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

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

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

Literature Review

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

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

in a pilot pre- and post-test study, Day (2014) explored the impact of the ENGAGE card (*E*ngaged by your senior team, *N*urtured by your manager, *G*lad to come to work, *A*cknowledged by your senior team, *G*uided by your manager, and *E*mpowered to improve patient care), improvement initiatives (i.e. nursing handover, safety briefings, and manager responsibilities), and focus groups on patient and nursing (n=57) outcomes. It was found that the incidence of pressure ulcers and falls dropped to zero and the overall experience of patients was improved at three months post-test (Day 2014). Another intervention that yielded positive patient outcomes was delivered in the form of emotional touchpoints (i.e. coming into hospital, going for tests, mealtimes, and so on) and associated negative and positive emotional words (Dewar et al. 2009). These were written on cards that were distributed to patients (n=16) and their relatives (n=12). Participants reported that the touchpoints enabled them to get in touch with the positive and negative aspects of their experiences and strengthen their relationships (Dewar et al. 2009).

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

practice. Similarly, Masterson et al. (2014) found that a compassionate care programme titled "Enabling Compassionate Care in Practice" successfully increased nurses' knowledge, understanding, and application of the 6Cs (*C*are, *C*ompassion, *C*ourage, *C*ompetence, *C*ommunication, and *C*ommitment).

The "Leaders for Compassionate Care Programme"

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

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

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

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

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

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

The Evaluation

This study measured the perceptions of nursing and midwifery leaders regarding the impact of the LCCP on their personal development, learning experience, service and care delivery, programme quality, and satisfaction with the programme. Six programmes (each with approximately 30 nursing and midwifery leaders) were delivered between October 2015 and July 2016. Leaders were recruited directly through the seven geographically dispersed Hospital 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 distrusted; 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; $p \leq 0.001$).

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

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

Quality and Satisfaction with the Programme

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

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

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

References

Allen JM, Nimon K. 2007. Retrospective pretest: a practical technique for professional development evaluation. Journal of Industrial Teacher Education. 44:27-42.

Bray L, O'Brien MR, Kirton J, Zubairu K, Christiansen A. 2014. The role of professional education in developing compassionate practitioners: a mixed methods study exploring the perceptions xof health professionals and pre-registration students. Nurse Educ Today. 34:480-486. doi:10.1016/j.nedt.2013.06.017.

Bridges J, May C, Fuller A, Griffiths P, Wigley W, Gould L, Barker H, Libberton P. 2017. Optimising impact and sustainability: a qualitative process evaluation of a complex intervention at compassionate care. BMJ Qual Saf. 26(12):970-977. doi: 10.1136/bmjqs-2017-006702

Burston S, Chaboyer W, Wallis M, Stanfield JA. 2011. A discussion of approaches to transforming care: contemporary strategies to improve patient safety. J Adv Nurs. 67:2488-2495. doi:10.1111/j.1365-2648.2011.05706.x

Byrne M, Flood B. 2003. Assessing the teaching quality of accounting programmes: an evaluation of the course experience questionnaire. Assess Eval High Educ. 28:135-145. http://dx.doi.org/10.1080/02602930301668

Clark CM, Ahten SM, Macy R. 2013. Using problem-based learning scenarios to prepare nursing students to address incivility. Clin Simul Nurs. 9:e75-e83. https://doi.org/10.1016/j.ecns.2011.10.003

Coffey A, Saab MM, Landers M, Cornally N, Hegarty J, Drennan J, Lunn C, Savage E. 2019. The impact of compassionate care education on nurses: a mixed-method systematic review. J Adv Nurs. [In Press].

Coffman S, Doolen J, Llasus L. 2015. Programme development and evaluation of the concierge model of simulation. Online Journal of Nursing Informatics (OJNI). Available from

http://www.himss.org/programme-development-and-evaluation-concierge-model-simulation

Day H. 2014. Engaging staff to deliver compassionate care and reduce harm. Br J Nurs. 23:974-980. doi:10.12968/bjon.2014.23.18.974

Department of Health and Social Care. 2015. 2010 to 2015 government policy: compassionate care in the NHS. UK: Department of Health and Social Care. Available from https://www.gov.uk/government/publications/2010-to-2015-government-policy-compassionate-care-in-the-nhs/2010-to-2015-government-policy-compassionate-care-in-the-nhs

Dewar B, Cook F. 2014. Developing compassion through a relationship centred appreciative leadership programme. Nurse Educ Today. 34:1258-1264. doi:10.1016/j.nedt.2013.12.012

Dewar B, Mackay R, Smith S, Pullin S, Tocher R. 2009. Use of emotional touchpoints as a method of tapping into the experience of receiving compassionate care in a hospital setting. J Res Nurs. 15:29-41.

Dewar B, Pullin S, Tocher R. 2011. Valuing compassion through definition and measurement: Belinda Dewar and colleagues describe a project that has enabled clinicians to improve patients' experience by identifying and changing aspects of care. Nurs Manag. 17:32-37. doi:10.7748/nm2011.02.17.9.32.c8301

Dorri S, Akbari M, Sedeh MD. 2016. Kirkpatrick evaluation model for in-service training on cardiopulmonary resuscitation. Iran J Nurs Midwifery Res. 21:493-497.

Drennan I. 2012. Masters in nursing degrees: an evaluation of management and leadership outcomes using a retrospective pre-test design. J Nurs Manag. 20:102-112. doi: 10.1111/j.1365-2834.2011.01346.x.

Francis R. 2013. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Available from https://webarchive.nationalarchives.gov.uk/20150407084231/http://www.midstaffspublicinquiry.com/report

Funkhouser E, Vellala K, Baltuck C, Cacciato R, Durand E, McEdward D, Sowell E, Theisen SE, Gilbert GH; National Dental PBRN Collaborative Group. 2017. Survey Methods to optimize response rate in the national dental practice-based research network. Eval Health Prof. 40:332-358. doi:10.1177/0163278715625738

Grove SK, Gray JR, Burns N. 2015. Understanding nursing research: building an evidence-based practice (6th ed.). Missouri: Elsevier Saunders.

Health Service Executive. 2015. Building a high quality health service for a healthier Ireland, Health Service Executive Corporate Plan 2015-2017. Available from https://www.hse.ie/eng/services/publications/corporate/corporateplan15-17.pdf

Hill LG, Betz DL. 2005. Revisiting the retrospective pretest. American Journal of Evaluation. 26:501-517. https://doi.org/10.1177/1098214005281356

Hyde A, Coughlan B, Naughton C, Hegarty J, Savage E, Grehan J, Kavanagh E, Moughty A, Drennan J. 2016. Nurses', physicians' and radiographers' perceptions of the safety of a nurse prescribing of ionising radiation initiative: a cross-sectional survey. Int J Nurs Stud. 58:21-30. doi:10.1016/j.ijnurstu.2016.01.004

Kirkpatrick DL. 1976. Training and development handbook: a guide to human resource development. R. L. Craig (Ed.). New York: McGraw-Hill.

Kirkup B. 2015. The Report of the Morecambe Bay Investigation. The Stationery Office. Available from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

Lown BA. 2014. Toward more compassionate healthcare systems; comment on “Enabling Compassionate Healthcare: Perils, Prospects and Perspectives.” Int J Health Policy Manag. 2:199-200. doi:10.15171/IJHPM.2014.41

Luxford K, Safran DG, Delbanco T. 2011. Promoting patient-centred care: a qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving the patient experience. Int J Qual Health Care. 23:510-515. doi:10.1093/intqhc/mzr024

MacArthur J, Wilkinson H, Gray MA, Matthews-Smith G. 2017. Embedding compassionate care in local NHS practice: developing a conceptual model through realistic evaluation. J Res Nurs. 22:130-147. doi:10.1177/1744987116678901

Masterson A, Robb E, Gough P, Machell S. 2014. Inspiring senior nurses to lead the delivery of compassionate care: Abigail Masterson and colleagues describe an innovative programme that gave participants the confidence to make changes in practice and return to the core values of nursing. Nurs Older People. 26:26-30. doi:10.7748/nop.26.8.26.e622

McSherry R, Pearce P. 2016. What are the effective ways to translate clinical leadership into health care quality improvement? J Healthc Leadersh. 8:11-17. doi: 10.2147/JHL.S46170

National Leadership and Innovation Centre for Nursing and Midwifery. 2015. Launch of the Leaders for Compassionate Care Programme. Available from https://www.hse.ie/eng/about/who/onmsd/leadership/nlic%20leaders%20for%20compassionate%20care%20programme.pdf

National Leadership and Innovation Centre. 2016. Programme guide September 2016-September 2017. Ireland: HSE. Available from https://www.hse.ie/eng/about/who/onmsd/leadership/programmeme.pdf

National Leadership and Innovation Centre. 2017. National Leadership and Innovation Centre for Nursing and Midwifery Office of the Nursing & Midwifery Services Director Clinical

411 Strategy and Programmes Division HSE Information Booklet 2017/18. Ireland: HSE.
412 Available from http://www.hse.ie/eng/about/Who/ONMSD/leadership/NLIC-
413 Information-Booklet.pdf
414 O'Driscoll M, Allan H, Liu L, Corbett K, Serrant L. 2018. Compassion in Practice – evaluating
415 the awareness, involvement and perceived impact of a national nursing and midwifery
416 strategy amongst health care professionals in NHS Trusts in England. J Clin Nurs. 27(5-
417 6):e1097-e1109. doi: 10.1111/jocn.14176
418 Peters MA. 2006. Compassion: an investigation into the experience of nursing faculty. Int J
419 Hum Caring. 10:38-46.
420 Smith S, Gentleman M, Loads D, Pullin S. 2014. An exploration of a restorative space: a
421 creative approach to reflection for nurse lecturer's focused on experiences of compassion
422 in the workplace. Nurse Educ Today. 34:1225-1231. doi:10.1016/j.nedt.2014.03.003
423 Straughair C. 2012a. Exploring compassion: implications for contemporary nursing. Part 1. Br
424 J Nurs. 21:160-164. doi:10.12968/bjon.2012.21.3.160
425 Straughair C. 2012b. Exploring compassion: Implications for contemporary nursing. Part 2. Br
426 J Nurs. 21:239-244. doi:10.12968/bjon.2012.21.4.239
427 Zubairu K, Christiansen A, Kirkcaldy A, Kirton JA, Kelly CA, Simpson P, Gillespie A, Brown
428 JM. 2017. An evaluation of National Health Service England's Care Maker Programme:
429 a mixed-methods analysis. J Clin Nurs. 26(23-24):4634-4645. doi: 10.1111/jocn.13809