
Creating Learning Environments for Compassionate Care (CLECC): a programme to promote compassionate care by health and social care teams

Jackie Bridges, Alison Fuller

Introduction

The relational aspects of care are key to shaping service user experiences of health and social care (Bridges 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 practice development programme that aims to promote compassionate care for patients/service users in health and social care settings. Its design draws on evidence from process evaluations of similar initiatives about potentially effective mechanisms for change and barriers/facilitators to change change (Bridges and Tziggili, 2011, Meyer et al., 2003, Nicholson et al., 2010b, Nicholson et al., 2010a). It draws on evidence that emphasises the importance of staff-well-being in the provision of high quality care (Davies et al., 1999, Nolan et al., 2006).

CLECC introduces a distinctive focus on using workplace learning to develop practices that enhance the capacity of the manager and work team to support the ongoing relational work of its individual members. By conceiving the workplace as a learning environment (Fuller and Unwin, 2004), CLECC brings a distinctive approach to using insights

from workplace learning research to develop practices that enhance the capacity of the manager and work team to provide compassionate care. This team capacity is a key characteristic of the unit/ward-level conditions needed to support nurses' relational work (Bridges et al., 2013) and is 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 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 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 as an antecedent of positive patient experiences, in particular staff experiences of good local work-group climate, co-worker support, job satisfaction, positive organisational climate and support, and supervisor support (Maben et al., 2012). Other compassionate care initiatives have not previously 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 manager and team practices such as

dialogue, reflective learning and mutual support, thus optimising the team's capacity to support and 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.

We hypothesise that bringing about change by focusing on the development of team capacity, sub-culture and generation of local ward-based practices is achievable regardless of the wider organisational context (such as culture, senior manager support). CLECC has been designed for use by ward nursing teams in inpatient settings but is potentially transferable for use by teams in other health and social care settings.

CLECC is a 4 month unit/ward-based implementation programme focused on developing team practices that enhance team capacity to provide compassionate care. The implementation programme takes four months but is designed to lead to a longer-term period of service improvement. Compassion is "a deep awareness of the suffering of another coupled with the wish to relieve it" (-Chochinov, 2007) and being compassionate requires "relational capacity" in practitioners, that is the capacity to experience empathy and to engage in a caring relationship (Hartrick, 1997). CLECC is based on workplace learning theory with the workplace itself (i.e. the ward in hospital settings) conceptualised as learning environment and team as a community of practice (Fuller, 2007, Fuller and Unwin, 2004, Wenger, 1998). The focus of the intervention is on creating what Fuller and Unwin (2004) call an 'expansive' environment that supports work-based opportu-

Author details
Dr Jackie Bridges
Professor Alison Fuller
Direct tel: +44 (0)23 8059 8282
Jackie.bridges@soton.ac.uk

nities 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. 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. 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 et al., 2007, Spector 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 (Patterson et al., 2011, Mimura and Griffiths, 2003, Maben et al., 2012).

The CLECC Intervention

The implementation programme for CLECC takes place over a 4 month period but it is designed to lead to longer term changes. 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, 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 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 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.

The minimum conditions for commencement of the CLECC implementation programme are:

- Ward manager in post for next six months, committed to project and able to attend action learning sets
- Staffing levels/shift patterns support the feasibility of all staff attending classroom training and the feasibility of scheduling the following work-based activities: cluster discussions, reflective discussions
- Suitable room available for reflective discussions
- Practice development nurse/practitioner in post

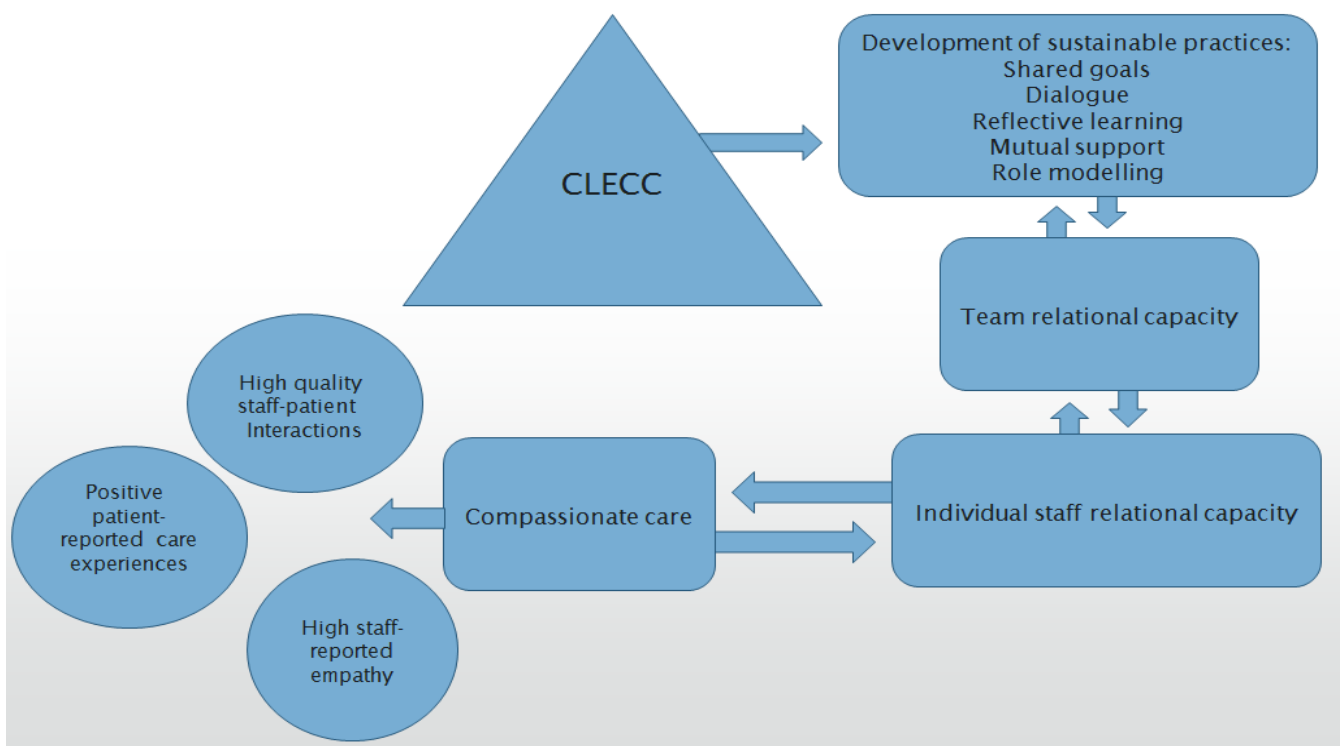


Figure One. CLECC: mechanisms for change

CLECC Activities

The CLECC implementation programme consists of several key kinds of activity 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 et al., 1999, Patterson 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 (Young et al., 2010, Meyer et al., 2003, Nicholson et al., 2010a).

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). Participants are encouraged to use the sets to devise a personal plan associat-

ed 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.

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 et al., 2011). Ward-level conditions can strongly influence nurses' capacity to build and sustain therapeutic relationships with patients (Bridges 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 should support 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, 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 undisciplined 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. 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 using a series of prompt questions developed from our findings from previous research which define what older people want from their hospital care (Bridges et al., 2010). All nursing staff on the ward at the time of the cluster discussion are encouraged to join the five minute discussion.

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, although the observation framework used was the Quality of Interactions Schedule (QUIS) (Nicholson et al., 2010a, Dean et al., 1993).

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 groupwork discussions on challenges in caring for people with complex needs and 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. The outline programme for classroom training is:

9.00-9.30 Introductions, ice breakers and expectations of the day. Introduction to BPOP (Best Practice for Older People) framework: "see who I am", "connect with me" and "involve me" (Bridges et al., 2010, Bridges et al., 2009a)

9.30-10.45 "See who I am". Life shield activity: to enable team members to get to know each other outside of work role and to get dialogue started. Group discussion about "see who I am" in relation to patients, using trigger questions from BPOP guidance.

10.45-11.00 Break

11.00-12.00 "Connect with me". Complete Assessment of Work Environment Schedule (Nolan et al., 1998) and lead

into group discussion about ward climate, dialogue and reflective learning on the ward.

12.00-1.00 Values clarification exercise about compassionate care (Warfield and Manley, 1990)

1.00-1.45 Lunch

1.45-3.45 "Involve me". Attended by three service users and/or family carers. Watch short videos of patient story of involvement and staff story of involvement. Facilitated discussion on the benefits and challenges of involving people with complex needs and their family carers in decisions about care. Discuss links with staff feeling involved in decisions about factors that affect their caring role.

3.45-4.00 Break

4.00-5.00 Introduction to workplace learning activities and discussion on how to implement/support/sustain.

5. Cluster discussions

At the end of the handover between night and morning shift staff, staff who are coming on shift take five minutes as a group to focus on the delivery of compassionate care and plan strategies as a group for the forthcoming shift that will enhance patient care. These cluster discussions (so called because they take place in a "cluster" of staff) are facilitated by the practice development nurse/practitioner and draw on the BPOP guidelines to agree behavioural "nudges" for the shift (Bridges et al., 2009a). For instance, the BPOP guidelines suggest that nurses respond quickly and willingly to requests for help. A brief team discussion could result in an agreement among the shift 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 et al., 2010b).

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 and 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 et al., 2010a)
- 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 et al., 2010a)
- Assessment of Work Environment Schedule analysis – drawing on collated results of ward climate analyses to identify factors that need supporting or changing (Nicholson et al., 2010a)
- 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 et al., 2010a)
- BPOP (Best Practice for Older People) – using resources and questions/prompts from BPOP essential guide to generate discussion (Bridges et al., 2009b) (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. Their successful use in development projects aimed at service improvement indicates that the guidance may be useful to guide 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 et al., 2010b, Nicholson et al., 2010a). A resource has been published for use alongside the main BPOP guidance, pro-

viding 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 et al., 2009b). 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 a plan for 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 includes the ward manager's personal learning objectives, including plans 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.

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 |

References

- BRIDGES, J., FLATLEY, M. & MEYER, J. 2010. Older people's and relatives' experiences in acute care settings: systematic review and synthesis of qualitative studies. *International Journal of Nursing Studies*, 47, 89-107.
- BRIDGES, J., FLATLEY, M., MEYER, J. & BROWN WILSON, C. 2009a. Best practice for older people in acute care settings (BPOP): guidance for nurses (2009). *Nursing Standard*, 24.
- BRIDGES, J., FLATLEY, M., NICHOLSON, C. & MEYER, J. 2009b. Best practice for older people in acute care settings (BPOP): essential guide (2009). *Nursing Standard*, 24.
- BRIDGES, J., NICHOLSON, C., MABEN, J., POPE, C., FLATLEY, M., WILKINSON, C., MEYER, J. & TZIGGILI, M. 2013. Capacity for care: meta-ethnography of acute care nurses' experiences of the nurse-patient relationship. *Journal of Advanced Nursing*, 69, 760-772.
- BRIDGES, J. & TZIGGILI, M. 2011. Piloting discovery interview technique to explore its utility in improving dignity in acute care for older people. *International Practice Development Journal*, 1, Article 4.
- CHOCHINOV, H. 2007. Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care. *British Medical Journal*, 335, 184-187.
- CLARKE, N. 2006. Developing emotional intelligence through workplace learning: findings from a case study in healthcare. *Human Resource Development International*, 9, 447-465.
- DAVIES, S., NOLAN, M., BROWN, J. & WILSON, F. 1999. Dignity on the ward: promoting excellence in care. *Good practice in acute hospital care for older people*. London: Help the Aged.
- DEAN, R., PROUDFOOT, R. & LINDESAY, J. 1993. The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry*, 8, 819-826.
- DEWAR, B. & MACKAY, R. 2010. Appreciating and developing compassionate care in an acute hospital setting caring for older people. *International Journal of Older People Nursing*, 5, 299-308.
- FULLER, A. 2007. Theories of learning and communities of practice. In: HUGHES, J., JEWSON, N. & UNWIN, L. (eds.) *Learning in communities of practice*. London: Routledge.
- FULLER, A. & UNWIN, L. 2004. Expansive learning environments: integrating organisational and personal development. In: RAINBIRD, H., FULLER, A. & MUNRO, A. (eds.) *Workplace learning in context*. London: Routledge.
- HARTRICK, G. 1997. Relational capacity: the foundation for interpersonal nursing practice. *Journal of Advanced Nursing*, 26, 523-528.
- KUSKE, B., HANNS, S., LUCK, T., ANGERMEYER, M. C., BEHRENS, J. & RIEDEL-HELLER, S. G. 2007. Nursing home staff training in dementia care: a systematic review of evaluated programs. *Int Psychogeriatr*, 19, 818-41.
- MABEN, J., PECCEI, R., ADAMS, M., ROBERT, G., RICHARDSON, A., MURRELLS, T. & MORROW, E. 2012. Exploring the relationship between patients' experiences of care and the influence of staff motivation, affect and wellbeing. NIHR Service Delivery and Organisation programme.
- MCCORMACK, B., DEWAR, B., WRIGHT, J., GARBETT, R., HARVEY, G. & BALLANTINE, K. 2006. A realist synthesis of evidence relating to practice development: final report to NHS Education for Scotland and NHS Quality Improvement Scotland Belfast: University of Ulster.
- MCGILL, I. & BEATY, L. 1992. *Action Learning: a guide for professional, management and educational development*, London, Kogan Page Ltd.
- MEYER, J., JOHNSON, B., PROCTER, S., BRYAR, R. & ROZMOVITS, L. 2003. Practitioner research: Exploring issues in relation to research capacity-building. *Nursing Times Research*, 8, 407-417.
- MIMURA, C. & GRIFFITHS, P. 2003. The effectiveness of current approaches to workplace stress management in the nursing profession: an evidence based literature review. *Occupational and environmental medicine*, 60, 10-15.
- NICHOLSON, C., FLATLEY, M., WILKINSON, C., MEYER, J., DALE, P. & WESSEL, L. 2010a. Everybody matters 2: promoting dignity in acute care through effective communication. *Nursing Times*, 106, 12-14.
- NICHOLSON, C., FLATLEY, M., WILKINSON, C., MEYER, J., DALE, P. & WESSEL, L. 2010b. Everybody matters. 1: How getting to know your patients helps to promote dignified care. *Nursing Times*, 106, 12-14.
- NOLAN, M., GRANT, G., BROWN, J. & NOLAN, J. 1998. Assessing nurses' work environment: old dilemmas, new solutions. *Clinical Effectiveness in Nursing*, 2, 145-154.
- NOLAN, M. R., BROWN, J., DAVIES, S., NOLAN, J. & KEADY, J. 2006. The Senses Framework: improving care for older people through a relationship-centred approach. Sheffield: University of Sheffield.
- PARKER, V. A. 2002. Connecting relational work and workgroup context in caregiving organizations. *The Journal of Applied Behavioral Science*, 38, 276-297.
- PATTERSON, M., NOLAN, M.,

RICK, J., BROWN, J., ADAMS, R. & MUSSON, G. 2011. From metrics to meaning: culture change and quality of acute hospital care for older people. NIHR SDO programme project, 3, 93.

SPECTOR, A., ORRELL, M. & GOYDER, J. 2013. A systematic review of staff training interventions to reduce the behavioural and psychological symptoms of dementia. *Ageing Research Reviews*, 12, 354-364.

WARFIELD, C. & MANLEY, K. 1990. Developing a new philosophy in the NDU. *Nursing Standard*, 4, 27-30.
WENGER, E. 1998. *Communities of practice: learning, meaning and identity*, Cambridge, Cambridge University Press.

YOUNG, S., NIXON, E., HINGE, D., MCFADYEN, J., WRIGHT, V., LAMBERT, P., PILKINGTON, C. & NEWSOME, C. 2010. Action learning: a tool for the development of strategic skills for Nurse Consultants? *Journal of Nursing Management*, 18, 105-110.