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

Key words: stories, compassion, reflection, person centred care, relationships, education, theory practice gap, student nurses

Abstract

Introduction

Current concern in health care about delivering care that is compassionate has important implications for how compassion is taught and made explicit in nurse education curricula. This paper will describe the use of stories within the curricula to enhance knowledge and skills in compassionate caring.

Methodology

The Leadership in Compassionate Care Programme (LCCP) was a 3-year action research project that sought to capture what compassionate care means within practice and utilise this learning within education. Stories gathered within clinical practice were used to stimulate reflective learning as part of a nursing module that teaches recognition of acute illness and deterioration at Edinburgh Napier University. Students listened to stories which included experiences of staff, students, patients and relatives and related these to their own experiences in practice. In this paper, examples from the online discussions are discussed with reference to one of six themes that emerged from the LCCP, that of caring conversations.

Findings

The discussions suggest that reflective learning and the use of stories about the experience of giving and receiving care can contribute to the development of the knowledge, skill and confidence that enable student nurses to provide compassionate relationship centred care within practice.

Conclusions

Reflective learning can be a valuable strategy for students to ponder new knowledge and allow predetermined ideas to be challenged. Stories can initiate this process and help student nurses to understand not only the needs of others, but their own expectations and values, which in turn can inform how they plan and deliver person centred compassionate care

Introduction

Patients and their families place a high a value on how they are cared for during the times in their lives when they need to access healthcare. Evidence suggests that this is as important to them as the nature of the care itself (Firth-Cozens and Cornwell, 2009; Pearcey, 2010; Smith et al., 2010; Edinburgh Napier University and NHS Lothian, 2012; Planetree, 2012: Dewar, 2013; Dewar and Nolan, 2013). However recent reports indicate that there remain cases where, for the most vulnerable, compassionate care has not been their experience. (Health Service Ombudsman, 2011; Lown et al., 2011; DoH, 2013a; Planetree, 2012: DoH, 2013b). The Francis reports (DoH, 2010a; DoH, 2013b) go further and suggest that NHS organisations appear to be falling short of meeting their responsibilities.

Policy makers worldwide continue to give compassionate person centred care a central place *(*Australian Nursing Federation, 2009; DoH, 2010 b; DoH, 2012; DoH Western Australia, 2012), and in 2012 the Director of Nursing for England launched a strategy for the development of a compassionate culture within the NHS (DoH, 2012). The strategy calls on healthcare professionals to commit to a series of actions underpinned by six key values that are believed to maximise high quality care. These values are care, compassion, competence, communication, courage, and commitment. Dewar (2011) suggests that embedding a culture of compassionate care requires the involvement and commitment of a wide range of players including educationalists.

Despite the launch of the strategy for compassionate care the meaning and definition of compassionate care, how it can be measured and whether it can be taught continues to be discussed (Bradshaw, 2009; Shea and Lionis, 2010; Adamson and Dewar, 2011; Curtis, 2013). The Willis report suggest that person centred care should be woven into all nursing programmes and Nurse educators are faced with this challenge as they plan, develop and deliver a curriculum that seeks to equip nurses with the knowledge and skills required to engage in compassionate care across all care settings ( Willis, 2012).

The Leadership in Compassionate Care Programme (LCCP) was a 3-year action research project that sought to capture what compassionate care means within practice, and translate this learning into practice development and education.

Action research is about doing research with and for people and emphasises the production of knowledge and action directly useful to practice (Dewar and Sharp, 2006). Action research is thus deliberately concerned with the processes of development, improvement and continuous learning. Phases typical to action research include data gathering, planning, acting, and reflecting. These activities are best seen as cycles where iterative processes of data collection and analysis are carried out and fed back into the setting to stimulate change (Hall, 2006). The critical reflection emerging from one cycle leads on to the next planning phase.

Data about caring was generated from the practice setting by working with practitioners, patients and families. The key components and processes of this care when identified then informed developments and initiatives that would enable NHS Lothian and Edinburgh Napier University (Scotland) to ‘embed compassionate care consistently within nursing practice and education (Edinburgh Napier University and NHS Lothian, 2012).

As part of the undergraduate strand of the programme, data gathered in clinical practice was used to inform changes within the nursing curricula. A number of tools and strategies were used to gather patient, relative, staff and student experiences within hospital, this included a process titled emotional touch points. This is a method used to elicit stories that focus particularly on the emotions evoked by experiences of care (Dewar et al., 2010). These stories provided a rich source of information and insight about experiences of giving and receiving care that were then used to initiate reflective learning within an acute nursing module that teaches recognition of acute illness and deterioration.

The focus of this paper is to share and discuss the reflective learning that took place as students engaged in guided reflection and online discussion initiated by the stories. The students were encouraged not only to reflect on the experience described in the story but also to relate this to their personal values, experiences and behaviours in clinical placement.

The students were also asked to consider how they would apply new learning in future practice. The stories were linked to the themes of compassionate care developed from the research (Edinburgh Napier University and NHS Lothian, 2012). These are illustrated in Table 1.

Table 1 (See end of article)

All of the themes were explored within a module which contributes to the under graduate nursing programme and teaches students how to recognise deterioration in acutely ill patients. In this paper, details of student discussions on the theme of ‘caring conversations’ will be presented.

Background

The provision of compassionate relationship centred care is determined by the “how” of caring (Goodrich and Cornwell 2008; Smith et al. 2010; DOH 2012; Dewar and Nolan 2013). It is therefore important that a nursing curriculum includes not only the technical and theoretical aspects of care but also how to care in a way that is compassionate and places the patient at the centre, but also acknowledges compassion with staff and families. Increasingly evidence suggests that in order to give compassionate care student nurses need to receive this themselves ( Gilbert 2010; Maben et al 2007).

Students who choose to enter the nursing profession are expected to be people who engage in caring behaviours at the outset so that this can then be nurtured throughout their programme of study (Murphy et al., 2009). It is therefore important that educators create learning environments that enable nursing students to make meaning of compassionate person centred care ( Hinds, 2013) and encourage and inspire them to develop, enhance and build on caring attributes (Bradshaw, 2009; Edinburgh Napier University and NHS Lothian, 2012; McLean, 2012). It is also important that students are encouraged to, and feel safe enough, be open-minded and allow their attitudes beliefs and values to be challenged (Ekebergh, 2007) and this can be achieved through reflection on their own experiences and also on the experiences of others. Reflecting on what we do can help us to identify and understand our caring values (Ghaye and Lillyman, 2000; Adamson and Dewar, 2011).

Reflecting on the lived experiences of others is known to be an effective learning tool (Lillieman and Bennet, 2012) that can, and should enhance or change our practice (Ghaye and Lilliman, 2000).Stories can be used to stimulate and facilitate reflection and debate (Moon, 2010) as listening and reflecting on the stories of others gives us access to the situations, thoughts and experiences of individuals as they live out their daily lives (McDrury and Alterio, 2003). Shea and Lionis (2011) found that students enrolled on a module that taught compassionate practice placed a high value on hearing about the real life situations and difficulties that families go through.

Moon, 2010) suggests that stories help us to build new knowledge and gain understanding of how other people think and reason. She proposes a constructivist approach where new knowledge is either added to existing knowledge, modifies that knowledge to fit in, or brings about a change in understanding through challenging the current cognitive structure (Moon, 2010). Listening to people share their personal experiences and feelings can help us to understand their needs, expectations and values, which in turn can help us to plan and deliver person centred compassionate care. Reflective learning enables the listener to ponder new knowledge and allow their predetermined ideas to be challenged in the light of it.

Stories can help the listener to understand the human response to health and illness and how this relates to a person’s life (Koeing and Zorn, 2002). McDury and Alterio (2003) describe a three stage reflective process where the listener becomes aware of a discrepancy between what they believe or understand and the experience of the story teller. The next conceptual phase initiates a process of critical analysis of new knowledge. From this process a new perspective emerges.

We can learn not only from the experiences of patients and families but also those of health practitioners (Wittenberg-Lyles et al.,2007). Learning from mentors in practice is a vital part of nurse education and listening to the stories of experienced staff can be inspirational to students. It can also help students to learn how they might deal with complex and challenging situations in practice (Firth-Cosens and Cornwell, 2009)

In the study reported in this paper (the Leadership in Compassionate Care Programme, LCCP) the experiences of others in the form of written and recorded patient, relative, staff and student stories were incorporated into an acute nursing module and used to initiate reflection and online discussion. Student nurses want to provide compassionate person centred care but can find this difficult in practice (Curtis, 2013). Using the resources from the LCCP we set out to facilitate learning through reflection on what patients and families have told us, how registered nurses and students have dealt with complex care situations, and the previous experiences of the students themselves.

Ethics

Ethical approval was granted from the University Ethics Committee for the overall project of which this development was part. Students were asked individually to consent to the use of their discussions in this paper.

The module

A module that uses a blended learning approach to teach student nurses how to recognise acute illness and deterioration was selected for a case study where compassionate care would be made more explicit and assessed. The module uses practical sessions where students engage in simulated practice using actors and mid fidelity manikins, and underpinning theory is delivered online through Moodle which is the online learning platform used within the University. Principles of compassionate care were woven into each component of the module including the assessments. Evaluation of the simulation is reported elsewhere (Adamson and Dewar, 2011).The focus of this paper however is reflection on stories of experiences of giving and receiving compassionate care, and relating learning to their own experiences in practice.

The patient, relative, staff and students stories gathered in practice were recorded and therefore available as audio files. They were also themed (see Table 1), which helped in the selection of appropriate stories that reflected the content of the module. Some of these stories were released as podcasts through a dedicated podcast site at strategic points throughout the module. Stories with content that related to the topic areas covered in the particular units of study were selected.

For example, in the “Decision Making” unit of study the students were asked to reflect on a decision made by a staff nurse where they exhibited courage and commitment in the provision of compassionate care despite criticism from colleagues. The students were asked to reflect on what informed their decision and discuss this with peers on the discussion board.

Appreciative questions were developed to accompany each story or excerpt that prompted the students to ponder what took place in the story (See table 1), the actions of the story teller, how they might have felt in that situation and what could have prompted the story teller’s actions. They were also encouraged to reflect on their own feelings, what they could learn from this account and whether their own experiences in practice where similar. Encouraging students to connect emotionally with the story was important since this is recognised as a crucial part of experiential learning (Taylor, 1987).

The discussions were moderated by lecturing staff. Research tells us that facilitation has an important part to play in reflective learning (Saunders, 2009; Dewar, 2012) therefore regular, sensitive moderation of the online discussions was important. Through commenting and questioning on the online discussion content beliefs, values and attitudes could be discussed and challenged helping the student to reflect further on their own experiences and the experiences of others.

Findings

*Student online discussion*

A group of 37 students were enrolled on the module. These were both pre-registration and registered nurses. Although the students were encouraged to listen to the podcasts and contribute to the discussion board this was not compulsory. All 37 listened to the podcasts, 33 students viewed the stories on up to twelve occasions however only16 students added posts to the online discussions. Despite this the students indicated in the module evaluation that they found listening to the stories valuable. As the stories selected mirrored the content of the teaching units and patient scenarios used during the practical sessions, the patient, relative and staff experiences could be referred to during the face to face reflective sessions and serve to enrich discussions about compassionate person centred care including constraints to providing it in practice.

One story excerpt (*n=5*) is presented related to the theme of ‘caring conversations’ and samples from the online discussion that emerged following reflection on the story are illustrated. Some of the quotes relate directly to the content of the stories and others to reflections on their own experiences and observations in practice. The story excerpt is illustrated in Table 2.

Table 2

Theme 1: Caring conversations: Discussing, sharing and debating how care is provided.

Sub theme: Being kept in the loop

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| --- |
| Being kept in the loop |
| *It was important to us that any decisions about my father’s care or simple changes to his treatment were communicated to us and the staff did keep us fully updated. The nurses would come at the end of their shift to say goodbye and to let us know when they would be back on duty or if they had a day off. Minor alterations in medication or change in the use of equipment could assume huge significance to our untrained eyes, which could be alarming without any real need to be, e.g. the intravenous infusion machine would suddenly beep repeatedly and no-one would come rushing to attend to it. We were at first quite alarmed by this until a nurse explained that it was just a warning that the bag was running low and would need changed. It would have been very easy for the doctors and nurses to bamboozle us with all the medical terminology but they were very good at keeping us informed without the use of jargon or confusing abbreviations.*  *I had no experience of being in hospital overnight and there were so many differences from the day shift. New staff came on duty who needed time to get up to speed with dad’s latest situation, the lights were dimmed, the ward became quieter but because of that we became much more aware if there was an emergency being attended to. I felt unsure of what rule and regulations applied e.g. was it still OK to use the kitchen? Was there a vending machine for drinks/snacks in the building or if you went out of the building would you be able to get back in? Was it permissible to watch TV in the patients or relatives lounge at 3am? At times we felt like intruders and we were unable to speak to staff about our concerns because we did not know what we were entitled to or if what we had been offered or given previously had been purely a kind gesture from a caring member of staff. We were very aware of various constraints within the Health Service. We realised that staff were ranked differently but did not always know who was more senior to whom and if rules or regulations were being applied on someone else’s say so. We did not complain as we were very aware that we were on an emotional roller coaster and that our perceptions could have been inaccurate and our reactions may have been overreactions. Relative*  Student were asked: Elizabeth and Margaret referred to the use of medical jargon and how important it was that they were kept informed in a way that they could understand.  Consider your own experiences and observations of communicating with patients and families in practice.  How has listening to this story influenced your practice as a nurse?  Share your thoughts and reflections about this story, and your experiences in practice on the discussion board. |

Students engaged with this story excerpt and provided the following comments:

*On many occasions the doctors overuse of jargon was incomprehensible, not only to the patient, but to myself.  As a spectator in this, I could sense the patient’s unease and their unwillingness to challenge such terminology, which I felt greatly frustrated and saddened by.  Student 1*

The student was able to relate aspects of this story to what they had observed in practice. The student engaged emotionally and had some sense of empathy with the patient. It was interesting that they talked about being a ‘spectator’. Many of the discussions described the student as an outsider looking in on situations. The lecturer would pick up on these points encouraging a greater understanding of the role of self in future similar situations. In addition barriers to embedding compassion particularly in relation to challenging custom and practice were explored.

*In placement I did witness that when a patient took a turn for the worst, they were placed into a side room to allow for privacy, etc. I didn't even give it a second thought that when relatives are still with a loved one during the night that they may not know about the night shift routine ……, mental note made for the future. Student 3*

In this quote the students are thinking quite deeply about their own practice in the future and how they might use this learning to enhance the patient and family experience. The reference to ‘I didn’t give it a second thought’ demonstrates how the story challenged previous thinking and helped the student have an enhanced awareness of the patient perspective and their experience of care.

*I was fortunate to have an opportunity to observe some urology consultations during my OPD placement, where the patient was very much the centre of attention during that time. All their questions were answered and they had one-to-one time with their consultant to allow them to understand their situation. Student 4*

It was refreshing to see this quote where the student was able to identify a positive story from practice. Many of the discussion quotes reflected negative experiences. In appreciative inquiry much can be learned from highlighting the good and considering how these good practices can happen more of the time (Dewar and Mackay, 2010). There could be more emphasis in the guidance questions on asking students to reflect on a time when, for example, information giving worked well.

*Doctors and nurses make judgments when communicating about what their patients understand of medical terminology and with what depth they can go into specifics before they ‘bamboozle’ the person at hand.  This is a process of estimation, it takes enhanced communication skills to get it right, and it will not be right every time for every person.  Asking a patient or relative to explain to you what they understand of the information they have been given can be a good way to ensure you have got it right for them. Student 5*

It was interesting in this quote that the student chose to use the same powerful terminology that the relative used in the story – that of feeling ‘bamboozled’. There was a mirroring of the language in the story and a sense of engagement with the content. Discussion focused on use of language and the potential value in using this more user friendly language to describe the ‘professional’ process of ’clear explanations, and accurate information giving’. Thus the story prompted reflection in and for practice. This discussion posting also suggested that the student concerned recognised the complexity of information giving, the individualistic nature of this and the skill that was required to make a careful judgement. Again this, including the benefits of using the teach back method to check patient understanding (Bowskill and Garner, 2012) was developed in reflective discussions.

*The patient had been admitted to hospital following a suspected Transient Ischaemic Attack (TIA). The multidisciplinary team completed their ward round, which included informing this patient of this, …..the patient had felt unable to ask further questions on the ward round as he believed the healthcare professionals had more important tasks to complete, rather than spending time explaining medical information to himself. The family and patient became quite anxious as they were unsure of what this meant and how this would impact their father’s life. In order to resolve this situation I managed to arrange a meeting with the doctor and family which would allow time for an explanation of the medical condition and allow any questions they may have had to be answered. Student 6*

This student recognised, through sharing a similar story from their own practice, the potential reluctance that many patients and families feel in coming forward to ask questions. The student considered the significance of the information for the patient and their family. The situation prompted them to take responsibility and move to action. It was interesting that this was one of the few examples of where a student posted a comment that highlighted personal action. Further discussion on this would have explored with the student how they felt about deciding to act in order to reinforce this good practice.

*Feedback about the experience of learning from the stories*

Feedback was also sought from students about the experience of listening and reflecting on stories. The following quotes illustrate some feedback which was very positive:

*‘I feel we sometimes are so focused on the medical side of illness that we forget the compassionate aspect. The podcasts helped reiterate this fact’ Student 7*

*The podcasts were extremely emotional and emphasised that you must care for the family too.’ Student 8*

*I'm really enjoying the podcasts as I feel that the stories are very open and honest accounts of particular situations which allow me to think about things from another perspective.  Student 9*

*……to hear the verbalised stories evokes a positive emotional response. The podcasts provide an archive of both the emotional complexities of caring and a reminder of the importance of simple thoughtful actions. The compassion, courage and reflection expressed by two relatives in their own story is priceless. Thoughtful actions can come from one’s own past experience, and at times these may have been painful. Within nursing it is rare to receive critical feedback from families and the value of sharing these personal stories seems to provide a powerful learning experience. Student 10*

The students indicated that they found listening to people share their unique experiences and reflecting on how they felt in that situation invaluable. They made particular reference to the emotions that the stories evoked, thus reinforcing the important point made earlier about the crucial role emotion plays in experiential learning.

The stories and discussions around compassionate care initiated reflection by the lectures on their own practice as demonstrated in the following quote

*“We as members of the module team need to be good role models of Compassionate Care to the students and we can do that. Things like knowing the students by name and ensuring that they don’t feel intimidated. Treating the students in a way that we would like them to treat their patients” Lecturer*

Discussion

It is apparent from the content of the online discussions and student feedback that the stories stimulated reflection on practice and the experiences of patients and relatives and discussion around the students’ experiences in placement. However student learning is also influenced by their life experience (Curtis, 2013), and their consequential beliefs and values and this needs to be acknowledged when facilitating learning about compassionate relationship centred care. Indeed Mclean (2012) promotes learning and teaching that encourages awareness of personal values and behaviour. Stories are a way to facilitate this reflection on one’s own beliefs and values. As part of this nursing module students were presented with personal accounts of patients, relatives, students and staff member’s personal experiences which challenged their beliefs, for example about patients feeling able to ask questions and the equal importance of the family in the care giving relationship. The stories raised issues such as how it feels to be in hospital and an understanding about the use and impact of healthcare terminology for the patient and their relatives. Evidence of the impact that this had on students and learning that took place can be seen in the content of the discussions and student feedback. However further investigation is required to determine how and to what extent this learning impacted upon or changed practice.

The literature indicates that educators can inspire and encourage students to develop caring attributes (Bradshaw, 2009: Edinburgh Napier University and NHS Lothian, 2012; McLean, 2012) and it is important that students feel safe enough to share and explore their beliefs and feelings. Some of the online posts were mainly descriptive. Through active and sensitive moderation lecturers provided an opportunity to encourage a safe space for deeper reflection and learning.

Reflection can mean that we need to unlearn what we previously believed and understood. Mann and Ghaye (2000, p. 51) suggest a process of

“ unravelling the complex whole of practice and then knitting it up again”

The content of the discussions indicated that students’ prior knowledge and beliefs were challenged. For example, the discussions raised awareness of the importance of clear communication, and also how using jargon can create confusion. Students discussed new understanding such as that they should not assume that relatives understood the hospital routine. A commitment to note this new learning for future practice expressed by students suggested not only learning but an intention to apply this is practice.

Furthermore listening to the experiences of others served to initiate reflection on the students own experiences in similar situations. It is important to help students to explore the meaning and significance of their experiences as this may well challenge their current understanding (Ironside, 2006). The students discussed observations of both compassionate care, and care that was not person centred. Observations of less than good practice prompted learning as much as exposure to good care and are therefore valuable in their own right. Never the less observation of poor care in practice can be disappointing to students leaving them feeling let down or disillusioned (Hamshire et al., 2012). It is therefore important to offer the opportunity for students to share these experiences, to consider and discuss what contributed to them and how this could have been different. In addition posing questions that enable students to consider good examples in practice can help to uncover what needs to happen for good practice to occur.

There was evidence that students were able to consider their emotions in relation to caring in this module. It is important to acknowledge that providing compassionate care can be incredibly fulfilling as well as emotionally ‘costly’ (Smith 2012) and that opportunities to explore emotions in a safe environment through reflection on stories can be useful.

It was interesting that the discussions suggested that students felt like outsiders rather than full contributors to the episodes of care that they described. There did not appear to be any indication of shared responsibility and being part of the team. This tells us something of how the students see themselves and the extent to which they feel able to act in practice. Further debate around this topic will be integrated into revisions for the module.

The aim of the LCCP was to embed compassionate care within practice and education. Using stories to enable students to gain insight into the experiences of those whom they care for and hearing the stories of nurses working within practice can provide this insight. The key themes that emerged from the programme helped to inform learning and teaching about compassionate care. The themes identified in Table 1 tell us something of what is important to patients and families and the processes and factors within organisations that make care compassionate, while the stories provide lived examples of what this means for an individual.

The examples of discussions shared in this paper demonstrate how stories can stimulate reflection (Moon, 2012) and the influence that listening to the voice of the patient, relative, fellow student or staff member can have on learning for nursing students.

Limitations and lessons learned

The group of students who participated in this nursing module was relatively small and studying adult nursing. Although all of the students chose to listen to the podcasts only a small number contributed to the online discussions. Excerpts from the students’ evaluations that articulated the perceived benefits could be used to encourage participation within subsequent groups. It may also be useful to allocate marks to participation ensuring that all students engaged in the process and as a consequence the experiences shared will be richer. The discussions were facilitated online only and follow up face to face tutorials where stories are read and discussed in real-time may also result in greater participation and engagement.

The discussion on the theme of caring conversations related mainly to information giving, inclusion and the use of language. The interpersonal competence required to engage in caring conversations is more complex than this. Further research by Dewar has identified seven attributes of caring conversations: be courageous, connect emotionally, be curious, collaborate, consider other perspectives, compromise and celebrate (Dewar and Nolan, 2013). Future development of the online discussions will incorporate reflection on the presence of these attributes within the stories.

Conclusion

Governments (DoH, 2012; DoH Western Australia, 2013) commit to the provision of compassionate care within healthcare while reports in the press question whether nurses have the skills to provide compassionate relationship centred care. Although there is evidence that compassionate relationship centred care is evident in practice, a major challenge is supporting healthcare staff to provide this care consistently to different patient groups and within differing contexts. Students who choose nursing as a career express a commitment to the provision of this care, and educators are charged with the challenge to ensure that the content of curriculum actively prepares nurses to consistently deliver this.

Nurse education is both theoretical and practical and bridging this gap is a challenge for educators. Using real examples of care can help students to relate one to the other and become entwined with their own life experiences and lived reality (Ekebergh, 2011).

The LCCP showed that nurses see caring compassionately as just part of the job but reflecting on care episodes and the experiences of those who give and receive it, can help health professionals and also student’s nurses to recognise the essential elements that make care compassionate (Dewar and Nolan, 2013; Edinburgh Napier University and NHS Lothian, 2012). In order to learn how to care compassionately it may be necessary to acknowledge and challenge our understanding of what compassion means and our underlying values. Ghaye and Lilliman (2010) suggest that reflecting on what we do can help us to understand our caring values.

Students demonstrated a commitment to deliver compassionate relationship centred care in their contributions to the discussions but this can be challenging for students within practice (Curtis, 2013). In the current climate where a perform and peril model often dominates where there is hierarchical structure, punitive cultures, and a focus on task rather than process it can be difficult to apply theory to practice (Patterson et al., 2011). Reflective learning and the use of story can contribute to the development of the knowledge, skill and confidence that enable student nurses to provide compassionate relationship centred care within practice.

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| Table 1 | | | |
| Themes | Subthemes | What this means in practice | Examples from LCCP |
| Caring conversations | * Caring for and about each other * Thinking and taking about how we do things and how to makes things even better * Recognising and sharing your emotion * Being kept in the loop * Safe to express your opinion * Being proud and firm sticking to the principles of person centred * Collective decision making care | Discussing, sharing, debating and learning how care is provided amongst staff, patients and relatives and the way in which we talk about caring practice | I feel listened to on the doctor’s rounds. The doctor will sit down and touch my arm and really look at me – you know he is listening – he doesn’t always touch your arm but this is nice. He will ask questions like tell me how you think you are doing rather than just telling me what he thinks. **[Patient comment** ] |
| Flexible, person centred risk taking | * Personal sharing * Confidence to challenge the way we do things * Considering when you can and can’t do person centred care * Valuating the professional knows best * Knowing when to use banter * Use of language to reflect the individual as a person | Making and justifying decisions about care in respect of context and working creatively with patient choice, staff experience and best practice | I asked a lady what was important to her and she said that she did not want her husband to be given a bag of her soiled laundry to take home to wash. Her husband was 92 and had never used a washing machine. She asked if we could rinse this through. We had to explore how we could work together to achieve a better experience for the patient and her family as hospital policy indicates we are not too wash through patient clothing **[ Staff comment]** |
| Feedback | * I am glad you are here today because… * Hearing and accepting feedback * Feeling safe to ask a and give feedback | Staff, patients and families giving and receiving specific feedback about their experience of care | I try to find out if I have done okay – I put it across in a jokey way so just like if I have given them a shower I try to ask them was it okay did you enjoy that – if they stay quiet I might think it has not been so good so I might say how would you like your shower tomorrow **[Staff comment]** |
| Knowing you knowing me | * Knowing you knowing me * Knowing the little things that matter * Knowing the person and using that to influence the way that care is given/received * Helping others to connect | Developing mutual relationships and knowing the persons priorities, to enable negotiation in the way things are done | It took me about two nights to get settled and get a normal sleep pattern, but if I can’t sleep I can pop out to the nurse’s station and have a chat with them and they make me a cup of tea. I lost my wife last year so I often feel lonely and so I enjoy the company of others when I am in hospital. They know I feel lonely and try to include me. **[Patient comment]** |
| Involving, valuing and transparency | * A deliberate welcome and smile cost nothing * Being open and real about expectations * Spotting the opportunities and knowing the possibilities * Sharing /co creating the way things are done * Systems to enable involving and transparency | Creating an environment throughout the organisation where staff, patients and families actively influence and participate in the way things are done | The nurses on duty welcomed us right from the start. It was things like offering cups of tea or coffee that made us feel welcomed. I stayed during the night and they gave me a pillow and blanket. They cared for me and this reassured me that it was fine for my husband to be there. Staff would tell me that, in fact, I was a help to them and they wanted me to tell them if anything changed or if I was worried about my husband. That reassured me that I was not imposing on them. **[Patient comment** ] |
| Creating spaces that work | * Knowing and respecting a space that works for me * Having my space and somewhere to go * Working together to make the most of our environment | The need to consider the wider environment and where necessary be flexible and adapt the environment to provide compassionate care | In the initial stages we were grateful to be able to have the environment and setting the way we wanted it. But as things became a little more complicated we had to shift some of our hopes and expectations, but, we always felt at the centre of things. The staff worked very hard to make it as close to the vision we had for the birth as possible. [**Relative comment**] |