

CREATING LEARNING ENVIRONMENTS FOR COMPASSIONATE CARE (CLECC): A PROGRAMME TO PROMOTE COMPASSIONATE CARE BY HEALTH AND SOCIAL CARE TEAMS

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Abstract

Background

The consistent delivery of compassionate health and social care to older people is a matter of global concern to the nursing profession and the public it serves. The development and evaluation of effective interventions to address this concern is of prime importance.

Aims and objectives

This paper draws on findings from previous research to propose the use of a novel implementation programme designed to improve and support the delivery of compassionate care by health and social care teams.

Intervention

Creating Learning Environments for Compassionate Care (CLECC) is a 4 month implementation programme designed for hospital ward nursing teams caring for older people, but relevant to other teams working with other client groups. The programme focuses on using workplace learning to promote change at unit/ward/team level by enabling the development of leadership and team relational practices which are also designed to enhance the capacity of individual team members to relate to older people. Existing research evidence suggests that optimising relational capacity in this way will support the delivery of compassionate care.

Conclusions

This evidence-based intervention is designed to develop and sustain the relational work required by managers and team members to support care delivery and has the potential to address widely documented variations in care quality.

Relevance to Clinical Practice

Attention should now be paid to establishing the feasibility of the intervention in practice.

Key words

Caring, compassion, nurses, professional-patient relations, workplace learning, older people

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Summary statement

What does this research add to existing knowledge in gerontology?

This paper draws on the learning from existing research to propose the use of a novel implementation programme designed to improve and support the delivery of compassionate care by health and social care teams.

The intervention centres on using workplace learning to promote change at unit/ward/team level by enabling the development of leadership and team relational practices explicitly targeted at enhancing the relational capacity of the team and its individual team members, a prerequisite for the delivery of compassionate care.

The focus on the team “micro-climate” reflects the value of service innovation at the level of team, a level clearly indicated by other research findings.

What are the implications of this new knowledge for nursing care with older people?

A detailed and evidence-based implementation programme is proposed to guide practice development in this key area.

How could the findings be used to influence policy or practice or research or education?

The feasibility of this intervention in practice should be established.

If the intervention is feasible, its impact on practice and patient experiences and outcomes should be carefully evaluated.

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Introduction

The relational aspects of care are key to shaping service user experiences of health and social care (Bridges, Flatley et al. 2010). Addressing variations in the provision of compassionate care has become a high priority across UK health and social care settings in recent years, and this focus has led to the development of a number of initiatives focusing on compassionate care, or dignity in care. CLECC (Creating Learning Environments for Compassionate Care) is one such initiative. It is a four month practice development programme that aims to promote compassionate care for patients/service users in health and social care settings. CLECC builds on the learning from other initiatives targeted at improving compassionate care or dignity in care, and introduces a novel workplace learning focus at work team level. This paper introduces CLECC and its key features with a view to informing service developments aimed at promoting compassionate care.

Background

The need to strengthen the delivery of compassionate care in UK health and social care services, in particular to older patients, is consistently identified as a high priority by policy makers (Department of Health 2014). In addition to a series of investigations into high profile failures, substantial and significant variations in the quality of hospital care for older people have been highlighted (Care Quality Commission 2011; Francis 2013). Variation exists between hospitals, but also between wards within hospitals and between staff within wards. Training, staffing levels, leadership, motivation and organisational culture are all implicated in failures of care. While these issues are widely reported in the UK, there is evidence to suggest that they are relevant internationally (Bridges, Flatley et al. 2010; Kagan 2013).

A recent systematic review into qualitative research reporting older patients' experiences of hospital care highlights the importance of the relational aspects of care to shaping experiences (Bridges, Flatley et al. 2010). Older people want nurses and others to use interactions to see the person behind the patient ("see who I am"), to establish a warm and human connection ("connect with me") and to establish

understanding and involvement (“involve me”) (Bridges, Flatley et al. 2010). Being compassionate reflects these ways of working and requires “relational capacity” in practitioners, i.e. capacity to experience empathy and to engage in a caring relationship (Hartrick 1997). Other research shows that nurses’ relational capacity can depend on ward level conditions, and that there is a greater tendency for nurses with low relational capacity to avoid relationships with patients and to burn out, in spite of aspirations to a higher standard of care (Bridges, Nicholson et al. 2013).

Recent evidence indicates that ward climate and ward leadership are key influencing factors on care quality in hospital settings (Patterson, Nolan et al. 2011; Tadd, Hillman et al. 2011; Maben, Peccei et al. 2012). This leadership and team capacity are key characteristics of the ward-level conditions needed to support nurses’ relational work (Bridges, Nicholson et al. 2013) and an important foundation for team activities such as using service user feedback constructively (Bridges and Tziggili 2011). A recent study on culture change and quality of acute hospital care for older people found that more positive patient and carer assessments of care were correlated with higher staff ratings of team climate in terms of “supporting each other” and “shared philosophy of care” (Patterson, Nolan et al. 2011). In addition, “leading by example” (i.e. ward leadership) was a strong indicator of staff in a team sharing a philosophy of care and feeling high levels of team support, a finding that, together with the qualitative data, highlighted the vital role of the ward manager in shaping a positive team climate for care (Patterson, Nolan et al. 2011).

These findings were mirrored in a second study which highlighted the key role of the ward leader in shaping the local ward climate of care, the importance of staff well-being, and in particular staff experiences of good local work-group climate, co-worker support, job satisfaction, positive organisational climate and support, and supervisor support as antecedents of positive patient experiences (Maben, Peccei et al. 2012). However, in an era of high patient throughput leading to reduced opportunities for team dialogue and reflective learning, increasing use of staff without professional qualifications, low nursing staff job satisfaction and “target-driven” organisational cultures, it cannot be assumed that the leadership and team practices such as role modelling, mutual support and dialogue needed to ensure staff wellbeing and thus their capacity for compassionate care are in place.

Recent years have seen the development of a number of interventions focused on improving compassionate care, or dignity in care, at hospital ward level, but none of these initiatives explicitly

targets the potential for intervention at work team level by focusing on the development of sustainable leader and work team relational practices (Meyer, Johnson et al. 2003; Dewar and Mackay 2010; Nicholson, Flatley et al. 2010; Nicholson, Flatley et al. 2010; Bridges and Tziggili 2011). McCormack and colleagues have used emancipatory practice development strategies to enable healthcare teams to “transform the culture and context of practice” with the aim of person-centred care, but a specific focus on the use of these or similar strategies to achieve compassionate care or dignity in care has not been previously developed (McCormack, Manley et al. 2008; McCance, Slater et al. 2009; McCormack, Dewing et al. 2010)

Typically initiatives aiming to promote compassionate care or dignity in care have been facilitated by a senior nurse, using reflective learning, action research and/or appreciative inquiry to work with ward-based nursing staff (often using patient stories and/or observations of practice) to strengthen support for existing good practice and to make changes where needed. These interventions are typically shaped by a “relationship-centred” philosophy in which achieving the well-being of all groups (patients, staff, family carers) is seen as fundamental to high quality care (Nolan 2013). They have used democratic and participatory processes involving patients, staff and sometimes family carers to articulate the patient’s needs and shape the practice changes made.

The introduction of these interventions has been accompanied by largely qualitative evaluations which have provided important information about the processes of change, and the factors enabling and inhibiting sustainable change. Some of these evaluations have reported concrete practice changes resulting from the intervention (Nicholson, Flatley et al. 2010; Nicholson, Flatley et al. 2010; Nicholson, Flatley et al. 2010; Dewar 2011; Dewar and Nolan 2013), while others report more variable success (Meyer, Johnson et al. 2003; Bridges and Tziggili 2011). For instance, Dewar used appreciative inquiry and action research to involve older people, staff and relatives in developing compassionate relationship centred care on an acute hospital ward (Dewar 2011; Dewar and Nolan 2013). This project was part of a wider initiative aiming to promote compassionate relationship centred care in a number of ways, including through establishing Beacon Wards in one NHS Scotland region and using practice development work on these wards to establish strategies suitable for use in other practice settings in the region (Adamson, Dewar et al. 2012).

Methods used included participant observation, interviews, storytelling and group discussions. Dewar’s findings indicated the value of appreciative caring conversations between staff, patients and relatives

enabling all parties to discover “who people are and what matters to them” and “how people feel about their experiences”, with this knowledge enabling them to “work together to shape the way things are done”. In the resulting model, Dewar and Nolan detail how older people, staff and relatives can work together to implement compassionate relationship centred care. In specifying “how people can work together to shape the way that things are done here”, Dewar identified a number of important conditions for staff to feel able to express emotions, share experiences and ideas with each other, consider others’ perspectives, take risks, use “curious questioning” to examine situations and challenge existing practice, all identified as important actions to support the delivery of compassionate care. These conditions included transformational leadership, the level of support received from colleagues and senior staff, a shared set of principles for caring, open dialogue within the team and opportunities where people had permission and space to reflect. These conditions echo the findings from other research as the conditions at team level that can support high quality care. Dewar reports how these conditions developed and how compassionate caring practices became embedded in the work of the team over the course of the year-long project, providing valuable evidence that change of this kind is possible.

However, Dewar’s project took place over the course of a year on an already high-performing ward with a strong leader. The findings informed development work across the wider Leadership in Compassionate Care project implemented across a number of health care settings, but evaluation of the impact of these strategies elsewhere does not report the influence of the ward climate or programme length on outcomes, so evidence is lacking that such strategies can be universally effective regardless of work team context (Adamson et al. 2012). In a contrasting study to Dewar’s that explored the use of discovery interviews with older patients as a way of improving dignity in care, Bridges and Tziggili (2011) found that ward teams required strong and consistent leadership and intense preparation before they were able to hear and respond to patient stories about care. Both organisations involved in this dignity project experienced significant delays in the progress of the project and limitations in its impact because of a lack of leadership at ward level and a lack of preparedness of the ward teams to engage in responding positively to patient feedback. One ward team with a strong leader was able to successfully engage with the patient stories, but only after some months of team preparation. These findings indicate that, while some wards may be ready to engage in programmes such as Dewar’s, others could benefit from a period of groundwork in which leadership and mutually supportive team practices are established.

In summary, research findings to date indicate the potential for change at the level of the ward “micro-climate”, and also signal that investing in the potential for ward teams to develop their own leadership and team practices may lay the necessary foundations for service improvement and the support and further growth of existing good practice. In spite of this growing evidence that intervention at a team level has potential, a programme that focuses specifically on relational practices across the team and that aims to develop these practices within a relatively short timescale to promote compassionate care has not previously been developed.

Creating Learning Environments for Compassionate Care (CLECC)

CLECC is a unit/ward-based implementation programme focused on developing leadership and team practices that enhance team capacity to provide compassionate care. Its objectives are to:

1. Create an expansive workplace learning environment that supports work-based opportunities for the development of relational practices across the work team;
2. Develop and embed sustainable manager and team relational practices such as dialogue, reflective learning and mutual support.
3. Optimise and sustain leader and team capacity to develop and support the relational capacity of individual team members;
4. Embed compassionate approaches in staff/service-user interaction and practice, and continue to improve compassionate care following the end of programmed activities

CLECC has been designed for use by ward nursing teams in inpatient settings for older people but is potentially transferable for use by teams in other health and social care settings. The implementation programme takes place over a 4 month period but it is designed to lead to a longer-term period of service improvement. By envisaging the workplace as a learning environment and the work team as a community of practice, CLECC brings a distinctive approach to promoting compassionate care. It uses insights from workplace learning research (Wenger 1998; Fuller and Unwin 2004; Fuller 2007) to develop practices that enhance the capacity of the manager and work team to provide compassionate care within a complex and dynamic organisational context. Fuller and Unwin’s research on workplace learning and workforce development in a range of public and private sector industries has shown the importance of identifying and analysing both the organisational and pedagogical features that characterise diverse workplaces as learning environments (Fuller and Unwin 2004). They argue that this approach allows

workplaces (for instance, hospital wards) to be located on what they term the 'expansive – restrictive' continuum. Those sitting at the expansive end are characterised by a range of features including: the knowledge and skills of the whole workforce (not just the most highly qualified or senior staff) are valued, managers facilitate workforce and individual development, team work is valued, innovation is important, team has shared goals focusing on the continual improvement of services (or products), there is recognition of and support for learning from 'each other', learning new knowledge and skills is highly valued, and the importance of planned time for off-the-job reflective learning is recognised. It follows that an expansive approach to workforce development is more likely to facilitate the integration of personal and organisational development. This has important implications for the design of learning interventions as it requires workplace learning to be perceived as something which both shapes and is shaped by the work organisation itself rather than a separately existing activity. Such an understanding highlights the importance of interventions which situate and integrate individual and team learning in the everyday life of the workplace (in this case the clinical unit/ward/team setting) as well as providing opportunities for off-the-job provision to foster reflection, consolidate learning and deepen understanding – so enhancing ownership and sustainability of new practices.

The development of 'expansive practices' also provides the foundation for other service improvements such as the development of "caring conversations" proposed by Dewar and Mackay (2010). Other compassionate care initiatives have not explicitly targeted this local leadership and team capacity, focusing instead on time-limited interventions with the aim of achieving wider organisational change and/or change at the level of individual practitioners. CLECC aims to develop and embed sustainable manager and team practices such as dialogue, reflective learning and mutual support. Through this approach it aims to improve the team's capacity to a) support the relational capacity of individual team members, and b) to continue to improve compassionate care following the end of the programmed activities, the departure of designated change agents, and the departure and arrival of other individual staff members (Figure 1). We hypothesise that by focusing on the development of team capacity, sub-culture and local ward-based practices, change is achievable regardless of the wider organisational context (such as culture, and senior manager support).

Insert Figure 1 about here

The focus of the intervention, then, is on creating an 'expansive' environment that supports work-based opportunities for the development of shared goals, dialogue, reflective learning, mutual support and role

modelling for all members of the team at an individual and group level (Fuller and Unwin 2004). Such an environment should facilitate staff to engage with and learn from service user experiences and their own emotional responses, share positive strategies and support, and optimise and sustain personal and team relational capacity to embed compassionate approaches in staff/service-user interaction and practice.

'Expansive outcomes' are theorised to include high quality interactions between service users and staff, and between care team members, positive care experiences reported by service users and staff reports of high empathy with patients and carers (Figure 1). Most learning activities are built into the working day to enable experiential techniques to prompt "real-time" reflective learning and to enable team members to draw on each other's expertise, experiences and support as resources. Wider opportunities are thus available for promoting learning and improving practice at an individual and team level. Learning in the workplace is supplemented by classroom-based experiential learning. This combined approach is theorised to lead to deeper learning and more significant practice change than one that relies on classroom training alone. Research evidence indicates that educational interventions that are strongly theoretically based, multi-faceted, of sufficient intensity and duration, and supplemented by additional supervision and sufficient management support, may deliver the best outcomes (Kuske, Hanns et al. 2007; Spector, Orrell et al. 2013) . Other research suggests that interventions which foster workplace learning, empathy, peer support and positive culture at unit/ward team level may be more effective than interventions that focus on the development of individual members of staff (Mimura and Griffiths 2003; Patterson, Nolan et al. 2011; Maben, Peccei et al. 2012).

During the 4 month implementation programme, CLECC learning activities are led by a senior (UK Band 7) practice development practitioner/nurse (PDN) with strong influencing and interpersonal skills. The PDN delivers the classroom training, "care maker" support (see below), facilitation of cluster and reflective discussions, facilitation of action learning sets and coordination of practice observations. This individual is not part of the hierarchy of the ward team and this enables a distinction between CLECC activities and performance management. The activities themselves are characteristic of a practice development approach (McCormack, Dewar et al. 2006). CLECC operates at two key levels: team and team manager. A focus on the team aims to develop team capacity to support team members to provide compassionate care. An equivalent focus on the leadership capacity of the team manager (in ward settings, this is the ward manager) aims to develop his/her role in leading the team, role modelling good practice and enhancing and embedding the desired team practices.

While the programme draws on elements that have been piloted in other programmes it is novel in combining these elements with an explicit focus on establishing reforms to routine practice and organisational resources that establish the basis for sustained changes in compassionate care. While the implementation process is a key element the essence of the programme are the ongoing processes of peer observation, daily cluster discussions, weekly reflective discussion and the use of evidence based guidelines.

CLECC Activities

The CLECC implementation programme consists of several key kinds of activity (Table 1) which are combined to produce an integrated intervention as follows:

1. Unit/Ward Manager Action Learning Sets

The crucial role of the unit or ward manager in influencing the caring culture and the work culture is well documented, with strong and visible leadership identified as an essential requirement for the delivery of dignified care (Davies, Nolan et al. 1999; Patterson, Nolan et al. 2011). In CLECC, ward managers attend 4x4 hours action learning sets during the programme. Action learning sets have been used in other projects, including other development projects focused on dignity in care and/or care for older people, to provide an extended reflective space for individuals in a key position of influence to explore and develop their leadership role (Meyer, Johnson et al. 2003; Nicholson, Flatley et al. 2010; Young, Nixon et al. 2010).

CLECC action learning sets follow the McGill and Beaty model for action learning, that is sets are made up of between 4 and 8 members and are facilitated by an experienced facilitator (McGill and Beaty 1992). Set members may or may not work in the same organisation but often have similar work roles in common. Participants bring work problems of their own choosing to the session and other set members aid them in reflecting on the issue and drawing up an action plan to address it. In addition, each of the action learning sessions is themed to encourage a focus on issues related to the manager's role in supporting the delivery of compassionate care. The first session focuses on establishing relationships among set members and agreeing ground rules. The themes for subsequent sessions are: (session 2) workplace climate/team values/valuing staff; (session 3) enhancing team capacity for compassionate care; and (session 4) influencing senior managers. Reflecting on results of other programme activities supports discussion in these themes. For instance, during the classroom sessions, all staff will have been

invited to complete a questionnaire on perceptions of ward climate. Reflecting on the results of these questionnaires is encouraged in the second action learning set, in addition to the results of the “I feel valued when...” exercise (see below) (Nicholson, Flatley et al. 2010). In addition to this reflective learning set, participants facilitate each other to develop practical ways of dealing with some of the issues that arise during the programme, these issues being informed by the findings related to ward manager strategies in the dignity in care project (Flatley 2013). Participants are encouraged to use the sets to devise a personal plan associated with their current and future role in promoting compassionate care, including planning clinical supervision sessions for themselves with a selected mentor and/or negotiating ongoing action learning set access.

In addition to action learning sets, ward managers are also facilitated to further develop their relationship with their line manager as a way of accessing additional support. This includes a one hour meeting every two weeks during the four month implementation period. These meetings provide an opportunity for the line manager to learn about the project and explore opportunities to participate.

Insert Table 1 about here

2. Team Learning

Interventions to improve care quality at a ward or unit level can succeed, even if the wider organization has features that inhibit service improvement on a wider scale (Patterson, Nolan et al. 2011). Ward-level conditions can strongly influence nurses’ capacity to build and sustain therapeutic relationships with patients (Bridges, Nicholson et al. 2013). Other work suggests that the work team can function as a buffer to stressors from the wider organisation, but that the team’s capacity to do so depends on the extent to which the group perceives its role as supportive of the relational work of individual members (Parker 2002). Social structures and relationships within the team and the capacity of team members to support each other are a primary influence on how individuals learn emotional abilities and how tacit emotional knowledge is transferred (Clarke 2006). Dialogue and reflection within the team, particularly with a focus on sharing experiences and narratives appear linked with the development of individual emotional abilities but these activities depend on the extent to which the workplace provides an environment in which staff feel safe to participate (Clarke 2006). Other work indicates that expecting staff to, for example, use patient feedback constructively in the absence of team preparation to hear the patient feedback is unlikely to lead to service improvements (Bridges and Tziggili 2011). A strong focus in

the intervention is on the development of shared team goals and expectations, team dialogue, reflection, and role modelling. Early activities in the intervention reflect a focus on developing a sense of security within the team (Nolan 2013), with dialogue and reflective learning activities providing the forum for the development of individual and team relational capacity, and the creation by the team of sustainable practices and plans to support ongoing capacity through:

- Commitment and role modelling by senior staff in team – providing information, opportunities for discussion and involvement in goal setting and decision-making
- Creating facilitated collective and reflective “spaces” – (a) daily scheduled 5 minute cluster discussions following morning handover between shifts, using trigger questions or observations as behavioural nudges in their planned work with patients (b) and twice weekly one hour reflective group meetings, which will draw on a variety of toolkit materials to prompt dialogue and reflective learning, and to give staff regular opportunity to stand back from the demands of their operational practice
- Building relationships in the team/ team - exercise in analyzing workplace climate
- Critical reflections by team on caring for and supporting each other, on team relational capacity, on delivery of compassionate care
- Team values - clarification and development of shared vision
- Developing shared ownership of compassionate care and understanding about how learning in the workplace can contribute to improved individual and team practice and ‘expansive outcomes’.
- Development of team learning plan, including plan for hearing and responding to patient feedback

Teams can be unidisciplinary or interdisciplinary but an inclusive approach is essential, so for instance, CLECC’s use with a nursing team includes the participation of all nursing staff- the ward manager, registered nurses, care assistants/health care support workers and nursing students.

3. Peer observations of practice

Two staff volunteer from the team to become “care makers”, their primary role being to undertake peer observations of practice for feedback to their colleagues. Care makers receive four hours training in peer observations of practice and undertake eight hours of observation each during the programme. Peer observations are conducted using a framework based on our work and findings are fed back at reflective

discussion meetings (see below) with the help of the PDN. The results from the care makers' observations of practice on the ward are shared to trigger discussions about how to build on existing good practice and improve practice where this is needed. Peer observations of practice were used in this way in the Dignity in Care project at City University London, using the Quality of Interactions Schedule (QUIS) as a framework (Dean, Proudfoot et al. 1993; Nolan 2013).

4. Classroom training

The PDN leads the delivery of classroom training. Service users / family members who have prior experience in facilitated group work with care professionals will participate in the classroom sessions through group discussions on challenges in caring for people with complex needs so that they can provide their perspectives and experiences.

On each ward, eight hours of classroom training will be delivered by the PDN four times during the first two months of the programme to enable all ward members to attend. Each staff member attends one classroom session. These eight hours will include two hours of input from older people and their carers (3 per session).

The purpose of the day is to prepare staff for the workplace elements (including Cluster and Reflective discussions) of the programme by providing opportunities to experience some of the techniques, to develop understanding of underlying concepts and to recognise an active role in their personal and team learning journey. Elements of the programme for classroom training are shown in Box One.

Insert Box 1 about here

5. Cluster discussions

Daily ward-based cluster discussions commence during the first month (following the delivery of two classroom sessions – see below) and run daily (Monday-Friday) throughout the 4 month intervention period. These five minute cluster discussions take place directly after morning handover and are facilitated by the PDN and all nursing staff on the ward at the time of the cluster discussion are encouraged to join the five minute group discussion.

The discussion focuses on the delivery of compassionate care and enables the team to plan strategies for the forthcoming shift that will enhance patient care. These cluster discussions (so called because they take place in a “cluster” of staff) draw on the BPOP guidelines (Best Practice for Older People – see

below) to agree behavioural “nudges” for the shift (Bridges, Flatley et al. 2009). For instance, the BPOP guidelines suggest that nurses should respond quickly and willingly to requests for help. A brief team discussion could result in an agreement within the team as to how to achieve that goal on the shift. Similar strategies have been used in other projects focused on developing dignity in care/compassionate care (Dewar and Mackay 2010; Nicholson, Flatley et al. 2010).

6. *Reflective discussions*

Twice a week, members of the team on duty at the time scheduled for a reflective discussion (usually the afternoon) arrange their work to enable their attendance at a one hour group meeting facilitated by the PDN. To enable all staff on a shift to participate, two sessions may need to be held on the same day, both attended by the ward manager. This interaction is held in a comfortable meeting room on or near to the place of care, but away from the immediate distractions of care delivery. The meeting is for all team members, including senior members of the team and temporary team members such as student nurses. The meetings will involve a variety of group work tasks, some of which will be repeated to enable the maximum numbers of team members to take part and others will be unique. Tasks are aimed at opening up dialogue and reflective learning among those present, and so are selected to prompt personal reflections and narratives about experiences on the ward. They include:

- “I feel valued at work when...” – those present are invited to complete this sentence to trigger discussions about valuing and supporting each other (Nicholson, Flatley et al. 2010)
- Team values clarification about compassionate care – drawing on collated results of values clarification exercise in classroom sessions to develop shared vision (Warfield and Manley 1990; Nicholson, Flatley et al. 2010)
- Drawing on collated results of ward climate analyses to identify factors that need supporting or changing (Nicholson, Flatley et al. 2010)
- Peer observations of practice – the results from the care makers’ observations of practice on the ward are shared to trigger discussions about how to build on existing good practice and improve practice where this is needed (Nicholson, Flatley et al. 2010)
- BPOP– using resources and questions/prompts from BPOP essential guide to generate discussion (Bridges, Flatley et al. 2009) (see next section)

- Team learning plan – working with managers to draw up a team learning plan focusing on compassionate care and using patient feedback.

7. *BPOP*

BPOP is a set of evidence-based UK guidelines for nurses working with older people in acute settings (Bridges, Flatley et al. 2009; Bridges, Flatley et al. 2009). Its successful use in development projects aimed at service improvement indicates that its use in guiding the practice of health and social care professionals working with other client groups (that is, not just nurses working with older people). One example of this wider use is the City University Dignity in Care project at two London hospitals (Nicholson, Flatley et al. 2010; Nicholson, Flatley et al. 2010). A resource has been published for use alongside BPOP, providing teams with trigger questions and guidance aimed at generating dialogue and reflective learning in the team, and opening up conversations in which team members give and receive support and help with difficult matters such as talking to patients about dying (Bridges, Flatley et al. 2009). In CLECC, this resource is used to identify areas for support, action and learning in the team, and to inform the development of strategies to address these areas. Examples of trigger questions in this resource are:

- What kind of patients are most difficult to communicate with, and why?
- What kind of patients are most difficult to involve, and why?
- What subjects are hardest to talk to patients about, and why?
- What kind of relatives are most difficult to involve, and why?

Sustaining the learning

The implementation stage of the programme takes four months and is facilitated during this time by a practice development nurse/practitioner, but it is designed to lead to a longer-term period of service improvement sustained by the ward team itself. Throughout the 4 month implementation period, ward managers and their teams develop a team learning plan that includes inviting and responding to patient feedback, and puts in place measures for continuing to develop and support manager and team practices that underpin the delivery of compassionate care. The team learning plan contains the ward manager's personal learning objectives, and actions for continuing to access mentoring through action learning or one-to-one input. The team learning plan is presented to a senior trust manager, together with a case for

support, and the relevant manager is invited to visit the ward team to discuss the plan and respond in person to the proposals.

Conclusion

This paper draws on the learning from previous research to propose the use of a novel implementation programme designed to improve and support the delivery of compassionate care by health and social care teams. The programme focuses on using workplace learning to promote change at unit/ward/team level by enabling the development of leadership and team relational practices explicitly targeted at enhancing the relational capacity of the team and its individual team members. Optimising relational capacity in this way is hypothesized to lead to the delivery of compassionate care. In a context in which health and social care services are struggling to consistently deliver high quality and compassionate care, this evidence-based intervention highlights the relational work and associated learning that is required by managers and team members to support care delivery. Moreover, it reflects a relationship-centred approach in which the wellbeing of staff is regarded as an important element in the delivery of enriched care (Nolan 2013). Elements of this programme have already been piloted but attention should now be paid to establishing the feasibility of the full intervention in practice. In common with other interventions to improve compassionate care, the effectiveness of the programme has not yet been demonstrated and it remains important to establish this through robust evaluations. While before and after studies with qualitative evaluations may give preliminary evidence a full evaluation will require a properly controlled trial to establish changes in the interactions between patients and nurses and the resulting impact on patient and carer experience.

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Box One: Classroom training elements

Introduction to BPOP (Best Practice for Older People) framework

Life shield activity and group discussion: "See who I am"

Questionnaires and discussion on ward climate, dialogue and reflective learning on the ward

Values clarification exercise about compassionate care (Warfield and Manley 1990)

Videos, stories and discussion with service users: "Involve me".

Introduction to workplace learning activities and discussion on how to implement/support/sustain.

Figure 1: CLECC mechanisms for change

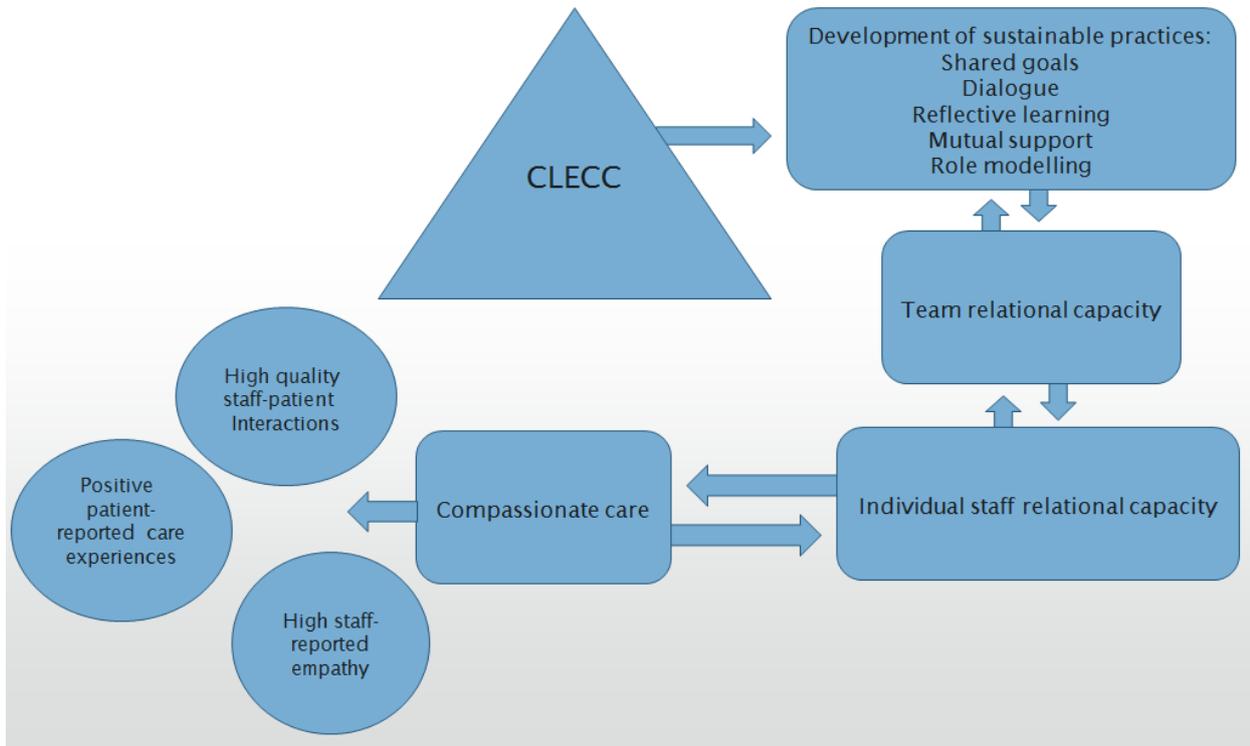


Table One: CLECC Programme Schedule

Activity	Month 1	Month 2	Month 3	Month 4
Unit/ward manager action learning sets	Session 1/setting up set, setting ground rules	Session 2/workplace climate/team values/valuing staff	Session 3/enhancing team capacity for compassionate care	Session 4/influencing senior managers
Team learning and service user feedback plan	Introduce and discuss	Discussion and draft by ward manager	Finalise, identify resources needed to support, present	Senior manager feeds back response to team plan
Peer observations of practice	Identify care makers	Train care makers	Observations of practice	Feedback observations of practice
Classroom sessions	1+2/team analysis of workplace climate/values clarification	3+4/team analysis of workplace climate/values clarification		
Cluster discussions	Ongoing	Ongoing	Ongoing	Ongoing
Reflective discussions	"I feel valued at work when..." exercise	Team values clarification exercise; BPOP activities	BPOP activities; Team learning + service user feedback plan discussions	Reflections on feedback from observations of practice

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