How did the Creating Learning Environments for Compassionate Care (CLECC) programme come to be? What methods were used to explore the feasibility of implementing the CLECC programme on hospital wards for older people? This article shines a light on the design and planning of the CLECC study. It is the second article in a six-part series explaining how research projects develop and how researchers ask questions in ways that can bring about changes in practice.

‘Post-Francis’ research

In 2013, the National Institute for Health Research (NIHR) invited applications for research that would help NHS organisations provide more compassionate care following the Francis report. Acknowledging that all organisations could learn from the ‘key system weaknesses’ identified in the report, the NIHR specifically called for “robust evaluations of interventions to improve the leadership, organisational culture and quality of frontline care” (see part 1).

I was in a good position to apply. As a nurse with a background in researching older people’s care with a focus on dignity in the hospital setting, I had plenty of relevant experience and knowledge. In 2013, I had already put a research team together and worked up some ideas to improve dementia care in hospitals. We had applied for NIHR funding for a dementia study that was later rejected, but we were able to use the ideas and design for a study that responded to the NIHR’s ‘post-Francis’ call for applications.
What is CLECC?

With Alison Fuller, an expert in workplace learning, I developed the CLECC practice development programme (Bridges and Fuller, 2015). Its philosophy is that nursing staff do not need training in how to be compassionate, but may find it useful to have a team culture that enables compassionate care. CLECC focuses on building a team and leadership that foster such a culture – an approach supported by existing evidence (Maben et al, 2012; Patterson et al, 2011) – and is designed for use by nursing teams in inpatient settings for older people.

The CLECC programme starts with a study day, during which team members get a chance to meet outside of the ward setting. This gives them the opportunity to experience some of the techniques, develop an understanding of the underlying ideas, and recognise their role in the learning journey. The Best Practice for Older People in Acute Care Settings guidance is used to guide discussion and focus on the importance of relationship-centred care (Bridges et al, 2009; Nolan et al, 2006). Staff complete a questionnaire about the culture on the ward and discuss what it is like to work there.

A four-month implementation period (Box 1) leads to a longer-term period of service improvement. Towards the end of the implementation period, the ward manager and team are encouraged to put together a plan for taking the CLECC ideas forward; they present the plan to a senior manager at the trust, identifying any resources they will need.

Setting up the study

When something new like CLECC is developed, there are three important questions to be answered:

- Can it be put into practice in ‘real-world’ settings?
- Does it make a difference to patient outcomes (and if so, under what circumstances)?
- Is it good value for money?

The CLECC study (Bridges and Fuller, 2015) laid the groundwork for answering these three questions. It focused on feasibility: the feasibility of CLECC in practice, the feasibility of measuring what difference it makes, and the feasibility of working out its value for money.

Answering these questions requires a team with different skills, as no one person is an expert in all areas. The research team I assembled had the collective expertise to design and deliver a study that would meet these different aims (Box 2).

Box 1. What happens during CLECC implementation?

During the implementation period, CLECC activities are led by a band 7 practice development nurse, who works with all members of the nursing team – both registered nurses and healthcare assistants – to try out new ways of working. Daily mid-shift five-minute cluster discussions are held with all nursing staff to establish how each team member is and offer support if needed.

The ward manager takes part in a monthly ‘action learning set’ to develop their leadership role in relation to compassionate care. They regularly meet their matron to discuss the programme and its progress.

Two team members take time out of their clinical role to observe patient care, focusing on the quality of interactions between nursing staff and patients. The results are shared with the team in twice-weekly reflective sessions. Questionnaire results from the study day at the start of the programme and other activities are also discussed in these sessions.

My co-investigators were all involved in putting the application together and in making decisions about the study once it was under way. A number of other people became involved, including researchers to collect and analyse data, research nurses to recruit patients, practice development nurses (PDNs) to implement CLECC, and patient representatives to give their perspective on the work.

We applied to the NIHR in May 2013. Our project was shortlisted and we were invited to submit a more detailed application (see part 1). This was sent to experts in the field who assessed its merits and weaknesses. The funding panel then met to make a decision. At that stage, we were asked to make some minor changes to our proposal and, in August 2014, a £485,000 funding award was confirmed. We applied for ethical approval, appointed the research team, got everything set up and began data collection in March 2015.

Testing CLECC in practice

Finding out whether CLECC would work in practice meant testing it out in more than one place and paying close attention to what actually happened (Bridges et al, 2018). We tested it in two NHS trusts in three medical wards for older people and two trauma and orthopaedics. PDNs were appointed to introduce CLECC in each ward from May 2015. We also had two control wards (one older people’s medical and one surgical ward) that continued with ‘business as usual’.

We suspected that what would happen with CLECC would probably be different on each ward, so we collected information about each ward, such as staffing (establishment, vacancies, skill mix, turnover and use of agency staff), bed numbers, patient types and average length of stay.

We interviewed staff from each ward at the beginning, midway through the implementation period, and a few months after the end of the implementation period. Individual perspectives can change over time, so we wanted to capture that. Different people have different perspectives on service change, so we tried to interview at least one person from each staffing band on every ward.

Interviews were carried out individually, often on the ward but away from patient care areas. They focused on whether CLECC was workable and whether it would be possible to integrate it into ward life. We audio-recorded the interviews and had them transcribed word for word. In total, we conducted 47 interviews with 25 people.

We also observed some of the learning activities and asked the PDNs to keep a diary of their experiences.

Measuring the difference

Many studies of improvements such as CLECC use a ‘before-and-after’ design; that is, they measure something, introduce a change, and then measure again. If a positive difference is found, it is often claimed that it is due to the change introduced, but this is a false claim. One cannot actually be sure about what has caused the difference.

A study design that can overcome this uncertainty is a randomised controlled trial (RCT). In an RCT, you still measure something, introduce a change and then measure again. If a positive difference is found, it is often claimed that it is due to the change introduced, but this is a false claim. One cannot actually be sure about what has caused the difference.

In the case of our study, allocating individual patients or staff to experimental or control conditions would not have made sense, because CLECC targets a ward team rather than individuals, so we randomly allocated four ward teams to the ‘experimental’
arm and two ward teams to the 'control' arm. In this kind of design, the group (in this case the ward team) is known as a cluster, so the study is called a cluster RCT.

**What to measure and when**

We also had to consider what outcomes we thought CLECC could achieve. What difference did we think CLECC could make? We reviewed the literature to work out how compassionate care had been measured in the past (Blomberg et al, 2016). We could not find agreement on what to measure and how, or strong enough research on outcome measures that would have made our choice obvious. We, therefore, decided to test out three outcomes:

- Quality of interaction between patients and staff;
- Nursing staff self-reported empathy;
- Patient-reported evaluation of emotional care.

We measured these outcomes twice: once before the start of the CLECC programme and once four months after the implementation period had ended. We left a four-month gap because we wanted to see whether CLECC 'stuck' in practice. If we had measured again straight after the first four months, we would not have learned anything about sustainability.

**Box 2. Research team’s expertise**

I have experience of a range of research methods, with particular expertise in qualitative methods such as observations of practice and semi-structured interviews. I have also done a lot of research in hospital settings with nursing staff and with older people, including people with dementia, so I had a good idea of what would work and what the constraints would be.

Alison Fuller, who helped design CLECC, brought her expertise in qualitative research.

Rosemary Chable and Greta Westwood, both senior nurses working in the NHS, helped design a study that would be workable in busy NHS settings.

Ava-Van Sayer, an academic geriatrician, brought expertise from her field of work.

My deputy was Peter Griffiths and the statistician on the study was Ruth Pickering. Both have plenty of experience of running randomised controlled trials, which was very relevant.

Finally, health economist Lily Yao helped develop the ‘value for money’ part of the study.

**References**


Patterson M et al (2011) From Metrics to Meaning: Culture Change and Quality of Acute Hospital Care for Older People. Bit.ly/NHRPatterson2011


**Conclusion**

A number of methods – qualitative and quantitative – were used to explore the feasibility of putting CLECC into practice, of evaluating its impact and of assessing its value for money. Because this was not a mature area of research, it made sense to focus on feasibility. We needed to do this study to lay the groundwork for a more definitive evaluation of CLECC. A mixed-methods approach allowed us to answer more than one question and evaluate feasibility from more than one perspective. Part 3 will look at how to read the research findings of the study.

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**Measurement tools**

We measured the quality of interaction using the Quality of Interactions Schedule (QuIS) (McLean et al, 2017; Dean et al, 1993), which is used to observe interactions between staff and one or more patients. Interactions are rated as ‘positive social’, ‘positive care’, ‘neutral’, ‘negative protective’ or ‘negative restrictive’. We carried out 120 hours of observation balanced between the wards, days of the week (Monday-Friday) and times of day (8am-10pm).

We invited patients to complete a questionnaire known as PEECH (Patient Evaluation of Emotional Care in Hospital) (Williams et al, 2011). Older people, especially those with dementia, are often excluded from research, but we wanted to make sure that they would be able to participate as much as possible. We, therefore, trained our team to work with patients in an inclusive way, drawing on consent principles and the Mental Capacity Act (Dewing, 2008; Department for Constitutional Affairs, 2007). Patients could be given help to complete the questionnaire if they wanted.

We asked all nursing staff to complete a written questionnaire that included the Jefferson Scale of Empathy, a 20-item questionnaire validated for use with health professionals (Hojat et al, 2001). For example, staff are asked to rate their agreement with the statement: “I try to imagine myself in my patient’s shoes when providing care to them”. In each hospital we gave high-street shopping vouchers to the team with the highest staff questionnaire response rate.

As groundwork for assessing CLECC’s value for money, we calculated its costs (primarily PDN and ward staff time), using some of the interviews with staff to explore whether CLECC activities increased staffing requirements. We also tested out inviting patients to complete quality-of-life questionnaires as part of assessing the benefit for the money spent.

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