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Impact of a Compassionate Care Leadership Programme

Abstract

Compassionate care delivery enhances patient satisfaction and quality of life and reduces nurse burnout. This study measured the perceptions of nursing and midwifery leaders regarding the impact of the “Leaders for Compassionate Care Programme” on their personal development, learning experience, service and care delivery, programme quality, and satisfaction with the programme. Seventy-nine leaders were surveyed using the Leaders for Compassionate Care Outcomes Evaluation Questionnaire and the Leaders for Compassionate Care Evaluation Questionnaire. Participants’ perceived ability to support peer learning, manage conflict, and build trust with patients increased significantly following the programme ($p \leq 0.001$). Over 80% of participants reported that they were able to apply to practice what they had learned from the programme and reported an increase in their motivation to lead in compassionate care delivery. Various strategies are needed to improve compassionate care leadership and further research is needed to explore the long-term impact of the programme.

Keywords: Compassion; care; leadership; midwifery; nursing; programme evaluation

23 Compassionate care is defined as “a deep feeling of connectedness with the experience
24 of human suffering that requires personal knowing of the suffering of others” (Peters 2006;
25 p.38). Dewar et al. (2011) conceptualised compassionate care in terms of the relationship that
26 exists between vulnerable human beings that must be nurtured so that one person perceives the
27 vulnerability of the other person and responds to it in a meaningful way.

28 Effective leadership is vital to the delivery of safe, quality, and compassionate
29 healthcare. In contrast, the lack of compassionate leadership has a negative impact on
30 healthcare outcomes and quality (McSherry and Pearce 2016). This was highlighted in two key
31 reports in the UK, namely Kirkup’s (2015) Report of the Morecambe Bay Investigation and
32 the Mid Staffordshire National Health Service Foundation Trust inquiry (also known as the
33 Francis (2013) inquiry). Within these reports, the failure of several nursing leaders in their role
34 and responsibility to care was identified as one of the key contributors to detrimental,
35 neglectful, and systemic failures to safeguard a culture of safety, quality, and compassion
36 (McSherry and Pearce 2016). Therefore, the importance of promoting patient-centred
37 compassionate leadership in healthcare was emphasised (Francis 2013; Kirkup 2015).

38 **Literature Review**

39 Coffey et al. (2019) conducted a mixed-method systematic review to summarise
40 evidence from 15 studies aimed at preparing nurses to lead on and/or deliver compassionate
41 care. Studies were published between January 2007 and February 2018 and sourced from four
42 electronic databases: CINAHL, Medline, PsychINFO, and SocINDEX. The methodological
43 quality of the included studies and the risk of bias per study outcome were measured and varied
44 between weak and strong.

45 It was found that training and educating nurses and midwives to become leaders in
46 compassionate care delivery yields positive patient outcomes (Coffey et al. 2019). For instance,

47 in a pilot pre- and post-test study, Day (2014) explored the impact of the ENGAGE card
48 (*Engaged by your senior team, Nurtured by your manager, Glad to come to work,*
49 *Acknowledged by your senior team, Guided by your manager, and Empowered to improve*
50 *patient care*), improvement initiatives (i.e. nursing handover, safety briefings, and manager
51 responsibilities), and focus groups on patient and nursing (n=57) outcomes. It was found that
52 the incidence of pressure ulcers and falls dropped to zero and the overall experience of patients
53 was improved at three months post-test (Day 2014). Another intervention that yielded positive
54 patient outcomes was delivered in the form of emotional touchpoints (i.e. coming into hospital,
55 going for tests, mealtimes, and so on) and associated negative and positive emotional words
56 (Dewar et al. 2009). These were written on cards that were distributed to patients (n=16) and
57 their relatives (n=12). Participants reported that the touchpoints enabled them to get in touch
58 with the positive and negative aspects of their experiences and strengthen their relationships
59 (Dewar et al. 2009).

60 Compassionate care leadership education was also found to impact positively on nurses.
61 Overall, there was a consensus across the reviewed studies regarding the positive role of
62 compassionate care leadership education in increasing nurses' sense of pride and ability to
63 reflect on practice, handle challenging situations, and obtain confidence to lead
64 compassionately (Coffey et al. 2019). Positive outcomes were linked to various factors such as
65 involving nurses from all levels in compassionate care leadership education (Bridges et al.
66 2017), and promoting a culture of compassionate care within healthcare organisations
67 (O'Driscoll et al. 2018). This helped increase nurses' commitment to offer compassionate care,
68 have a positive outlook regarding their role as leaders, and contribute to improving the patient
69 experience (Zubairu et al. 2017). For instance, Dewar and Cook (2014) found that nurses who
70 attended a 12-month leadership programme on compassionate care delivery reported
71 heightened self-awareness, better relationships with colleagues, and greater ability to reflect on

72 practice. Similarly, Masterson et al. (2014) found that a compassionate care programme titled
73 “Enabling Compassionate Care in Practice” successfully increased nurses’ knowledge,
74 understanding, and application of the 6Cs (Care, Compassion, Courage, Competence,
75 Communication, and Commitment).

76 **The “Leaders for Compassionate Care Programme”**

77 In the UK, the Department of Health and Social Care (2015) stressed the importance of
78 compassionate care leadership, education, and training. Similarly, the Health Services
79 Executive (2015) which is the main provider of public health and social care services in Ireland,
80 has care and compassion imbedded in its core values and emphasised the need to facilitate
81 nursing and midwifery leaders to serve as advocates for compassionate care delivery (National
82 Leadership and Innovation Centre 2017). As a result, the “Leaders for Compassionate Care
83 Programme” (LCCP) was implemented.

84 The LCCP is a development programme for nursing and midwifery leaders facilitated
85 by the Florence Nightingale Foundation in the UK and launched in Ireland in July 2015. This
86 programme provides experienced and frontline nursing and midwifery leaders with time away
87 from their organisations where, together with other leaders from a wide range of services and
88 specialties, participate in their own and each other’s leadership development (National
89 Leadership and Innovation Centre 2016). The LCCP provides several opportunities for leaders
90 to learn about patient-focused quality improvement and compassionate leadership. The goal
91 from the LCCP is to empower leaders while supporting their teams in delivering high quality
92 and compassionate patient-centred care (National Leadership and Innovation Centre 2016).

93 The LCCP is offered over three days, is grounded in experiential learning, and is highly
94 interactive. On the first day, leaders are introduced to each other and to the facilitators. The
95 first session explores what “Leading for Compassionate Care” means to the leaders and aims

96 to elicit responsibilities and challenges faced in everyday practice. The second session is
97 conducted in groups and aims to explore the concepts of presence and personal impact. The
98 first day includes three plenary sessions discussing topics emerging from the conversations and
99 linking leadership to compassionate care delivery.

100 During the second day, leaders are divided into two groups; one group is introduced to
101 quality improvement and equipped with tools and techniques to improve patient care and the
102 second group is introduced to co-consulting in order to build their leadership practice
103 experiment and get to know their learning partners. This is followed by the administration of
104 the Myers Briggs Type Indicator personality inventory and a plenary session discussing the
105 programme and arrangements for the third day.

106 The third and final day takes place six to eight weeks following the first two days. This
107 day begins with a postcard exercise whereby various images are displayed on cards and leaders
108 are asked to select two cards; the first card symbolises what has been going on for the leaders
109 since the first day of the LCCP and the second card symbolises what they hope to gain from
110 the third day. This is followed by an informal session on managing change where leaders share
111 examples of changes that they have implemented following the LCCP and discuss the impact
112 of the LCCP on their clinical practice.

113 **The Evaluation**

114 This study measured the perceptions of nursing and midwifery leaders regarding the
115 impact of the LCCP on their personal development, learning experience, service and care
116 delivery, programme quality, and satisfaction with the programme. Six programmes (each with
117 approximately 30 nursing and midwifery leaders) were delivered between October 2015 and
118 July 2016. Leaders were recruited directly through the seven geographically dispersed Hospital
119 Group Chief Directors of Nursing and Midwifery in Ireland (National Leadership and

120 Innovation Centre for Nursing and Midwifery 2015). All the leaders who completed the three
121 days of the LCCP (n=168) were invited to participate in this study.

122 A cross-sectional descriptive survey incorporating a modified retrospective pre-test
123 design was used (Allen and Nimon 2007). This was deemed most appropriate to determine the
124 participants' perceptions and experiences of the programme. In addition, this design has utility
125 when pre-test data are not available to assess change at post-test (Hill and Betz 2005).

126 Ethical approval to conduct the study was obtained from the Clinical Research Ethics
127 Committee and participants provided written informed consent. Data were collected between
128 November 2016 and March 2017. Participants were provided with the option of either returning
129 the questionnaire by post or responding via the web-based survey platform SurveyMonkey®.
130 This strategy is known to yield higher response rates (Funkhouser et al. 2017). Postal surveys,
131 web-based surveys, and two e-mail reminders were sent by the organisation that offered the
132 LCCP, rather than the researchers. This was attempted to maintain participant confidentiality
133 of and minimize intrusion. Fifty-four electronic and 25 postal surveys were completed, yielding
134 a sample size of 79 participants (47% response rate).

135 Data were collected using a structured questionnaire that was developed based on
136 instruments previously used to evaluate the impact of educational programmes for nurses
137 (Drennan 2012; Hyde et al. 2016). Participants' demographic and professional data were
138 gathered using six items. The *Leaders for Compassionate Care Outcomes Evaluation*
139 *Questionnaire (LCCOEQ)* contained 35 items based on course content that measured outcomes
140 related to four domains of leadership practice: understanding of context; introduction to skills
141 in quality improvement and management of change; personal development; and relational
142 development. The *Leaders in Compassionate Care Experience Questionnaire (LCCEQ)*
143 contained 34 items and measured the participants' experiences and satisfaction with course

144 organisation, teaching, and workload. *LCCEQ* was developed based on the *Course Experience*
145 *Questionnaire* (Byrne and Flood 2003).

146 Data were entered into IBM SPSS Statistics and analysed using descriptive and
147 inferential statistics. Data from *LCCOEQ* were not normally distributed; therefore, the
148 Wilcoxon signed-rank test was used to compare the participants' scores before and after the
149 programme. The Bonferroni Correction; 0.25 was used as the critical level of significance to
150 prevent against the possibility of a type I error ($\alpha = 0.25$). The items comprising the *LCCEQ*
151 were summated into eight scales measuring participants' experiences of good teaching;
152 appropriate assessment; preparation to lead compassionate care; workload; teaching support;
153 programme organisation; infrastructure; and satisfaction. In order to interpret and standardise
154 scores across the *LCCEQ*, the mean item scores were based on a linear transformation and were
155 recoded to range from 0 to 100, with higher scores indicating greater satisfaction.

156 **Participant Characteristics**

157 All but one participant were female. The mean age of participants was 46.09 years
158 (SD=6.9). Participants reported that, on average, they had been qualified as nurses/midwives
159 for 23.52 years (SD=7.5). The majority of participants were Clinical Nurse and Midwife
160 Managers (92.5%, n=73). Participant characteristics are presented in **Table 1**.

161 **Personal Development, Learning Experience, Service and Care Delivery**

162 Out of a maximum score of 7, participants' perceived ability to show respect in their
163 interactions with people increased significantly following the programme (mean before 5.86,
164 SD=1.25 vs. mean after 6.78, SD=0.44; $p \leq 0.001$). In addition, their perceived ability to
165 demonstrate consideration and empathy in their communication and interaction with people
166 showed a significant increase following the programme (mean before 5.56, SD=1.30 vs. mean
167 after 6.63, SD=0.74; $p \leq 0.001$).

168 Participants made significant gains in all items related to the development of leadership
169 capabilities. Of particular note was the high level of change that participants perceived in
170 relation to developing and understanding themselves as leaders; this was one of the lowest rated
171 capabilities before the programme (mean 3.96, SD=1.31), but increased significantly following
172 the programme (mean 6.22, SD=1.02; $p \leq 0.001$).

173 The development of leadership capabilities was also highly evident in the participants'
174 perceived ability to apply leadership for quality improvement in practice (mean before 4.43,
175 SD=1.40 vs. mean after 5.91, SD=1.23; $p \leq 0.001$) and implement leadership interventions that
176 are effective and grounded in best practice (mean before 4.47, SD=1.44 vs. mean after 5.96,
177 SD=1.25; $p \leq 0.001$) (**Table 2**).

178 **Quality and Satisfaction with the Programme**

179 Over 90% of participants agreed that they were able to apply what they learned on the
180 programme in practice. Moreover, over 80% of participants reported that the programme
181 increased their motivation to lead on compassionate care, enhanced their ability to work as
182 members of the multidisciplinary team, and equipped them with the skills needed to deliver
183 compassionate care. The highest levels of satisfaction related to the support received from the
184 programme facilitators; this was particularly the case in relation to linking theory to practice,
185 communicating effectively, encouraging group work, and fostering critical thinking (>90%).
186 Moreover, most participants agreed that the programme facilitators were good at explaining
187 content (96.2%) and made the subject interesting (96.2%).

188 The vast majority of participants agreed that the programme used problem-solving
189 approaches as opposed to rote recall or memorization of facts. Although there were relatively
190 high levels of satisfaction with the programme workload, responses in this domain were not as

191 high as in the other domains. In addition, 76% of participants agreed that they received helpful
192 feedback from the facilitators.

193 Overall, 96.2% of participants agreed that they enjoyed the programme and 88%
194 reported that they felt confident to lead in compassionate care delivery. However, agreement
195 was below 80% for the statement: “I have changed my attitude towards my work as a
196 consequence of the programme,” with 75.9% in agreement.

197 The mean scale scores on the *LCCEQ* indicated that participants were highly satisfied
198 with: the quality of teaching (mean 82.27, SD=14.45); teaching support (mean 81.54,
199 SD=13.94); preparation to lead compassionate care in practice (mean 77.16, SD=16.96);
200 assessment (mean 74.57, SD=16.60); workload (mean 73.64, SD=12.49); organisation (mean
201 73.58, SD=15.85); and infrastructure (mean 70.89, SD=16.95) (**Table 3**).

202 **Discussion**

203 The LCCP and subsequent evaluation aimed to address major causes of failure in care,
204 namely the lack of compassionate care delivery and lack of nursing leadership (Francis, 2013).
205 Moreover, the LCCP and findings from the present study helped meet several nursing
206 recommendations from the Francis (2013) inquiry. These include: (i) building a “culture of
207 compassion and caring in nurse recruitment, training and education” (p. 76); (ii) increasing the
208 “focus in nurse training, education and professional development on the practical requirements
209 of delivering compassionate care in addition to the theory” (p. 105); and (iii) including
210 leadership training as part of the “training and continuing professional development for nurses”
211 (Francis 2013, p. 106).

212 Overall, positive and significant changes were reported following participation in the
213 LCCP. These related to the participants’ understanding of compassionate care delivery,
214 preparedness to act as compassionate care leaders, and acquisition of new problem-solving

215 skills. Moreover, participants were satisfied with the organisation of the programme, the
216 competence of programme facilitators, teaching support, and workload.

217 Participants were predominantly in managerial roles and had extensive clinical
218 experience. Enabling clinical leaders to undertake programmes such as the LCCP has been
219 identified as a crucial step in adopting and sustaining change and fostering patient centeredness
220 (Luxford et al. 2011; MacArthur et al. 2017). In fact, participants in the present study reported
221 an increase in their ability to implement change and support their staff whilst offering
222 compassionate and patient-centred care. Nevertheless, Burston et al. (2011) recommended a
223 hybrid model of change involving both, top-down and bottom-up leadership. Similarly, Francis
224 (2013) stressed that offering training and continuing professional development opportunities
225 for nurses “should apply at all levels, from student to director” (p. 76). In fact, Bridges et al.
226 (2017) found that involving nurses from all levels in compassionate care leadership education
227 yielded a number of positive clinical outcomes. This highlights the importance of involving
228 both, junior and senior nursing staff in initiatives such as the LCCP in the future.

229 Participants reported gaining abilities and building understandings in several areas. Of
230 note was the change that occurred in the participants’ understanding of themselves as leaders,
231 implementing change, assuming authority, and supporting peer learning. The LCCP also
232 positively affected the participants’ perceived relationship with patients and their families.
233 Participants also reported that their perceived abilities to demonstrate consideration and
234 empathy in interactions with patients and to build trust with patients and their relatives
235 increased significantly following the programme. These findings were echoed in a study
236 conducted by MacArthur et al. (2017) who evaluated the impact of a three-year initiative aimed
237 at embedding compassionate care into clinical practice. It was found that wards that adopted
238 the programme reported an increase in caring conversations among the staff and between the
239 staff, patients, and their relatives. Moreover, the three-year programme was successful in

240 eliciting the views of patients and their families, which is key to promoting holistic and person-
241 centred care (MacArthur et al. 2017).

242 In the present study, participants were highly satisfied with their experience of the
243 LCCP; this was particularly the case in relation to programme layout and the support offered
244 by the facilitators. Teaching support was also highly rated with the use of approaches that
245 facilitated critical thinking, reflection, and linking theory to practice. The role of professional
246 education and training in developing compassionate practitioners had been highlighted in the
247 literature on compassionate care education (Bray et al. 2014; Lown 2014; Straughair 2012a,
248 2012b). For instance, a study exploring healthcare professionals' understanding of compassion
249 and the role of healthcare professionals as compassionate care educators, found that education
250 plays a key role in developing compassionate practitioners and promoting compassionate care
251 delivery (Bray et al. 2014). Similarly, Lown (2014) identified "teaching compassion" as an
252 essential commitment to fostering compassionate care in healthcare organisations and
253 Straughair (2012a, 2012b) highlighted the importance of educators as role models for
254 compassionate care delivery. The role of educators in fostering compassionate care was also
255 highlighted at undergraduate level and among novice nurses (Coffey et al. 2019; Smith et al.
256 2014).

257 In this study, high levels of satisfaction were evident in the preparation received to lead
258 compassionate care in practice, including the development of knowledge, skills and
259 competencies to deliver compassionate care, the ability to apply what was learned during the
260 programme to practice, and motivation to deliver compassionate care. Similarly, a 12-month
261 compassionate care leadership programme helped nurses influence clinical decision-making
262 and enabled them to discuss tough issues (Dewar and Cook 2014). The LCCP also helped
263 participants engage in compassionate conversations, build better work relationships, and reflect
264 on their clinical practice. Another area of greatest growth in the present study was the change

265 in the participants' understanding of themselves as leaders and their level of confidence.
266 Similarly, a programme titled "Enabling Compassionate Care in Practice" was successful in
267 increasing nurses' courage and confidence to lead and to make positive changes in clinical
268 practice (Masterson et al. 2014).

269 This study is not without limitations; non-probability convenience sampling was used
270 to recruit study participants. Despite being commonly used in the nursing literature (Grove et
271 al. 2015), this sampling strategy is known to increase the risk of self-selection bias.
272 Furthermore, despite using electronic and postal surveys with multiple reminders,
273 approximately half of the nursing and midwifery leaders who undertook the LCCP participated
274 in this study; thus, compromising the generalisability of findings. Finally, a retrospective pre-
275 test approach was used to rate the participants' understandings and abilities before and after
276 the programme. Therefore, a longitudinal study and/or a pre-post study would help enhance
277 rigor. In addition, it is worth considering conducting a randomised controlled trial in order to
278 evaluate the impact of the LCCP in comparison to no programme and/or alternative
279 programme(s).

280 Further research is recommended using a longitudinal 360-degree research
281 methodology to explore the long-term impact of the LCCP on leaders, healthcare organisation,
282 and patients. This research should also include outcomes for services and service users in
283 different healthcare settings using valid and reliable instruments and sample sizes to enhance
284 generalisability. This could be achieved through using pre-existing frameworks for programme
285 evaluation. An example is the Kirkpatrick (1976) Model that uses four levels of programme
286 evaluation as follows: Level 1 (Reaction) evaluates the participants' response to the
287 programme; Level 2 (Learning) measures knowledge and skill acquisition; Level 3 (Behaviour)
288 measures the application of knowledge into practice; and Level 4 (Results) measures the degree
289 to which outcomes occur as a result of the programme. This model proved effective in a number

290 of nursing contexts including problem-based education (Clark et al. 2013), simulation
291 (Coffman et al. 2015), and cardiopulmonary resuscitation training (Dorri et al. 2016).

292 The organisation of future leaders in compassionate care programmes should reflect the
293 work situation of nursing and midwifery leaders and their practical concerns in relation to
294 programme delivery and layout. Moreover, given the positive outcomes achieved, high-level
295 management (i.e. Directors and Chief Directors of Nursing and Midwifery) is encouraged to
296 build an infrastructure that supports nurses and midwives from all levels to avail of
297 programmes such as the LCCP periodically.

298 **Conclusion**

299 This study illustrates the role of programmes such as the LCCP in enabling nurses to
300 lead change and better understand themselves, peers, patients, and their families. Overall,
301 participants were highly satisfied with the organisation, delivery, and outcomes of the
302 programme. In particular, leadership capabilities were highly developed and resulted in
303 participants reporting that they had developed the ability to apply these capabilities in clinical
304 practice. Study findings highlight the need to: (i) conduct a longitudinal study to capture the
305 long-term impact of the LCCP; (ii) compare outcomes from the LCCP to those from other
306 programmes; (iii) evaluate the impact of the LCCP on healthcare organisations and patient
307 outcomes; and (iv) promote a culture and infrastructure that support nurses and midwives from
308 all levels to avail of programmes like the LCCP.

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310

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