within the design the key 'subjects' were deemed to be the nursing staff. Insight in to the impact and outcomes of the LCC Programme for patients and families were obtained through specific questioning of staff and identification of outcomes from the other data collection sources. The longitudinal nature of the study allowed examination of the CMO configurations prospectively with the possibility of drawing conclusions on issues of early sustainability of the LCC Programme and its aim of embedding compassionate care in practice.

It was anticipated that a key output of using Pawson and Tilley's (1997) realistic evaluation methodology would be the generation of a conceptual model of enabling factors to enhance organisational capacity to deliver compassionate care. This model would be the type of 'middle range theory' developed through analysis of CMO configurations that Blamey and Mackenzie (2007) describe as generalisable mechanisms that explain why groups of individuals (within a particular context) respond in a relatively predictable way to an intervention (or an aspect of an intervention).

Sample

In their realistic evaluation framework, Pawson and Tilley (1997: 161) identify three stakeholder groups and these were used to identify the purposive sample for the semi-structured interviews:

- *Subjects* (on the receiving end of the LCC Programme mechanisms) - charge nurses and nurse managers in the Beacon Wards and Development Sites (n=14).
- *Practitioners* (translating the Programme theories into practice) – Senior Nurses within the LCC Programme (n=7).
- *Policy Makers* (influencing the direction of the Programme) – senior individuals in the NHS organisation and higher education institution (n=5).

Participants were invited to participate by email and gave written consent prior to taking part.

Interview Schedules

The majority of data was collected through semi-structured interviews (n=39) and focus groups (n=3), which lasted 57 minutes - 2 hours. The interview schedules reflected each phase of the study:

Phase 1 (2008)	Context and rationale for the LCC Programme
	Meaning of compassionate care
	Predicted outcomes/indicators of success
	LCC Programme mechanisms that may influence change
	Macro and micro forces that may promote/limit achievement of LCC Programme outcomes

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Phase 2 (2009)	Compassionate care within Beacon Wards and Development Sites
	Reflective analysis of mechanisms and sustainability in Beacon Wards
	Analysis of macro and micro forces influencing implementation of LCC Programme and its organisational profile
Phase 3 (2010)	Compassionate care within Development Units
	Reflective analysis of application of mechanisms in different contexts
	Outcomes of LCC Programme in Beacon Wards and Development Sites
	Sustainability of LCC Programme and wider organisational impact

Ethics

Ethical approval was sought from the Scotland A Research Ethics Committee (07/MRE00/120) and the partner university's Faculty Ethical Committee. Management approval was obtained from the local Research and Development Office (2007/P/UO/03). The main ethical issues were confidentiality and preservation of anonymity in a relatively small sample group.

Level of Adoption

An important aspect of the study was to understand the 'level of adoption' of the LCC Programme in each ward according to the following criteria:

1. Engagement with the LCC Programme during the period of facilitation;
2. Engagement with the LCC team once the initial period of facilitation had come to an end;
3. Self-association with the LCC Programme, including self-identification as a Beacon Ward/Development Site;
4. Continued adoption of the appreciative approaches within the setting;
5. Continued use of some of the key LCC Programme techniques.

Analysis

Data were subjected to thematic analysis (Boyatzis, 1998), involving initial immersion in the interview transcripts (n=42) and field notes by the researcher (JM). Analysis was

inductive and used the realistic evaluation framework (context, mechanisms and outcomes) and research questions to create an initial organisational structure. Data were coded, recorded and managed in QSR NVivo 9 and the initial analysis led to the identification of 833 open codes that were subsequently organised into categories and themes. The main themes emerged from analysis of the contextual elements of the CMO configurations within and across the eight wards and how these interplayed with the Programme mechanisms leading to the overall outcomes for different patients, families and staff.

To maximise trustworthiness all interviews were digitally recorded and transcribed verbatim. The rigour of the preliminary coding framework was enhanced by the supervisors (HW, MG) independently coding a number of initial transcripts.

Results

Sample Characteristics

Data relating to Wards A-D were collected over three years and for Wards E-H over two. The findings presented in Table 2 are based on interviews, access to data management systems and wider organisational knowledge recorded in field notes. The eight wards were heterogeneous in terms of specialty, size, bed occupancy, length of stay, team composition, management support and experience of the leader.

Level of Adoption

There was varying degrees of adoption of the LCC Programme, which in turn provided insight into both impact and factors that embed compassionate care in clinical settings. According to the criteria previously outlined wards were judged to be 'high' (4-5 criteria), 'medium' (= 3 criteria) or 'low' (≤ 2 criteria) adopters as follows:

Beacon Wards			**Development Sites**		
Ward A	High	(5)	Ward E	High	(5)
Ward B	High	(5)	Ward F	High	(4)
Ward C	Low	(1)	Ward G	Medium	(3)
Ward D	Low	(2)	Ward H	High	(4)

Table 2.
Summary of contextual information and characteristics of the Beacon Ward and Development Sites.

Ward (Level of Adoption)	Patient Group	Ward Profile *Number of beds; % occupancy; average length of stay* (where data available)	Team Characteristics & Involvement in LCC Programme	Management Support	Experience of Leader
Ward A High	Older people Acute medicine	24 beds 95.1% 19.4 days	Established team Strong involvement multidisciplinary team	Mainly stable but some change Supportive at higher level	New charge nurse
Ward B High	Older people Mental health	30 beds Long stay	Established team Minimal multidisciplinary involvement	Stable and supportive at immediate and higher level	Established charge nurse
Ward C Low	Mainly older people Acute medical specialty	22 beds 90% 8.7 days	Established team Stable multidisciplinary team – no medical staff involvement	Variable and number of changes Supportive at higher level	Acting charge nurse
Ward D Low	Mixed age Acute & long term medical specialty	46 beds 122.1% 6.6 days	Established nursing team Minimal multidisciplinary involvement	Variable and number of changes Supportive at higher level	Experienced charge nurse during year 1 Two changes of charge nurse during year 2 & 3
Ward E High	Mixed age Mental health rehabilitation	25 beds Medium stay	Established nursing and multidisciplinary team Strong involvement	Strong at all levels	New charge nurse
Ward F High	Older people Frail health Continuing /palliative care	34 beds Long stay	Established nursing team Minimal multidisciplinary involvement	Stable and very supportive at immediate and higher level	Experienced charge nurse
Ward G Medium	Mixed age Acute assessment	72 beds 70.6% 0.6 days	Very large team Regular turnover of medical and nursing staff Partial involvement	Mainly stable but some change Supportive at higher level	Three charge nurses, only one directly involved in LCC Programme.
Ward H High	Mixed age Rehabilitation National centre	19 beds Medium to long stay	Small established multidisciplinary team Good involvement	Good local management support	Several changes in leadership New charge nurse

Outcomes categories

There were three principal outcome categories:

a) relationships – changes between groups and individuals over time as a result of the exploration of the meaning of compassionate care and the introduction of methods for giving and receiving feedback.

b) care delivery – new approaches, attitudes and behaviours influenced by practice development techniques that placed emphasis on values and expression of emotions.

c) developments in practice – specific action projects that had been initiated by staff as a result of the action research elements of the LCC Programme.

Views, experiences and perceptions of the impact of the LCC Programme

Where there was high levels of adoption of the Programme the outcomes for different stakeholder groups were palpable and served to indicate key elements of compassionate care for patients, relatives and staff. Conversely where there was a low level of adoption the views and experiences of the participants were less positive and examples of specific outcomes were more limited.

An important feature of the Programme was the opportunity to elicit the views, experiences and perceptions of patients, families and staff. The charge nurse in Ward A described this as *'hearing the patient's voice and hearing the staff's voice'* and indicated that it resulted in '*being open to listening and open to trying new ideas, grasping opportunities as they arise'* [CN1]. Successful engagement impacted the wards in different ways with a primary focus being improvements in care for patients and families; as the charge nurse in Ward E reflected '*the compassionate care [Programme] is actually educating me, and you're learning how to take care forwards'* [CN5].

Through understanding the meaning of compassion it became evident that being treated compassionately was important for patients, families *and* staff. One of the LCC senior nurses proposed that to deliver compassionate care *'you really understand the whole situation, the whole context you're working in. What it means to you, the person, the family'* [SN6]. In keeping with the underpinning principle of relationship-centred care (Nolan et al. 2006), improving relationships between staff and patients, staff and

families and between staff themselves was core to embedding compassionate care. As the charge nurse in Ward F reflected, an overriding aspect of her experience of the LCC Programme was the focus on *'relationships with everyone that you come into contact with'* [CN6].

Listening to patients. For patients, it was the opportunity to express their feelings as well as having individual needs met through the personalisation of care that enhanced their experience of compassionate care. One of the senior nurses designed and introduced an 'All About Me' sheet to elicit more detailed background information about older people or those with cognitive impairment in order to support staff to deliver person-centred care. One example of the outcome of its use was in Ward F *'a lot of our patients can't vocalise what they want to wear but we know what their favourite colour is, so we can try and put something on them with their favourite colour'* [CN6]. The various practice development techniques equipped staff with new approaches to listen to patients and respond to their care needs. This was recognised in Ward E by one of the policy makers who described important changes in practice being based on *'actually listening to patients and hearing what they are saying, in terms of making changes to their management'* [PM3]. This was echoed by the charge nurse recognising that previously staff *'were talking but we weren't listening'* and that as a result of the Programme they had *'become better listeners. More looking for solutions rather than problems, so a much more appreciative way as well'* [CN5].

Relationship with relatives. This emerged as an important issue in each of the settings and at the outset of the Programme several wards acknowledged this as an area of weakness on their part, with a great deal of contact being reactive rather than proactive. During activities such as 'beliefs and values clarification' and 'emotional touchpoints' some staff admitted they were anxious about approaching relatives, with fear of criticism or eliciting complaint. This was acknowledged by the charge nurse in Ward B, following an interview with a family using emotional touchpoints, *'the daughter said 'sometimes you avoid us'. And to be honest we probably did, because you knew there were problems coming'* [CN2]. In each of the high adopting wards there were positive outcomes in terms of relationships with relatives, with the introduction of systems and processes to enhance proactive engagement such as charge nurse ward rounds, key workers, regular phone calls to families living at a distance, involvement

in completion of 'All About Me' documents and in Ward E sharing information with family members that had been obtained during interviews with patients using emotional touchpoints. The charge nurse described the impact of the latter for one mother, saying she *'felt their son was being well looked after, that some of the needs she didn't even know existed were being discovered and met. We couldn't have done that had we not started looking a bit deeper and listening a bit more.'* [CN5].

Supporting staff and stimulating reflection. Where staff had the opportunity to fully engage in the LCC Programme there were positive outcomes both at an individual and team level. For individuals a crucial change was increased confidence to of challenge care practices that were not considered to be compassionate, positive risk taking to support personalised care and contribution to discussion about care practices. The charge nurse in Ward E suggested that this was because the staff were now *'working within codes of conduct yes, but [staff] weren't afraid of repercussions if they didn't get it just so ..[it] just allowed people a bit of freedom'* [CN5]. Although not universal there were examples of very profound individual outcomes, such as one described by a senior nurse, *'if I look at [nurse] the change in her is the enthusiasm that she has, this reconnecting with her profession, this understanding of compassion that she believes in, and that she can articulate* [SN1].

At a team level there became a strong emphasis on communication and staff support in the high adopting wards, with some introducing new systems such as daily 'catch up' meetings and in Ward A a weekly reflective sessions with the hospital chaplain. Some of the practice development activities were designed to facilitate what the LCC team termed 'caring conversations' and served to encourage team discussions focussed on improving practice; for example in Ward F *'we really think and stimulate an awful lot of conversation and discussion .. what we can do to take it [LCC Programme] ahead and really getting everyone on board and involved'* [CN6].

Influence of LCC Programme mechanisms on outcomes

There were a number of mechanisms that influenced the outcomes of the LCC Programme. The underpinning theoretical framework was seen to have been very important, particularly appreciative inquiry and relationship-centred care. Appreciative inquiry offered a fresh approach to examining care practices and giving real time

feedback, which gave staff confidence in their care. The adoption of the Senses Framework (Nolan et al. 2006) to introduce the concept of relationship-centred care in such a way that staff could see its application to patients, relatives and themselves left a lasting impression on many of those involved. The facilitation skills of the senior nurses focussed on building trusting relationships in each ward area and demonstrated sensitivity to local context, something the charge nurse in Ward E described as *'subtle leadership'* [CN5]. Of additional influence was the pace of implementation and the focus on investing time in initial groundwork with the ward teams and recognition at senior level that implementing cultural change takes time. This was acknowledged by one of the policy makers when they said *'this is a very deep and fundamental thing and it needs time for people to be able to appreciate, understand and get to grips with on a personal level within the ward and areas'* [PM5].

Other mechanisms that influenced outcomes were the practice development techniques that focussed on the identification and sharing of care values (i.e. 'beliefs and values clarification', use of imagery and the development of 'positive care practices'). Perhaps the most successful mechanisms were those that led to 'hearing the voice' of patients, families and staff though 'emotional touchpoints' and sharing stories. As a result of all these approaches staff in the high adopting wards received regular feedback on their delivery of compassionate care, which in turn influenced communication systems and the routine introduction of 'caring conversations'. As the charge nurse in Ward F commented *'I know that we give good care but now we've got the evidence to show [it]'* [CN6].

Sustainability
Indicators of sustainability reflected the 'level of adoption' criteria through continued engagement with the LCC Programme, self-identification as a Beacon Ward or Development Site, sustaining an appreciative approach and use of practice development techniques to engage with patients, families and staff. The long term use of 'emotional touchpoints' was a clear illustration of this: for example being used to augment traditional nursing and medical assessments of patients in Ward E; becoming part of the personal development planning process in Ward A; adoption as a feedback mechanism with families expressing concerns across many settings; and as a method for seeking student feedback in Ward H.

Leadership emerged as the most significant factor influencing sustainability of the LCC Programme, principally at charge nurse level. A common element in the low and medium adopting wards (Wards C, D and G) were ongoing changes in leadership, the impact of which was summed up by one of the senior nurses *'where there hasn't been consistent and continuous leadership they've absolutely struggled* [SN2]. Successful leadership was particularly enhanced by participation in the one year LCC Leadership Programme that ran in parallel to the Beacon Ward/Development Site work, especially if this was extended beyond the charge nurses. During the Programme Wards E and H also had management changes at ward and directorate levels and yet remained high adopters largely as a result of succession planning based on shared values and an established ethos of compassionate care. The new charge nurse in Ward H reflected on her position *'I find myself in a different place, a different role and I feel confident to do it. I feel a lot more ready to take on more difficult situations than I would have been. I think because they see me as a leader taking this forward .. I feel very proud as well, of the work we've done'* [CN8].

Other important factors were an expectation of change and development by senior managers as a result of participating in the LCC Programme. Where the managers were engaged and interested in local activities and outcomes the charge nurses felt empowered to drive care forward, even if this involved taking what might be perceived as positive risks because they were *'given trust to [have] that autonomy to go on and make mistakes and learn from them'* [Ward E, CN5]

Discussion

This research study was conducted at a time when there was limited research focussing on what is required to embed and sustain a culture of compassionate care within contemporary healthcare environments. It adds to a growing body of work building the evidence base of what compassionate care means to different stakeholders including bereaved relatives, nurses, doctors and lecturers (Crowther et al., 2013; Masterton et al., 2014; Post et al., 2014; Smith et al., 2014) and a recognition of the need for cultural change within complex health systems (Patterson, 2010; The King's Fund, 2013).

Conceptual Model

The findings have led to the development of a conceptual model of factors that can enhance organisational capacity to develop and sustain a culture of compassionate care (Figure 2).

Figure 2.
Conceptual model of factors that enhance organisational capacity to deliver compassionate care.
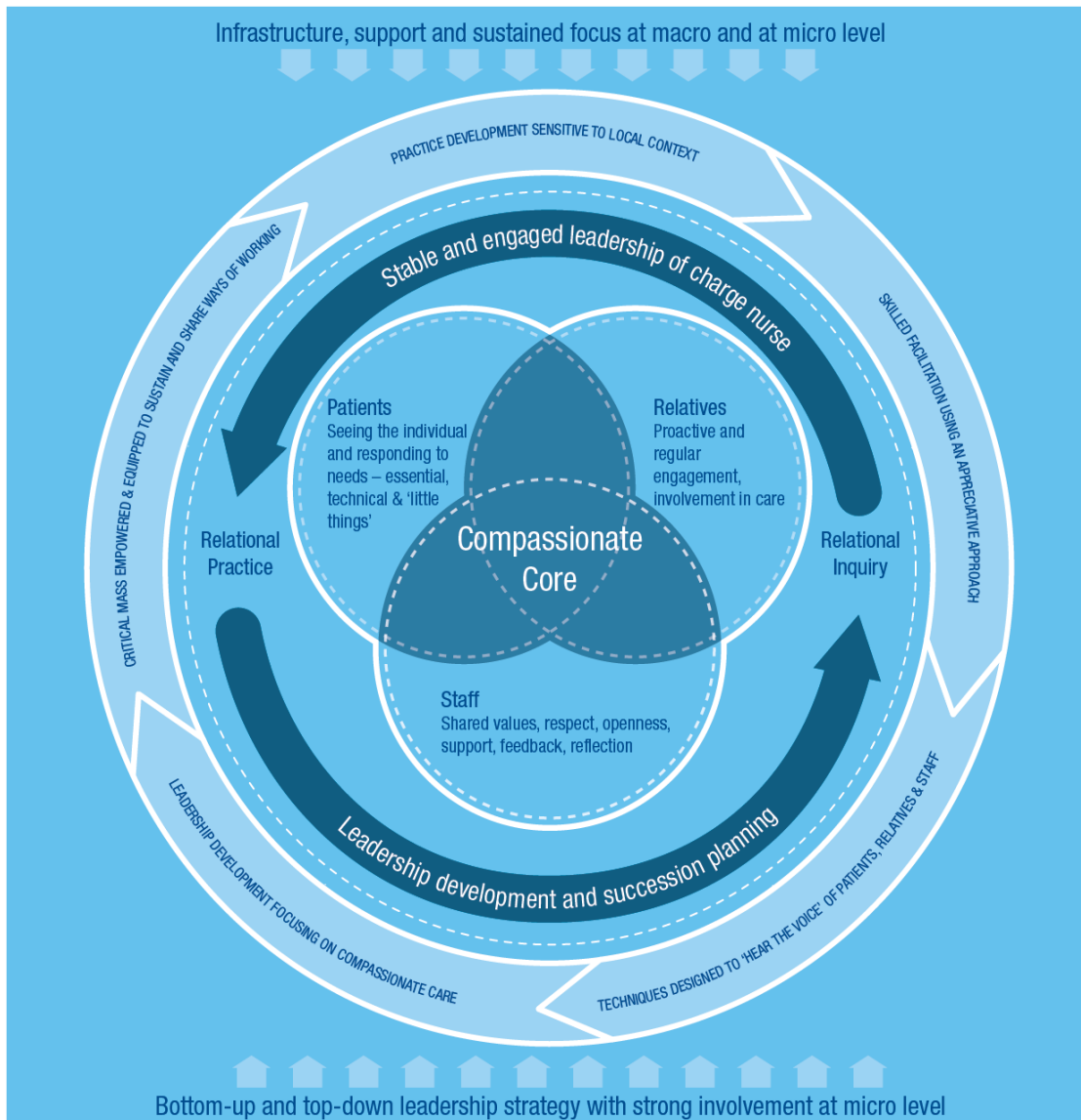
Compassionate Core

At the core of the model is an expression of the elements that foster compassionate care by focusing on the needs of: i) the patient; ii) their relative(s); and iii) the staff

caring for them. Delivering compassionate care necessitates meeting all these needs: for example, it was evident in the high adopting wards that staff were working in environments where they had shared values, were reflective, respected each other's contribution, were open in their exploration of ways to enhance care, were encouraged to give feedback, supported each other and were in turn supported by their managers. Conversely where some or all of these elements were lacking, implementation of the LCC Programme, regardless of the input of the Senior Nurse progress was limited. Such findings accord with Christiansen et al.'s (2015) study into barriers and enablers for compassionate care in which they delineate individual and relational factors, organisational factors and leadership and team factors as being vital.

Enhancing organisational capacity for compassionate care

Supporting the 'compassionate core' are four essential layered but interconnected elements that together strengthened organisational capacity to deliver compassionate care. Working from the inside of the model outwards these are:

1. Sustained focus on relational practices
2. Leadership at all levels
3. Investment in practice development
4. Strategic vision and infrastructure

Relational practices: relational work and relational inquiry. Relationship-centred care (Tresolini, 1994; Nolan et al., 2006) had been at the foundation of the LCC Programme. This study illuminated the importance of 'relational work' (Parker, 2000) and 'relational inquiry' (Doane and Varcoe, 2007) in sustaining interpersonal relationships. Parker (2000) describes relational work between care providers and recipients through the use of open-ended questions, reflective listening and empathy to establish rapport and develop understanding. Doane and Varoe (2007) argue that where there is a focus on individual nurse-patient relationships there may be little consideration of the personal and contextual factors that can make fostering trusting, fruitful and therapeutic relationships challenging. Relational inquiry is put forward as a mechanism which integrates responsive, compassionate, therapeutic relationships and ethical competent nursing by foregrounding the ways in which the personal and contextual factors shape both patients' and nurses' capacities for connection. The creation of what Doane and Varoe (2007) describe as 'relational spaces' was achieved in the LCC Programme

through the use of techniques such as emotional touchpoints and the integration of the Senses Framework (Nolan et al., 2006) as the foundation of the LCC Leadership Programme.

Leadership. The charge nurses had a strong part to play in influencing the adoption of the LCC Programme, which accords with the acknowledgement of the crucial role they play in determining the quality of patient care (Royal College of Nursing, 2009). There has been recognition of a diminution in the authority of the charge nurse (Bradshaw, 2010; Francis, 2013) with calls that they should work in a supervisory capacity (Royal College of Nursing, 2010). Whilst the charge nurses in the LCC Programme did not formally have this status, within the high adopting wards their roles strongly mirrored the fundamental elements in terms of being visible and accessible; working alongside the team to facilitate learning; monitoring and evaluating standards; providing regular feedback and creating a culture to sustain person-centred, safe and effective care.

Practice Development. Manley et al. (2008) present practice development as a systematic process of transformative action towards developing person-centred cultures that focus on changing people and practice rather than just systems and processes. They argue that it is practice development that has the potential to translate complex organisation and strategic agendas into practice through input of facilitators who have the skills and ability to address culture change. Within the LCC Programme the facilitation and critical analytic skills of the Senior Nurses were fundamental to its success as was the appreciative inquiry approach that they adopted (Trajkovski, 2013). In particular the use of techniques such as emotional touchpoints and beliefs and values clarification allowed the stakeholders to 'hear the voice' of patients and staff.

Strategy. Luxford et al., (2011) argue that strong, committed senior leadership is a critical factor in changing and sustaining a more patient-centred approach, whilst Powell et al., (2009) highlight that managers need to be actively involved in quality improvement initiatives for both symbolic and practical purposes. One of the defining features of the LCC Programme was that it had strong strategic leadership through an effective Steering Group and it was included as a key objective for the Health Board. Whilst high-level strategic support is vital, Burston et al. (2011) emphasise the need for a hybrid of approaches to change involving a blend of top-down and bottom-up

leadership to sustain behaviour change. This was seen in the high adopting wards where local Compassionate Care Groups were established and required reporting of outcomes and accountability.

Limitations

The main limitation of this study is that it did not include any primary data collection with patients or relatives. Rather the perspective of patients and families was drawn from secondary data that was made available from two sources: firstly from the perspectives of the Senior Nurses and charge nurses during interviews when they described patients and relatives' stories and experiences; and secondly through analysis of the action research findings that the LCC Team published internally during the data collection phase of this study.

Conclusion

Compassionate care is central to debates about care delivery in the NHS and other health systems. There have been recommendations for professional and leadership development of existing staff and for innovative methods for the selection and preparation of future generations of nurses. What has been less clear is the organisational infrastructure that is needed to embed and sustain a focus on compassionate care alongside all the other health service pressures and priorities.

The LCC Programme was one of the earliest focussed 'interventions' that took a systematic approach to investigating the complex issue of compassionate care and through this developed an evidence-based approach to practice development that could be implemented across a range of specialties. It was, in part, the heterogeneity of the practice settings involved in the Programme that enhances the potential impact of these findings.

Given the fact that the debate surrounding enhancing compassionate care remains live at both policy and practice level within the UK and elsewhere there is a need for evidence-based recommendations that offer real insight into enabling cultural and practice changes within the NHS. Discussions of compassionate care have rightly centred on the experiences of patients and relatives. This research has generated a dynamic, practice-based model for strengthening organisational capacity for

compassionate care. It demonstrates that focussing on the needs of staff and supporting them to develop and work within a shared culture of compassion is instrumental to the sustained delivery of compassionate care. This demands a strategic vision for compassionate care that recognises and values the role of relationships and invests in practice development and leadership at all levels.

References

Adamson E and Dewar B (2015) Compassionate care: student nurses' learning through reflection and the use of story. *Nurse Education in Practice* 15 (3) 155–161.

Aiken LH, Sermeus W, Van der Heed K et al. (2012) Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. *British Medical Journal* 1136 344.

Agnew T (2007) Dignity in care: a genuine commitment? *Nursing Older People* 18 (12) 17-18.

Betcher DK (2010) Elephant in the Room Project: Improving caring efficacy through effective and compassionate communication with palliative care patients. *MedSurg Nursing* 19 (2) 101-105.

Blamey, A and Mackenzie, M (2007) Theories of change and realistic evaluation: peas in a pod or apples and oranges? *Evaluation* 13(4) 439-455.

Bond P and Goudie K (2015) Identifying and managing patients with delirium in acute care settings. *Nursing Older People* 27 (9) 28-32.

Boyzatis RE (1998) *Transforming Qualitative Information: Thematic Analysis and Code Development* Sage Publications, California.

Bradshaw A (2010) Is the ward sister role still relevant to the quality of patient care? A critical examination of the ward sister role past and present. *Journal of Clinical Nursing* 19 (23-24) 3555-3563.

Bramley L and Matiti M (2014) How does it really feel to be in my shoes? Patients' experiences of compassion within nursing care and their perceptions of developing compassionate nurses. *Journal of Clinical Nursing* 23 (19-20) 2790-2799.

Bridges J, Nicholson C, Maben J et al. (2013) Capacity for care: meta-ethnography of acute care nurses' experiences of the nurse-patient relationship. *Journal of Advanced Nursing* 69 (4) 760-722.

Burston S, Chaboyer W, Wallis M, Stanfield J (2011) A discussion of approaches to transforming care: contemporary strategies to improve patient safety. *Journal of Advanced Nursing* 67 (11) 2488-2495.

Christiansen A, O'Brien MR, Kirton JA et al. (2015) Delivering compassionate care: the enablers and barriers. *British Journal of Nursing* 24 (16) 833-887.

Clarfield AM, Bergman H, Kane R (2001) Fragmentation of Care for Frail Older People - an International Problem. Experience from Three Countries: Israel, Canada, and the United States. *Journal of the American Geriatric Society* 49 (12) 1714-1721.

Cooperrider DL, Whitney D, Stavros JM (2008) *Appreciative Inquiry Handbook*. Lakeshore Communications Inc & San Francisco: Berrett-Koehler Publishers Inc., Bedford OH.

Corbin-Dwyer S, Buckle JL (2009) The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal of Qualitative Methods* 8 (1) 54-63.

Crowther J, Wilson KC, Horton S, Lloyd-Williams M (2013) Compassion in healthcare – lessons from a qualitative study of the end of life care of people with dementia. *Journal of the Royal Society of Medicine* 106(12) 492–497.

Curtis K, Horton K, Smith P (2012) Student nurse socialisation in compassionate practice: A Grounded Theory Study. *Nurse Education Today* 32 (7) 790-795.

Department of Health (2009) *The NHS Constitution for England: The NHS Belongs to Us All.* Available at: http://collections.europarchive.org/tna/20090216230913/http:/www.dh.gov.uk/en/Healthcare/NHSConstitution/index.htm (accessed 17.03.16).

Department of Health (2012) Compassion in Practice: Nursing, Midwifery and Care Staff. Our Vision and Strategy. Available at: http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf (accessed 26.02.16).

Dewar B, Pullin S, Tocher R (2011a) Compassion: can it be defined and measured? *Nursing Management* 17 (9) 30-35.

Dewar B, MacKay R, Smith S et al. (2011b) Use of emotional touchpoints as a method of tapping into the experience of receiving compassionate care in a hospital setting. *Journal of Research in Nursing* 15 (1) 29-41.

Dewar B (2012) Using creative methods in practice development to develop and understand compassionate care. *International Practice Development Journal* 2 (1) 1-11.

Dewar B and Nolan M (20130 Caring about caring: developing a model to implement compassionate relationship-centred care in an older person care setting. *International Journal of Nursing Studies* 50 (9) 1247-1258.

Doane GH and Varcoe C (2007) Relational practice and nursing obligations. *Advances in Nursing Science* 30 (3) 192-205.

Edinburgh Napier University and NHS Lothian (2012) *Leadership in Compassionate Care Programme: Final Report.* Available at: http://researchrepository.napier.ac.uk/5935/1/CompCare_Fin_Rept_All_Apr_13.pdf (accessed 27.02.16).

Firth-Cozens J and Cornwell J (2009) *The Point of Care: Enabling Compassionate Care in Acute Hospital Settings*. The King's Fund, London.

Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive Summary*. The Stationary Office, London.

Healthcare Commission (2007) *Caring for dignity: A national report on dignity in care for older people while in hospita*l. Commission for Healthcare Audit and Inspection. Available at: http://i.telegraph.co.uk/telegraph/multimedia/archive/00669/nwards127_pdf_669224a.pdf (accessed 26.02.16).

Holmes D (2013) Mid Staffordshire scandal highlights NHS cultural crisis. *The Lancet* 381(9866) 521-522.

Lown B, Rosen A, Marttila JJ (2011) An agenda for improving compassionate care: a survey shows about half patients say such care is missing. *Health Affairs* 30 (9) 1772–1778.

Luxford K, Safran DG, Delbanco T (2011) Promoting patient-centered care: a qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving the patient experience. *International Journal of Quality in Health Care.* 23 (5) 510-515.

MacArthur J (2014) *Embedding compassionate care in local NHS practice: a realistic evaluation of the Leadership in Compassionate Care Programme*. PhD Thesis Edinburgh Napier University. Available at: http://researchrepository.napier.ac.uk/7248/ (accessed 29/02/16)

Manley K, McCormack B, Wilson V, (2008) *International Practice Development in Nursing and Healthcare*. Blackwell Publishing Ltd, Oxford.

Mannix J, Wilkes L, Daly J (2015) Watching an artist at work': aesthetic leadership in clinical nursing workplaces. *Journal of Clinical Nursing* 24 (23-24) 3511-3518.

Masterson A, Robb E, Gough P, Machell S (2014) Inspiring senior nurses to lead the delivery of compassionate care. *Nursing Older People* 26 (8) 26-31.

McCormack B and McCance T (2010) *Person-centred Nursing: Theory and Practice*. Wiley Blackwell, Oxford.

Meyer J (2000) Qualitative research in healthcare: Using qualitative methods in health related action research. *British Medical Journal* 320 (7228) 178-181.

Nolan M, Brown J, Davies S, Nolan J, Keady J (2006) *The Senses Framework: Improving Care for Older People through a Relationship-Centred Approach* GRIP: University of Sheffield. Available at: http://shura.shu.ac.uk/280/ (accessed 27.02.16).

Nursing and Midwifery Council and General Medical Council (2012) *Joint statement of professional values*. Available at: https://www.england.nhs.uk/wp-content/uploads/2013/11/DH-4.pdf (accessed 26.02.16).

Odell J (2014) Using stories within practice development. *International Practice Development Journal* 4 (1) 1-3.

Parker VA (2002) Connecting relational work and workgroup context in caregiving organizations. *Journal of Applied Behavioural Science* 38 (3) 276-297.

Patients Association (2011) *We've been listening, have you been learning?* Available at: http://www.patients-association.org.uk/wp-content/uploads/2014/08/Patient-Stories-2011.pdf (accessed 26.02.2016).

Patterson M, Nolan M, Rick J et al. (2010) *From Metrics to Meaning: Culture change and quality of acute hospital care for older people*. Report for the National Institute for Health Research Service Delivery and Organisation programme. Available at: http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1501-93_V01.pdf (accessed 26.02.16).

Pawson R and Tilley N (1997) *Realistic Evaluation*. Sage Publications Ltd, London.

Post SG, Ng LE, Fischel JE et al. (2014) Routine, empathic and compassionate patient care: definitions, development, obstacles, education and beneficiaries. *Journal of Evaluation in Clinical Practice*. 20 (6) 872–880.

Reed J, McCormack B (2007) Editorial: the importance of dignity. *International Journal of Older People Nursing* 2 (3) 61.

Royal College of Nursing (20090 *Breaking down barriers, driving up standards: The role of the ward sister and charge nurse*. Available at: https://www2.rcn.org.uk/__data/assets/pdf_file/0010/230995/003312.pdf (accessed 28.02.16).

Royal College of Nursing (2010) *Making the business case for ward sisters/team leaders to be supervisory to practice*. Available at: https://www2.rcn.org.uk/__data/assets/pdf_file/0005/414536/004188.pdf (accessed 28.02.16).

Royal College of Nursing 2012 *Quality with Compassion: the future of nursing education. Report of the Willis Commission on Nursing Education*.

Sheild RR, Tong I, Tomas M, Besdine RW (2011) Teaching communication and compassionate care skills: An innovative curriculum for pre-clerkship medical students. *Medical Teacher* 33 (8) 408-416.

Scottish Government (2010) *The Healthcare Quality Strategy for NHSScotland*. Available at: http://www.gov.scot/Resource/Doc/311667/0098354.pdf (accessed 26.02.16).
Scottish Health Council (2014) *Emotional Touchpoints*. Available at: http://www.scottishhealthcouncil.org/patient__public_participation/participation_toolkit/emotional_touchpoints.aspx#.VtH5glJJbAM (accessed 27.02.16).

Smith S, Dewar B, Pullin S, Tocher R (2010) Relationship centred outcomes focused on compassionate care for older people within in-patient care settings. *International Journal of Older People Nursing* 5 (2) 128–136.

Smith S, Gentleman M, Loads D, Pullin S (2014) An exploration of a restorative space: A creative approach to reflection for nurse lecturer's focused on experiences of compassion in the workplace. *Nurse Education Today* 34 (9) 1225-1231.

Springham N and Glenn R (20150 Experience based co-design reduces formal complaints on an acute mental health ward. *BMJ Quality Improvement Reports* 4 (1) doi: 10.1136/bmjquality.u209153.w3970.

The Kings Fund (2013) *The Francis Inquiry: Creating the right culture of care*. Available at: http://www.kingsfund.org.uk/projects/francis-inquiry-creating-right-culture-care (accessed 28.02.16).

Trajkovski S, Schmied V, Vickers M, Jackson D (2013) Implementing the 4D cycle of appreciative inquiry in health care: a methodological review. *Journal of Advanced Nursing* 69 (6) 1224-1234.

Tresolini CP (1994) *Health Professions Education and Relationship-centered Care*. Pew Health Professions Commission, San Francisco, CA.

Van der Cingel M (2011) Compassion in care: A qualitative study of older people with a chronic disease and nurses. *Nursing Ethics* 18 (5) 672-685.

Williams S, Nolan M, Keady J (2009) Relational practice as the key to ensuring quality care for frail older people: discharge planning as a case example. *Quality in Ageing and Older Adults* 10 (3) 44-55.

Youngson R (2008) Futures debate: compassion in healthcare – the missing dimension of healthcare reform? *NHS Confederation Futures Debate Series Paper 2* Available at:
http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/compassion_healthcare_future08.pdf (accessed 26.02.16).

Youngson R (2014) *Cynical about compassion*. Available at:
http://heartsinhealthcare.com/cynical-compassion/ (accessed 26.02.16)