**Coordinating Compassionate Care Across Nursing Teams: The Implementation Journey of a Planned Intervention**

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**Abstract**

Bridges and colleagues offer important insight into how elements of context can be identified and mobilised in planned improvement efforts targeted at health care delivery. Their analysis of the implementation journey of a compassionate care intervention targeted at hospital ward nursing teams highlights the implications for intervention design and implementation.

They report that the degree of impact and sustainability of such interventions is highly context-specific, mediated by factors at micro and meso level. Bridges and colleagues conclude that design and implementation of care interventions should include the identification and mobilisation of contextual elements that bear directly on individual health care professionals’ capacity to provide the nature and quality of care desired.

**Keywords**

Implementation, intervention design, compassionate care, nursing, hospitals, older people.

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Delivering care that combines compassion with clinical and cost effectiveness is a priority for health systems globally and in the UK. We define compassionate care as care that focuses on the patient or client as an individual person, with needs and desires, and worthy of dignity, rather than exclusively as a task-focus of health work. In the UK, the findings of the Francis inquiries into care failures at Mid Staffordshire NHS Foundation Trust have been the stimulus for renewed attention on compassionate care (Francis, 2010, Francis, 2013). As Francis’ findings reflected, older people in hospital are a group at particular risk of a lack of compassion in their care. A recent study into NHS wards with high numbers of older patients in two hospitals reported that 10% of all staff-patient social interactions are negative (Barker et al., 2016). Addressing the problem of promoting health professionals’ delivery of compassionate care has largely focused on interventions that encourage individual professional behaviour change (Blomberg et al., 2016). However, the results of these interventions are uneven, and the evidence base to support them is under-developed. Against this background, our understanding of how to embed such interventions at a whole system level (across a team, clinical directorate, or whole hospital) is limited. While there is evidence about the role of contextual factors in shaping health professional-patient interactions, such research has tended to focus on the ways that contexts place constraints on practice, particularly the way that work is defined, and workload distributed and organised. Nevertheless, context can also be considered as elements in one’s environment that influence individual action, such as policies, norms, technology and resources. Therefore, without a more complete understanding of the role of contexts, further development of interventions that aim to engender individual behaviour change on their own, are unlikely to support the promotion of compassionate care in hospital.

Research that focuses on implementation of planned interventions indicates that contexts (e.g. role definitions, organising logics, material and informational resources for practice) can be understood as both sources of complexity (May, 2013, May et al., 2016) and as dynamic resources for improvement (Cammer et al., 2013, Hawe et al., 2009, Pfadenhauer et al., 2017, Rycroft‐Malone, 2008). Discerning how individual behaviour change processes amongst hospital-based professionals are shaped by dynamic structural and relational elements of context can lead to improved knowledge of how interpersonal, person-system, and person-technology interactions can lead to normative and relational restructuring in the wider health system (Bridges et al., 2007, Hawe, 2015, Hawe et al., 2009, Hewison and Sawbridge, 2015, Hewison et al., 2018, Martin et al., 2012, May, 2013, May et al., 2016). Most importantly, the development and evaluation of interventions that mobilise elements of contexts in which professionals encounter patients are likely to increase the capacity of whole systems to support improvements in care.

Compassionate nursing care interventions tend to be focused on staff training, staff support, or introducing new models of care (Blomberg et al., 2016). Yet, our systematic review of studies to evaluate the effectiveness of compassionate nursing care interventions found that the quality of evaluation in this field tended to be poor, with mainly small-scale before-and-after studies (Blomberg et al., 2016). Although a small number of additional studies have used qualitative methods to evaluate the mechanisms for the change and impact of the intervention, and often include an analysis of the enablers and barriers to change, these studies do not examine in depth the process of implementation itself. As such, these studies are unable to systematically identify the contexts in which successful implementation is more likely to occur, or, in cases where contexts are unreceptive, how resources, relationships, and norms in the wider system may need purposeful restructuring to support implementation and sustain longer-term change (Bridges et al., 2018). This chapter seeks to more thoroughly investigate the processes and outcomes of implementing an intervention, Creating Learning Environments for Compassionate Care (CLECC), aimed at supporting the delivery of compassionate care by hospital teams. This detailed study is guided by Normalization Process Theory (NPT), an implementation theory that identifies, characterizes, and explains empirically demonstrated factors that shape implementation processes and their outcomes (May et al. 2018).

CLECC is underpinned by workplace learning principles to inform leadership and team practices (such as dialogue, reflective learning, mutual support, and role modelling) that support the ongoing relational capacity of individual team members (Bridges and Fuller, 2015, Fuller, 2007, Fuller and Unwin, 2004, Wenger, 1998). We define relational capacity here as the capacity to embed and sustain compassionate caring practices within a complex and dynamic organisational context. We build on the assumption, from our previously published work, that relational capacity is a property of the necessary ward-level conditions that support caring work, and thus improve patient experiences (Bridges et al., 2013, Bridges and Tziggili, 2011). CLECC’s focus on the work team draws on research indicating associations between work group mechanisms that promote shared norms, social and practical support for individual members, and care quality (Bolton, 2005, Maben et al., 2012, Parker, 2002, Patterson et al., 2011).

CLECC (Bridges et al., 2009, Bridges and Fuller, 2015) was implemented in each of the four ward settings over a four-month period, with a view to embedding and sustaining new practices (Table 1). Implementation was facilitated by a senior practice educator, a clinically-trained member of the hospital staff seconded to the ward team. The intervention consisted of a set of:

1. Regular CLECC meetings between the ward manager and matron to enrol individuals in CLECC.
2. Action learning sets to facilitate ward managers to explore their role in leading and supporting CLECC in their teams.
3. Team learning activities, including study days and twice weekly reflective discussions on results from team exercises, including climate analysis, values clarification, and peer observations of work with patients.
4. Mid-shift five-minute cluster discussions to support each other’s wellbeing through social support and rebalancing individual workloads when needed.
5. Team-developed learning plans to share with senior hospital managers; learning plans included sustainability measures for practices that underpin the delivery of compassionate care, such as identifying and requesting resources needed for ward managers to continue to attend action learning sets.

Table 1: CLECC set activities

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Activity** | **Month 1** | **Month 2** | **Month 3** | **Month 4** |
| **Ward manager action learning sets** | Session 1:Set up set, establish ground rules | Session 2:Focus on workplace climate, team values, valuing staff | Session 3: Focus on enhancing team capacity for compassionate care | Session 4:Focus on influencing senior managers |
| **Team learning plan** | Introduce and discuss learning plan | Discuss ward leader drafts | Finalise, identify resources needed to support, present | Senior manager gives feedback on team plan |
| **Ward manager/matron meetings** | Introduce and discuss | Ongoing – every two weeks | Ongoing – every two weeks | Ongoing – every two weeks |
| **Peer observations of practice** | Identify two volunteer observers from staff team | Train observers | Observe practice | Give feedback on observations of practice |
| **Team study day (all staff)** | Team analyses workplace climate, clarifies values | - | - | - |
| **Mid-shift cluster discussions (all staff)** | Ongoing | Ongoing | Ongoing | Ongoing |
| **Reflective discussions (twice weekly) (all staff)** | "I feel valued at work when…" exercise | Team values clarification exercise; BPOP activities (Bridges et al., 2009)  | BPOP activities (Bridges et al., 2009); Team learning + service user feedback plan discussions | Reflections on feedback from observations of practice |

Each practice educator worked simultaneously with two wards in their allocated hospital, organising specified CLECC activities.

**Methods**

A qualitative process evaluation of CLECC was undertaken, guided by NPT (May, 2013, May and Finch, 2009, May et al., 2016). We sought to understand the dynamics of implementing a complex relational intervention, and to explain the extent to which CLECC was incorporated into existing work practices. Recognising that little is understood about identifying and mobilizing elements of context in health care interventions, we applied NPT to our analysis of CLECC, a theory developed from multiple studies of many different health care systems. NPT provides a robust framework for analysis of system implementations in that it ‘identifies, characterises, and explains mechanisms that have been empirically demonstrated to motivate and shape implementation processes and affect their outcomes’ (May et al. 2018). Because NPT focuses on outcomes of individuals and groups, rather than intentions or beliefs in outcomes, we apply its four dynamic processes (coherence, cognitive participation, collective action, and reflexive monitoring) that motivate and shape implementation processes (May and Finch, 2009).

Part of a wider feasibility study of CLECC implementation and evaluation (Bridges et al., 2018), our evaluation of the implementation of the complex relational intervention focused on:

1. Exploring how and in what ways the new practice was initially received, how people conceptualised and made sense of it individually, collectively, and in practice (coherence).
2. Assessing the degree of ownership of and participation in the new practice by key individuals and teams (cognitive participation).
3. Identifying the work that individuals and teams did to enact the new practice (collective action).
4. Exploring the perceived impact of the new practice on staff work and on patient outcomes (reflexive monitoring).

The CLECC intervention was introduced to four inpatient wards in two general National Health Service (NHS) hospitals in England. Wards with relatively high proportions of older patients (medicine for older people, and orthopaedics) were recruited through ward manager agreement.

Individual face-to-face semi-structured interviews were undertaken with staff over a 12 month period beginning in May 2015, at the outset of the implementation period, followed by two further interview rounds (at 3-6 months, and 7-12 months) (Figure 1). Purposive sampling was used to capture variations in staff grade and ward. Participants were invited to take part in repeat interviews so that variations in implementation over time could be tracked. Where there was attrition, new participants were recruited to maintain ward and grade variation. Senior nursing managers were invited to an interview in the final phase. Interview schedules reflected NPT dynamic processes and changed over time to reflect implementation stages. Interviews were conducted by university researchers and lasted on average 46 minutes. Interviews were audio-recorded and transcribed verbatim. Practice educators leading CLECC implementation kept detailed field notes. A sample of CLECC learning activities was also observed by researchers (n=7 over 26 hours). Staffing data were gathered through a ward manager questionnaire.

Figure 1: CLECC process evaluation timeline



Data analysis involved reading, familiarizing, and open coding, undertaken independently by research team members and then collaboratively in data analysis workshops. A preliminary coding frame focused on implementation and mechanisms of impact. All interview data were coded against this frame. The use of constant comparison enabled the generation of new categories and the comparison of data in relation to these categories. Narrative data summaries and matrix/charting techniques were then used to facilitate comparison with the NPT framework to test and refine emerging theories of implementation processes (Pope et al., 2013). All data from observer and practice educator field notes, and from quantitative analyses of staffing data, were then systematically interrogated and compared against these emerging theories, the purpose being to use multiple perspectives to elicit more complex and situated understandings (Richardson, 2000). Ethical approval for the study was granted by the Social Care Research Ethics Committee 14/IEC08/1018.

**Findings**

In total, 47 interviews were conducted with ward managers (n=4), deputy ward managers (n=2), registered nurses (RNs) (n=8), health care assistants (HCAs) (n=7), senior hospital nurses (n=2), and practice educators (n=2). Ward-based interviewees had worked on their current ward between two weeks and 14 years, on average for four years. Two study days and five action learning sets were observed in full.

Findings illustrate the work that staff needed to do, individually and collectively, to implement CLECC in practice. While many of the individual elements of CLECC were possible to implement during the implementation period, sustaining such work beyond this time was difficult for some ward teams to achieve. The findings that follow explain how and why this was the case.

**Coherence: CLECC as a limited set of concrete practices versus as an underpinning philosophy**

Interview and observation data clearly indicated that all care staff were able to articulate activities associated with the CLECC intervention. Staff valued the principles behind many concrete CLECC activities, appreciating the focus on staff wellbeing and consequent impact on patient care quality. For RNs, the CLECC principles resonated with their aspirations for successful teamwork and patient care. For HCAs, the intervention was a new and welcomed way of thinking about their workplace. Nevertheless, beyond the activities staff were directly involved in, they struggled to explain the purpose and potential of CLECC. Even so, staff tended to associate CLECC with cluster discussions that took place part way through each shift, thus providing an opportunity to gather as a team and check on each other’s wellbeing.

So, whereas before they might know that orange bay is heavier [in workload] than green bay, they might not necessarily have volunteered to go and help. Now they are much more aware that if [staff in orange bay]are going ‘well actually we're struggling’; [we realize] ‘well, we're not, we'll come and help you’. And I think that's because of the [clusters] and the fact that we're all sitting down and going ‘is there anything we can do to help you?’ And if they are going ‘well actually I've got a really poorly patient, so I've been struggling with the others’; [we say] ‘right, well then, we'll come and help you’. And it's made them more aware of each other. **N003[[1]](#endnote-1) (HCA, Hospital A)**

All staff attended the study days and, on prompting, were able to associate these sessions with CLECC. Furthermore, participating in a study day where only other team members were present was considered unusual and was welcomed.Staff saw the study day as a way of ensuring that they were working together and as an opportunity to engage with the ward vision, which was not previously explicit. The most important aspect of the study day was the chance to get to know each other, which staff reported they had not had the opportunity to do previously. As a result, the study days served to promote coherence or sense-making work around CLECC, but also team cohesion.

We had the study days and they were all very good, and I found that I got to know the different people within those study days, or how they felt and I thought: ‘oh, I didn't know that’. So that was useful. **N001 (Staff Nurse, Hospital B)**

The ward managers and practice educators charged with facilitating CLECC were involved in a wider range of CLECC activities; these individuals and the senior nurse managers were generally able to provide a more articulate philosophy of CLECC and to identify associated behaviours.

 To me, CLECC is about giving staff tools to ensure that they support themselves to do a hard job. So it’s about providing a nurse with the knowledge of what they need to deliver ... compassionate care or high-quality person-centred care, whatever you want to describe it as – every day, at a high quality standard, [That] is what we have to aim for, but also with you having some insight into how your behaviour affects both your patient and your staff. **SN002 (Senior Nursing Manager, Hospital B)**

On average, over one third of staff left over the course of the study, and this turnover rate was consistent with other (control) wards we were monitoring.There was, however, no provision for this turnover in the design of CLECC delivery through a one-off implementation period, which limited the opportunity for staff arriving after this period to make sense of CLECC.

In summary, although ward staff appreciated the potential value of CLECC, their understanding of CLECC was limited to and shaped by the concrete activities that they participated in.

**Cognitive participation: staff keen to participate but not sure who should drive it forward**

Staff were keen to participate in CLECC, but there were varied levels of clarity between the teams and hospitals about whose responsibility it was to ensure CLECC was implemented. Each practice educator took a different approach to their role, and these differences were enabled by the relative flexibility of the intervention. Such differences in practice educator approach, and their interactions with existing ward cultures, influenced the ward staff’s degree of ownership of the intervention. For example, one practice educator (in Hospital B) was perceived to have a relatively autocratic style of leadership, seeing her role as informing teams how to do things , rather than working alongside them to support them in changing practice. In this way, the practice manager passed the responsibility for CLECC to teams before they had learned how to take ownership.

[The practice educator] was very adamant that it wasn't her responsibility to [make sure the cluster discussions were convened]; it could have been anybody's [responsibility]…. **N008 (HCA, Hospital B)**

After the implementation period, staff on some wards reported that cluster discussions were no longer taking place, attributing the cessation to the fact that no one was actively implementing them. In contrast, another practice educator (Hospital A), who was perceived to have a more democratic style of working, actively worked with staff to make CLECC more flexible and fit better with resource pressures.

It [cluster meeting] doesn’t always stick to that time. It kind of depends how it’s going. So we’ve had, like, busy days when stuff’s been happening on the ward. At one point they [nursing staff] kind of ask permission to make it [cluster meeting] later. It’s kind of sad. But I’m like…’yeah, do it whatever time it works in the ward. If we can do it, that’s a bonus.’ So, quite often it’s the [HCAs] asking for it [cluster meeting]. **N035 (Practice Educator, Hospital A)**

Although this practice educator and more senior team members initially originated the cluster discussions, as the intervention became embedded over time, other team members, including HCAs, initiated cluster discussions without waiting for more senior direction. The cluster discussions on these wards continued to run after the implementation period.

They [HCAs] will remind whoever is in charge of the ward, and say “Are we having a [cluster] today?” I’ve seen that quite a few times. **N035 (Practice Educator, Hospital A)**

CLECC also gave staff in all participating teams, including HCAs, the opportunity to see themselves as innovators, providing a mechanism through which individuals could articulate their ideas for improving practice on the ward. As a result, staff felt more empowered than before to respond to ideas and to implement change. They approached the ward manager and the matron simultaneously, when previously communication was directed through the ward manager.

Quite a few of the staff have [become] involved in various different things that have come out of the study days – what they wanted to change, and thought they could do better. And they’ve gone off [in] sort of little groups, or twos and threes, and are bringing that stuff back, passing it through the matron. **N030 (Ward Manager, Hospital B)**

However, not all ideas were implemented in practice, and this appeared to be linked with uncertainty in certain teams about whose role it was to realise or authorise the implementation of particular ideas that emerged. In one team in Hospital B, since staff clearly expected that the ward manager or matron had the requisite authority to realise proposed ideas, their lack of “follow through” evidenced in later interviews was demoralising for the staff involved.

Some of them felt a little bit disappointed that they'd made these suggestions and [the staff] took their time to [develop the ideas], and then no one really followed it through or said ‘yes, we can use that or no we can't’. It just got left. **N001 (Staff Nurse, Hospital B)**

Nevertheless, all interview participants conveyed that they saw CLECC as a way to build the team and improve care, and this ethos underpinned their participation in prescribed activities. Consequently, study days and action learning sets were all well attended across the teams. Even so, fortnightly CLECC meetings between ward managers and their matrons did not proceed in one hospital site (Hospital B), indicating a lack of clarity about the role of the matron in implementing CLECC activities.

Both ward [managers] felt that there has been a negative impact [on CLECC implementation] from the lack of support from the matron. Items identified by the nursing teams that were considered areas requiring improvement were unsupported, and even, in some instances, rejected. **N036 (Practice Educator field note, Hospital B)**

The early establishment and continuation of meetings between ward managers and their matrons at the other hospital site (Hospital A) appeared to be linked with a more proactive matron role in supporting CLECC.

So my matron's been very supportive the whole way through; we've kept in regular contact. She's been asking for updates, she's known about the interventions that we've done on the ward and has been really supportive. **N034 (Ward Manager, Hospital A)**

Furthermore, levels of cognitive participation varied between the ward managers, and this shaped CLECC implementation by their teams. In Hospital A, the Ward A manager was initially skeptical about CLECC, but found it a helpful way to manage continuity through the disruption caused by two major ward relocations and changes in team membership during the project. Ward B manager (Hospital A) was new to the ward and her post, and embraced CLECC enthusiastically as a way to establish the team and guide her leadership. Ward D manager (Hospital B) expressed a high level of support for CLECC and attended all the study days and action learning sets, but struggled with team cohesion owing to a large influx of new staff that outnumbered the original team members. The manager of Ward E (Hospital B) kept a distance from CLECC, sending her deputy in her place to the study days and the ward manager action learning sets. Consequently, while the majority of staff were eager to participate, the extent to which individuals saw it as their role to undertake specific CLECC activities varied between teams and hospitals.

**Collective action: participation shaped by organisational context**

Whether or not the activities went ahead as planned was mediated by the extent to which the proposed activity harmonised with the priorities of the wider hospital organisation and resources available to the ward team. A particular influence was the organisational priority afforded to material patient care activities over CLECC activities in the context of high patient care workloads. Although staff in all teams reported struggling to find the time to engage with the five minute cluster discussions, the planned 20 minute reflective learning sessions were perceived to be impossible to integrate into ward practice. CLECC’s flexibility enabled staff to develop strategies that partly overcame time barriers.

Because [the clusters are] five minutes you can work it and actually if you're having a day where you're too busy to run them, then that's the day that you realise that you need to go round and make sure everyone's okay… And I think that's definitely been my biggest struggle throughout it all – it's just being able to release staff to do things. **N005 (Ward manager, Hospital A)**

Despite these struggles, staff reported that senior hospital managers in both hospitals had endorsed the work that had resulted from the CLECC intervention, suggesting that the benefits were visible and valued outside of the immediate ward team.

They seemed to be really positive about it and [the visiting senior manager] said – ‘if this is working for you, continue.’ **N009 (HCA, Hospital B)**

Nonetheless, staff’s participation in CLECC activities was viewed as of secondary importance to providing direct patient care. In Hospital B, in spite of a supportive senior manager, ward staff and the practice educator reported a lack of support from the matron for the participating wards. This lack of support was also suspected by the senior manager.

I assumed that my matron was working with the ward [managers] on a weekly basis, but I doubt it was what I expected it to be. So, we should have put more nursing leadership resources into it, just to provide that support and recognise it. **SN002 (Senior Nursing Manager, Hospital B)**

Interestingly, many cluster discussions proved possible to integrate into the working day and went ahead during the implementation period. However, across all teams, cluster discussions were less readily convened when patient care demands were particularly high and staffing resource was low. CLECC properties of plasticity enabled staff to develop and adapt practices that suited local circumstances, but were constrained by the available resources and priorities of the wider organisation.

**Reflexive monitoring: valued by staff but challenging to sustain**

Staff from all four participating teams reported benefits to personal wellbeing and capacity to care from CLECC participation. They spoke of engaging more consciously and deliberately with patients as individual people, prioritising such personalised attention over the completion of tasks. Although staff reported that their practice was already compassionate, CLECC had given them opportunities to prioritise compassionate practices and to further commit to compassion.

CLECC, for me, is about giving the staff the empowerment to feel like they can sit and do things with patients that are compassionate rather than task orientated, so rather than just doing the [observations] and just doing the washes, just having a chat with the patient about their life, their family or sitting and doing an activity with them; rather than just: ‘we've got to get the washes done, we've got to get the observations done’ – which do still need to be done, but it's about giving the staff that empowerment of being able to say: ‘let's do something a bit different’. **N034 (Ward Manager, Hospital A)**

CLECC was associated with an improvement in staff morale and staff wellbeing and viewed as impacting positively on patient care. The legitimacy for CLECC practices seemed to come partly from the fact that staff were part of a named programme, and perhaps because they were also part of a research study. One interviewee cited an instance in which a senior manager (Hospital A) visiting the ward came across a cluster discussion, which was also used by some teams to make sure that staff had a drink of water. This shared concern for colleagues belied appearances, initially being seen as simply taking an unscheduled break.

I don’t know who it was, but someone very high in the hospital [came to the ward] and was like, ‘why are people standing and drinking in the corridor?’ **N025 (HCA, Hospital A)**

Once the manager was told the cluster discussion was part of CLECC, she was reported to have then understood the purpose behind an activity considered unusual enough to remark upon.

Furthermore, the improved teamwork reduced the burden for some staff and provided opportunities to undertake activities that previously would have been rare occurrences.

… Because of the task orientated work, we've managed to go, ‘right, we've finished, [they] haven't’ and then so we can go ‘right, we'll give you guys a hand and then we can all be finished together.’ And then that means we've got more time to do things that we might not be able to normally do, like, wash someone's hair, do their nails.” **N009 (HCA, Hospital B)**

The principles of compassion and concern that underpin CLECC continued to be understood and valued across the teams, even several months after the implementation period. Hospital A ward teams continued with the cluster discussions, a concrete marker of CLECC’s sustained impact. Although Hospital B wards had not continued, their overall, attention to supporting each other appeared to have increased the relational capacity of individual team members and the team as a whole, at least setting a memorable norm for working more closely together.

**Discussion**

The CLECC intervention was feasible in practice, welcomed across the teams, and served as a broader stimulus to collective action. CLECC developed cultures, at least temporarily, in which reflection, learning, mutual support, and innovation were more legitimate within the work-team, and in which expertise was seen to be distributed more widely among team members. However, the findings also indicated that the degree of impact and sustainability were highly context-specific and were mediated by factors at ward-team level and at other levels of the organisation.

Staff at all levels of the hierarchy were able to identify the benefits to patient care of ward staff engaging in CLECC activities, echoing other findings that the creation of unmanaged spaces for work-team members to “take shelter” provides the potential for valued learning and social support for difficult work with clients (Bolton, 2005, Parker, 2002)(Bolton 2005, p.134). Furthermore, our findings confirm that intervening at work-team level can be successful, corroborating an association indicated in other research (Bridges and Fuller, 2015, Maben et al., 2012, Mimura and Griffiths, 2003, Patterson et al., 2011). Despite high workloads, CLECC empowered managers and frontline care staff to reflect on local norms governing team practice, on the relationships and resources that aligned with them, and to make some changes. Thus, interventions at work-team level can play a part in shaping relational capacity (Billett, 2004). However, we also found that implementation was uneven between hospitals and teams, particularly over the longer term, reinforcing the value of both tailoring intervention to particular contexts and paying attention to the sustainability of complex interventions beyond initial set-up (Bridges et al., 2007, Bridges et al., 2017, Martin et al., 2012, May, 2013).

Team-specific factors, and factors outside of the direct influence of the ward teams, mediated the impact and sustainability of the intervention. Such factors included norms regarding the legitimacy and nature of nursing work; staff learning and staff support; interpretation of key stakeholder roles, particularly the ward manager and matron role in supporting implementation; workforce characteristics such as staffing levels in relation to patient workload; and stability of workforce over time. We saw how these factors influenced the extent to which planned CLECC intervention activities consistently took place and were sustained over time. Some factors were related to the busyness and priorities of acute care contexts, including changes in team membership between shifts and over time, while others varied across the individual settings, such as the participation of individual ward leaders.

While CLECC draws on principles of democratic working, its longer term success relies on consistent cognitive participation from more senior members of the hierarchy. Since such cognitive participation is, in turn, shaped by structural and relational elements of context, further study would be helpful here to better understand these specific features and their impact. Overall, our findings indicate the need for more study to better understand the scope, sources, and impact of variation, including a wider range of settings than studied here, to enable more systematic study of contextual layers beyond the individual teams.

Framing interventions such as CLECC as events within complex, adaptive systems focuses attention, not only on the properties of the intervention, or the actors’ contributions, or lack of contribution, to implementation, but also on the dynamic properties of the system itself (Hawe, 2015, Hawe et al., 2009). A successful intervention is one that leaves a “lasting footprint,” one that is able to trigger new and sustained structures for interaction and new shared meanings (Hawe et al., 2009)p.270). The extent to which interventions such as CLECC can sustainably transform the system depends on their engagement with their contexts and the capability this creates. Successful intervention, therefore, depends on a thorough understanding of context, as prescribed by NPT, but may well also include a deliberate harnessing of system properties to support implementation, in advance of and alongside the introduction and support of the intervention package.

**Conclusion**

This case study of a compassionate care intervention illustrates a number of implications for intervention design and implementation. Our analysis of CLECC, guided by NPT, sought to identify the dynamics of human agency in complex health care systems. In particular, the study reinforced the value of both tailoring interventions to particular contexts and paying attention to the sustainability of complex interventions beyond initial set-up. Despite staff from all participating teams reporting benefits to personal wellbeing, team building, and the capacity to care from the CLECC participation, many participants noted challenges in sustaining intervention adoption. Sustainability and success of the intervention required consistent cognitive participation from all levels of the health care service hierarchy, but particularly the engagement and participation from more senior members. Intervention implementation also required clearly defined roles and responsibilities for program implementation, given that the extent to which individuals took responsibility for CLECC implementation and operation varied between teams and hospitals. Clearly defined roles and responsibilities would also have the additional benefit of contributing to succession planning, as participants noted that CLECC did not provide for ensuring continuity following attrition in the design of CLECC delivery. This limited the opportunity for staff commencing after the initial implementation period to make full sense of CLECC.

Despite the discourse on compassionate care often primarily focused on individual caregiver disposition and agency, our findings from CLECC highlight that complex health care programs also require the support of resources, norms, and relationships located in the wider system. Successful intervention design and delivery in complex adaptive systems, such as health care, should include the careful identification and mobilisation of relevant elements of context. As our case study of CLECC demonstrates, it may be necessary to undergo extensive organizational restructuring, both culturally and structurally, to re-shape the conditions in which people are able to act and adopt change.

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1. N denotes nursing team membership, SN denotes senior nursing manager, number represents order of entry into study [↑](#endnote-ref-1)