OPTIMIZING NURSING POTENTIAL WITHIN A PUBLIC HEALTH APPROACH TO EMBRACE PALLIATIVE CARE

OPTIMIZING NURSING POTENTIAL WITHIN A PUBLIC HEALTH APPROACH TO EMBRACE PALLIATIVE CARE

by

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GLOSSARY OF TERMS

Palliative care: healthcare that is focused on improving quality of life and relieving the suffering of individuals who are facing serious illness by addressing and managing physical symptoms and psychosocial, spiritual, emotional, and practical needs (Canadian Hospice Palliative Care Association, 2024a; Government of Canada, 2024; Ontario Palliative Care Network, n.d; World Health Organization, 2020)

Palliative approach to care: the integration of palliative care with other types of care in the early phases of an illness and includes honest and sensitive discussions regarding the prognosis and trajectory of one's illness, advanced care planning, and goals of care discussions (Sawatzky et al, 2016; Quality End-of-Life Care Coalition of Canada et al, 2015)

Serious illness: an illness that has a significant impact on health and quality of life and could shorten life

End of life care: a component of palliative care that is provided to an individual in the last days, weeks, or months of their life (Canadian Hospice Palliative Care Association, 2024b; Canadian Institute for Health Information, 2023)

Public health approach to palliative care: the application of the prevention and early intervention principles of health promotion to issues of death, dying, loss, and care (Public Health Palliative Care International, n.d.c)

Compassionate Communities: neighbourhood or community networks that collaborate to support individuals living with serious illness or grief (Public Health Palliative Care International, n.d.b)

Compassionate Cities: municipal jurisdictions that have developed social policy and action based on the Compassionate Cities Charter (Abel et al, 2018a; Public Health Palliative Care International, n.d.b)

ABSTRACT

Background: Many Canadians do not receive adequate palliative care. Even though nine out of ten deaths in Canada are caused by chronic conditions, most Canadians do not receive a palliative approach to care early within their disease trajectory. Public health approaches to palliative care, specifically Compassionate Community and Compassionate City initiatives, have the potential to improve access to and quality of palliative care in Canada. Nurses have been strong partners in the development of many initiatives across Canada, yet there is no literature describing their role.

Purpose: To describe and understand the different ways that nurses are engaged in the planning and implementation of Compassionate Community and City initiatives in Canada.

Methods: The overarching methodology used to guide the design of this study was interpretive description (Thorne, 2025). Twelve one-on-one, semi-structured interviews were conducted on Zoom with ten registered nurses (n=10) and two non-nurse interdisciplinary team members (n=2) who are engaged in the planning and implementation of Compassionate Community and/or City initiatives across Canada. The data were analyzed using thematic analysis (Braun & Clarke, 2006).

Findings: The participants engaged in the planning and implementation of Compassionate Communities and Cities to support individuals who have poor access to palliative care. Nurses had three main roles in the planning and implementation of Compassionate Community and City initiatives in Canada, including: (1) catalysts who move initiatives forward, (2) health promoters who apply the health promotion principles to palliative care, and (2) bridges who form connections between community partners, researchers, and the healthcare system. The

participants also discussed the importance of integrating the public health approach to palliative care into everyday nursing practice across the healthcare system.

Conclusion: Nurses have a key role in facilitating and strengthening the spread of the Compassionate Community and City movement to improve the quality of life of individuals facing issues associated with chronic, progressive, and serious illness.

LAY ABSTRACT

Compassionate Communities and Compassionate Cities are community initiatives that focus on helping communities to support people who are facing illness or who have lost a loved one. Members of Compassionate Communities work together to support one another through these issues. Nurses can help support these initiatives in many ways. This study was done to understand how nurses help to support Compassionate Communities and Cities. Ten nurses who help to plan and start Compassionate Communities and/or Cities participated in interviews. One physician and one social worker who work with nurses doing this work also did interviews. The findings of this study were that nurses helped start Compassionate Communities and Cities by being (1) leaders and initiators, (2) health promoters, and (3) bridges. The people who participated in this study also talked about how it is important for nurses in all settings to know about and talk about palliative care. They also made recommendations for nursing education to teach nurses how to do this type of work.

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In loving memory of my Grampa, Jon Groen.

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DECLARATION OF ACADEMIC ACHIEVEMENT

This thesis reports original research that I conducted under the supervision of Dr. Sharon Kaasalainen, Dr. Susan Jack, and Dr. Melissa Northwood. The supervisory committee members provided guidance regarding the content, methodology, and analysis of this study. Scholarship funding was provided by the Nursing Graduate Program at McMaster University and by the Dr. Moyra Allen Nursing Academic Grant.

SUMMARY OF THESIS CHAPTERS

This thesis consists of six distinct chapters. Chapter One provides an introduction including a background of the thesis topic, a reflexivity and positionality statement, and an introduction to the study purpose. Chapter Two provides a literature of the thesis topic including a rationale for conducting this study and the study purpose and research question. Chapter Three provides a description and rationale of the methodology and methods used in this study. Chapter Four shares the findings of this study. Chapter Five provides a discussion of this study including a summary of key findings, a discussion of the key findings in relation to the literature, and a reflection of the methodology used, including the key strengths and limitations of this study. Chapter Six discusses the implications of this study and is followed by the study conclusion.

CHAPTER ONE: INTRODUCTION

This chapter introduces the thesis topic – nursing in a Compassionate Community and City, which includes a background of the topic including challenges in palliative care, an introduction to the concept of public health palliative care, and nursing and public health. In addition, this chapter includes a reflexivity and positionality statement and concludes with a purpose statement.

Background

Challenges in Palliative Care

As Canada's population ages, many people are living with multiple comorbidities for longer (Canadian Institute for Health Information, 2018). Canada's population of adults aged 65 and older tripled in size between 1977 and 2017 (Canadian Institute for Health Information, 2017). As of 2019, 44% of Canadian adults are living with chronic illness which can negatively impact quality of life (Hu et al, 2024; Public Health Agency of Canada, 2019). Given these demographic trends, the need for palliative care is expected to rise (Canadian Institute for Health Information, 2018).

Palliative care, as defined by the World Health Organization in 1990, is care delivered to achieve the best possible quality of life for individuals where curative treatment is no longer possible (Alcalde & Zimmermann, 2022). Given that the principles of palliative care are applicable across the illness trajectory, the World Health Organization redefined palliative care (Alcalde & Zimmermann, 2022). Currently, a more contemporary definition of palliative care includes references to being a type of healthcare that is focused on improving quality of life and relieving the suffering of individuals who are facing serious illness by addressing and managing physical symptoms and psychosocial, spiritual, emotional, and practical needs (Canadian

Hospice Palliative Care Association, 2024a; Government of Canada, 2024; Ontario Palliative Care Network, n.d; World Health Organization, 2020). A serious illness is an illness that has a large impact on health and quality of life and could shorten life (Canadian Hospice Palliative Care Association, 2024a).

A "palliative approach to care" integrates palliative care with other types of care in the early phases of an illness and includes honest and sensitive discussions regarding the prognosis and trajectory of one's illness, advanced care planning, and goals of care discussions (Sawatzky et al, 2016; Quality End-of-Life Care Coalition of Canada et al, 2015). Advanced care planning is a reflection process and discussion of what care an individual would wish to have in the future given different scenarios, which is especially important should they become unable to speak for themselves (Advanced Care Planning Canada, n.d.). Goals of care discussions involve making informed decisions about current care based on the individual's values and clear understanding of their prognosis and illness trajectory (Quality End-of-Life Care Coalition of Canada et al).

A palliative approach to care can be integrated into care at any time during an illness and should not be limited to the last few months or days of life (Canadian Hospice Palliative Care Association, 2013; Ontario Palliative Care Network, 2019b) as it is beneficial based on need, rather than stage of illness or prognosis (Canadian Hospice Palliative Care Association, 2024b). Any individual who has a chronic illness or is becoming frail may benefit from a palliative approach to care (Quality End-of-Life Care Coalition of Canada et al, 2015). A palliative approach to care leads to better outcomes when it is introduced and integrated into care early, including at the presentation of disease symptoms or time of diagnosis (Canadian Hospice Palliative Care Association, 2013; World Health Organization, 2020). Integrating a palliative approach to care early in the illness improves quality of life, increases participation in advanced

care planning, decreases depression and anxiety, decreases use of aggressive and unwanted treatment, avoids misuses of acute and critical care, decreases healthcare spending, and improves satisfaction with care (Evans et al, 2015; Ontario Palliative Care Network, 2019b, World Health Organization, 2020). Over time, as the individual moves forward in the disease trajectory and nearer to the end of their life, the focus of care may shift from disease modifying treatment to end of life care (Canadian Hospice Palliative Care Association, 2013). End of life care is a component of palliative care that is provided to an individual in the last days, weeks, or months of their life (Canadian Hospice Palliative Care Association, 2024b; Canadian Institute for Health Information, 2023).

To be accessible and sustainable, a palliative approach to care must be integrated into primary care, community care, home-based care systems, (Canadian Hospice Palliative Care Association, 2013; World Health Organization, 2020) long-term care, and hospitals (Quality End-of-Life Care Coalition of Canada et al, 2015). A palliative approach to care employs the use of a shared care model where primary care providers continue to care for the individual and palliative care specialists are available for education, support, and consultation (Quality End-of-Life Care Coalition of Canada et al, 2015). It has been recommended that all healthcare professionals working with populations of individuals with or at-risk for chronic or serious illnesses have some competency in providing a palliative approach (Ontario Palliative Care Network, 2019a). Specifically, it is important that all nurses working with these populations understand the philosophy of a palliative approach, be able to identify individuals who would benefit from a palliative approach to care, understand the role of the interdisciplinary team in a palliative approach to care, and collaborate with the team to assess and manage symptoms (Ontario Palliative Care Network, 2019a).

The early integration of a palliative approach into the overall care management process leads to a better use of healthcare resources (Quality End-of-Life Care Coalition of Canada et al, 2015). Three quarters of Canadian healthcare spending at the end of life is used for acute care services (Canadian Hospice Palliative Care Association, 2012), however, 70% of older adults prefer treatment which focuses on comfort rather than aggressive treatments (Fowler & Michael, 2013).

Many Canadians do not receive adequate care and support throughout the course of their illness. Only 15% of Canadians have access to an early palliative approach to care (Canadian Institute for Health Information, 2018). Of deaths in Ontario in 2021-2022, 40% of people did not receive any palliative care and of those who did, 50% were already in the last 22 days of their life (Canadian Institute for Health Information, 2023). Since 90% of deaths in Canada are caused by chronic disease most deaths are predictable (Government of Canada, 2018). This means that many people are known to be living with chronic or serious illnesses, yet they are not being supported within a palliative approach. It is estimated that between 62-89% of people who die would have benefitted from palliative care (Canadian Institute for Health Information, 2018). Additionally, Health Canada (2023) reported that up to 70% of people who are seriously ill in Canada do not understand that their illness is not curable and will advance over time. Some groups of Canadians have less access to care than others. Race, religion, language, geography, and housing status have all been shown to affect access to palliative care (Canadian Institute for Health Information, 2023).

Most Canadians prefer to die at home yet 60% still die in the hospital (Canadian Institute for Health Information, 2023; Government of Canada, 2024; Health Canada, 2018). In 2021-2022, only 13% of Canadians who died, died at home (Canadian Institute for Health Information,

2023). Care provided by family and friends accounts for 99% of palliative care provided at home and amounts to approximately $25 billion in unpaid labour (Canadian Institute for Health Information, 2018; Pallium Canada, n.d.a). Supports for family and friends in this role are a critical component of a palliative approach (Health Canada, 2018).

There are multiple social, system, provider or individual factors that serve as barriers, limiting individuals' access to and use of palliative care. At the individual level, a lack of awareness or knowledge of palliative care, feelings that accepting palliative care means "giving up," or a fear of upsetting family and healthcare providers with the decision to accept this form of care have been identified as barriers limiting engagement with palliative care services. At the provider level, barriers are lack of awareness and knowledge of palliative care among healthcare professionals, fear of upsetting the individual with the serious illness, or holding of a belief that the offering of palliative care is an admission of failure. At the system level, barriers are lack of awareness and knowledge of palliative care among policy-makers, geography, and restrictive eligibility criteria (Hawley, 2017; Lalani & Cai, 2022; World Health Organization, 2020).

Public Health Approach to Palliative Care

The World Health Organization first recognized access to palliative care as a public health issue in 1990 (Stjernswärd et al, 2007). A public health issue is a population health problem that has a high burden in terms of morbidity, mortality, quality of life, and cost and affects some groups more than others (Farkas et al, 2013). The lack of access to high-quality, equitable palliative care has impacted the quality of life of many Canadians, making this a public health issue. This issue can be addressed through a public health approach to palliative care. The public health approach to palliative care applies the prevention and early intervention principles

of health promotion to issues of death, dying, loss, and care (Public Health Palliative Care International, n.d.c).

The World Health Organization introduced a public health strategy for palliative care in 1990. The four components of this strategy are 1) appropriate policies, 2) adequate drug availability, 3) education of healthcare workers and the public, and 4) integration of palliative care into all levels of the healthcare system (Stjernswärd et al, 2007).

The concept of a public health approach to palliative care was further advanced by Kellehear (1999) in the publication of his book *Health Promoting Palliative Care*. When the public has a vested interest and involvement in promoting their own health and wellbeing, Kellehear argues that this creates a context where this same interest can be applied to promote the uptake of community-based palliative care strategies. Health promoting palliative care applies the World Health Organization's health promotion principles, 1) prevention, 2) harm reduction, 3) early intervention, and 4) sustainability, to palliative care. This involves the following methods: 1) participatory relations, 2) community development, 3) partnerships, 4) education, 5) population health approach, 6) ecological emphasis (Public Health Palliative Care International, n.d.c).

The public health palliative care movement gained international interest and support, leading to the development of the Compassionate Cities Charter for public health and end of life care (Kellehear, 2005). The Compassionate Cities Charter recommends 13 social actions for cities to implement in schools, workplaces, places of worship, long-term care homes, and hospices to heath promote palliative care (Abel & Kellehear, 2021).

In the last 19 years, Compassionate Communities and Compassionate Cities have been implemented around the world. Compassionate Communities are neighborhood or community

networks that collaborate to support individuals living with serious illness or grief (Public Health Palliative Care International, n.d.b). Compassionate Cities are municipal jurisdictions that have developed social policy and action based on the compassionate cities charter (Abel et al, 2018a; Public Health Palliative Care International, n.d.b). Today, there are Compassionate Communities and Cities in India, the United Kingdom, Germany, Canada, Spain, Latin America, Taiwan, the United States of America, Belgium, and Switzerland (Public Health Palliative Care International, n.d.a).

Nursing and Public Health

While any member of a community may initiate the implementation of a Compassionate Community or City, it has been recommended in the literature that both health and social care professionals in palliative care and other contexts participate in the planning and implementation of Compassionate Community and City initiatives, including the implementation of the Compassionate Cities charter (Abel et al, 2018a; Pallium Canada, n.d.b). Many registered nurses (hereafter referred to as nurses) have knowledge and skills that equips them to participate in the development of Compassionate Community and City initiatives.

The College of Nurses of Ontario's (2019) *Entry to Practice Competencies for Registered Nurses* states that nurses must be competent clinicians, professionals, communicators, collaborators, coordinators, leaders, advocates, educators, and scholars. Additionally, the College of Nurses of Ontario (2019) states that nurses must have knowledge of population health, determinants of health, and health promotion to move towards health equity. Nurses have a role in empowering people to improve and gain control over their own health and wellbeing not only through individual interventions but by also leading and engaging in social and environmental intervention. According to the College of Nurses of Ontario (2019), nurses' assessment and care

must be holistic, taking into consideration emotional, socioeconomic, spiritual, and physical needs. Additionally, nurses are advocates (Canadian Nurses Association, 2021; College of Nurses of Ontario, 2019). Nurses advocate for health equity and for client-centered care which empowers people to be in control of their own healthcare to receive care that is in accordance with their goals, wishes, and values (College of Nurses of Ontario, 2019).

Nurses have a long history as innovators and leaders in public health and community-based healthcare throughout its history. Within the discipline of nursing, Lillian Wald was the first to identify and name the specialty of public health nursing in 1893, after recognizing the ways that a person's socioeconomic and physical environment affects their health and ability to be involved in their own health (Buhler-Wilkerson, 1993). As the public health movement moved into Canada in the early 20th century, nurses were the front-line workers of health education and promotion. To this day, nurses remain at the forefront of health promotion programming in Ontario (The Government of Ontario (n.d.).

Nurses spend more time with patients than any other healthcare professional (Malloy et al, 2018; Teike Luthi et al, 2020). Often, it is nurses who identify individuals who would benefit from a palliative approach to care. Specifically, palliative nurses are experts in symptom management, ethical issues and mitigation, therapeutic communication, and end of life care (Rosa et al, 2020). Nurses particularly also often have knowledge of community resources (Dahlin et al, 2022). Many nurses participate in interprofessional public health palliative care efforts and are on the frontlines to promote health equity (Buchanan et al, 2023; Castillo Rodriguez, 2019; Dahlin et al, 2022). Given the vast scope of nursing practice, nurses have the skill and knowledge to engage in the planning and implementation of Compassionate Community and City initiatives. The purpose of this study was to describe and understand the

different ways that nurses are engaged in the planning and implementation of Compassionate Community and City initiatives in Canada.

Reflexivity and Positionality Piece

Reflexivity and positionality are essential components of rigorous qualitative research. The social constructivist underpinnings of qualitative research posit that knowledge is socially co-constructed between the researcher and participants and it is therefore impossible to separate the researcher's own values, beliefs, assumptions, or position from the research (Rees et al, 2020). Rather than attempting the impossible, reflexivity and positionality are practiced to embrace this reality. Reflexivity is an ongoing process in which the researcher reflects on how their own subjectivity and context may influence their research process (Olmos-Vega et al, 2022). Positionality involves reflecting on own's own position in the world and its impact on how we see the world, what questions we ask, how we approach participants, and how we interpret data (Jacobson & Mustafa, 2019). In this section I reflect on my own position in the world, my personal experiences of end of life scenarios, my values, beliefs, and assumptions about society's relationship with the topic of death, and the relationship between nursing and public health palliative care. This reflexivity and positionality piece is only one component of an ongoing process. Reflexivity and positionality were practiced throughout the research process in the form of personal journaling and engaging in thoughtful and reflective discussion with my thesis supervisory committee.

My theoretical allegiance is to social constructivism. I believe that knowledge is socially co-constructed, that there are multiple socially constructed realities within human experience, and that each individual's experience is unique. While there are multiple unique realities, I believe that themes can be socially constructed by the researcher and the participants to tell a

meaningful story that conveys the truth of the participants' experiences. Throughout this study, I sought to construct themes that accurately portray patterns within the experiences of the participants to tell a story about the different ways that nurses engage in the planning and implementation of Compassionate Communities and Cities.

I am a hospice palliative care registered nurse and a graduate student at McMaster University in Hamilton, Ontario. In my time as a hospice palliative care nurse, I have noticed that many patients arrive at hospice in a state of crisis, with unmanaged symptoms and little understanding of what is happening to them. Then, when I had my own experience as a loved one of someone at the end of life, I began to gain some insight. My Grampa's illness was brief - he was diagnosed with stage 4 lung cancer only four weeks before he died. Despite his significant functional and physical decline, medical appointments were focused on "staying strong" for treatment such as surgery, chemotherapy, and/or radiation. Even though many healthcare professionals were involved in his care, none of them discussed or engaged with the topic of death until the last two days of his life. This led to confusion for my Grampa and his family and it robbed our family of the ability to plan how we wanted to spend our last days together. Instead of sitting together to cherish the short time we had, this time was spent focusing on medical tests and interventions that in the end did not prolong his life or increase his comfort. I do not believe that this was any one person's fault, but that as a society we avoid talking about death for as long as we possibly can, and the healthcare system is not immune to this. It has been said that we live in a "death denying society", although I wonder if this true. Perhaps there are many people who recognize that death is inevitable and wish to talk about it, but don't have the knowledge or comfort to engage with this topic. As I thought about this, I began to feel that there must be some way that we can better prepare individuals for the end of life. When I became a

graduate nursing student and learned about the public health approach to palliative care, I was immediately interested in this movement that aims to increase awareness and knowledge of issues of death, dying, loss, and care among the public and to support individuals living with serious illness. As I learned about public health palliative care and Compassionate Communities, I began to realize how closely aligned the values of nursing are to the values of public health palliative care and compassionate communities. This led me to ask the question, "What can be learned from nurses and interdisciplinary team members about the different ways that nurses engage in the planning and implementation of Compassionate Community initiatives in Canada?" I believe that nurses have the values, knowledge, and skills required to be strong partners in the planning and implementation process of compassionate communities. My hope for this study is that the research findings can be used to provide nurses with practice guidance that they may use to engage in the planning and implementation of Compassionate Community and City initiatives. I believe that nurse involvement and leadership in the planning and implementation of Compassionate Community and City initiatives has the potential to increase the amount of Compassionate Communities and Cities planned, implemented, and sustained and improve current and future Compassionate Communities and Cities. The development of more Compassionate Communities and Cities and the increased effectiveness of current Compassionate Communities and Cities has the potential to improve the quality of life of Canadians living with chronic, progressing, and serious illness.

CHAPTER TWO: LITERATURE REVIEW

This chapter provides a review of the literature regarding Compassionate Communities and Cities in terms of the nursing role, the purpose and function, implementation, and evaluation of outcomes. Then, the study purpose and research question is introduced.

A literature review was conducted to search for and review literature regarding Compassionate Communities and Cities and the role of nursing. While minimal research regarding the role of nursing was found, the review of the literature revealed important information regarding the purpose, function, implementation, and outcomes of Compassionate Communities and Cities.

Search Strategy

CINAHL, Emcare, and Ovid Medline 1946 to Present were searched for literature regarding compassionate communities in December 2024. The search terms used were compassionate communit* OR compassionate cit* OR public health palliative care OR public health within three words adjacent to palliative care. The Public Health Palliative Care International website resources tab was also searched for relevant literature. No time limit was placed due to the novelty of the topic. This search yielded 856 results. After the removal of duplicates, 417 titles and abstracts were screened. Following this screening process, 359 articles were excluded due to irrelevance or not being in the English language. Of the remaining set, 58 articles were screened and assessed for eligibility. Thirty studies were excluded based on quality of study and study purpose. Critical Appraisal Skills Programme checklists (Critical Appraisal Skills Program, n.d.) were used to guide decisions regarding quality of studies included. Twenty-eight studies were included in this literature review. A table summarizing author, date, country, purpose, methodology, findings, and critical appraisal can be found in Appendix A.

Purpose and Function of Compassionate Communities

This literature revealed eleven studies that identified the purpose and function of their Compassionate Community or City initiative. The purposes and functions of Compassionate Communities and Cities identified in the literature are to build community awareness of palliative and end of life care (Librada-Flores et al, 2023; Matthiesen et al, 2014), change social attitudes regarding palliative and end of life care (Gómez-Batiste et al, 2018; Mesquita et al, 2023), provide integrated care for the seriously ill (Abel et al, 2018a; Aoun et al, 2022b; Gómez-Batiste et al, 2018; Librada-Flores et al, 2018; Liu et al, 2022; Matthiesen et al, 2014), provide the public with education about palliative and end of life care (Kelley et al, 2018; Librada-Flores et al, 2018; Liu et al, 2022; Paul, 2016), engage the community in palliative and end of life care (Aoun et al, 2022b; Librada-Flores et al, 2018; Liu et al, 2022; Matthiesen et al, 2014; Mesquita et al, 2023; Pesut et al, 2022) and engage the civic sector to promote supportive policies (Abel et al, 2018a; Kelley et al, 2018).

Social Awareness and Attitudes

A common aim of many Compassionate Community and City initiatives is to improve social awareness of the importance of caring for people who are experiencing serious illness (Librada-Flores et al, 2023; Matthiesen et al, 2014) and social attitudes towards palliative care and end of life (Gómez-Batiste et al, 2018; Mesquita et al, 2023). In this way, Compassionate Community and City initiatives build palliative care capacity among the public.

Integrating and Mobilizing Care

The World Health Organization's Public Health Strategy for Palliative Care calls for palliative care to be integrated into all levels of healthcare and society (Stjernswärd et al, 2007). Abel et al (2018a) call for collaboration between palliative care specialists, generalists,

communities, and the civic sector in the provision of palliative care and end of life care. Compassionate Communities such as in Vic, Spain (Gómez-Batiste et al, 2018), Taipei, Taiwan (Liu et al, 2022), and Sevilla, Spain (Librada-Flores et al, 2018), aim to provide integrated care for people who are seriously ill. This may involve efforts to identify the unmet needs of people living with serious illness (Librada-Flores et al, 2018) and collaboration between stakeholders to link and strengthen existing organizations and social groups that provide services to meet these needs (Kelley et al, 2023; Liu et al, 2022), as well as strengthen existing social networks and families (Aoun et al, 2022b). Two case studies in the United Kingdom revealed that communities want to engage in issues of death and dying but do not know how to begin. Several communities in the United Kingdom (Matthiesen et al, 2014) have adopted an asset-based model of community engagement based on McKnight and Kretzmann's asset-based model (McKnight, 2017) to mobilize communities to begin to engage in issues of death and dying. In the Compassionate Community in Sevilla, Spain (Librada-Flores et al, 2018), community promoters were described as key players in the implementation process of compassionate communities. Community promoters are individuals who are committed to the aims of the Compassionate Community and work to mobilize and strengthen resources and networks to provide care to meet the needs of people living with serious illness. Community promoters have most often been health or social professionals but can be any community member who is willing to assume this leadership role (Librada-Flores et al, 2018).

Education

Providing palliative care education to the public, healthcare professionals, and policy makers is an important piece of taking a public health approach to palliative care (Kelley et al, 2018; Stjernswärd et al, 2007). Participatory action research done by Prince et al (2019) in four

First Nations communities in Canada identified that participants wished for increased education resources regarding palliative care to improve their community capacity to care for those who are seriously ill. Focus groups, surveys, and interviews were conducted to identify specific educational needs of the communities and led to the development of an educational workbook available for use by Indigenous communities in Canada. In addition to addressing the identified educational needs, the workbook describes a capacity development approach to equip people to live at home until the end of life (Kelley et al, 2018). The 'All With You' program developed in Spain implemented awareness campaigns, workshops, and training courses to educate professionals about palliative care. While increasing public knowledge of palliative care was not a specific objective of this initiative, it was identified that public knowledge of palliative care is low and future efforts should aim to raise public awareness and educate society (Librada-Flores et al, 2018). The Taipei experience of implementing Compassionate Communities aimed to increase public knowledge, leading them to implement workshops and conferences (Liu et al, 2022). In an action study done by Paul (2016), health promoting activities were developed that mobilize individuals caring for elementary school aged children to provide children with education and support around death, dying, and bereavement. This involved adding death and health education to the curriculum, bereavement training for school staff, fundraising to raise awareness, workshops for parents/carers, and evaluation of bereavement policies in the schools. These activities were implemented through collaboration between two hospices and an elementary school.

Community Engagement

Another key aim of Compassionate Communities and Cities is to engage the community in care for individuals who are near the end of their life (Hasson et al, 2022; Liu et al, 2022;

Librada-Flores et al, 2018). A Compassionate Community initiative in Taipei implemented a Life Issues Café where university students and older adults were invited to gather to discuss various topics surrounding death and dying (Liu et al, 2022). Various Compassionate Community initiatives in Brazil, Canada, and Australia trained community volunteers to engage in palliative care by visiting individuals in the community who would benefit from palliative care visits (Aoun et al, 2022b; Pesut et al, 2022; Mesquita et al, 2023).

Policy Impact

The above-described efforts of professional and community services to provide care for the seriously ill are not sustainable without the cooperation and participation of the civic sector (Abel et al, 2018a). Policy and education of policymakers is an essential component to public health palliative care initiatives (Kelley et al, 2018; Stjernswärd et al, 2007). Kellehear's (2005) Compassionate City Charter makes recommendations for the civic sector to engage in health promotion of palliative care. The charter recommends schools, workplaces, trade unions, and worship places to annually review their policies regarding dying, death, loss, and care. Additionally, the charter recommends cities to host events that raise awareness of the experiences of aging, dying, death, loss, and care. Abel et al (2018a) recommend the identification of key civic leaders to form a steering committee for a compassionate city and for the steering committee to collaborate with compassionate community program leaders, health service representatives, schools, workplaces, places of worship, and other public sectors.

Implementation

Four articles describe and present a model or method for the development or implementation of a Compassionate Community or City (Pfaff et al, 2020; Kelley, 2023, Librada-Flores et al, 2018; Mesquita et al, 2023). Two of these models were developed within a

Canadian context (Pfaff et al, 2020; Kelley, 2023). The other two models were developed in Spain and Brazil (Librada-Flores et al, 2018; Mesquita et al, 2023). Additionally, four articles describe the elements of a successful implementation process (Bakelants et al, 2024; Howard et al, 2022; Meesters et al, 2024; Pesut et al, 2022).

Health Impact Change Model

The Health Impact Change Model, developed by Pfaff et al (2020), takes a health promotion approach to palliative care, aiming to strengthen community action, create supportive environments, develop personal skills, reorient health services, and build healthy public policy. The model considers determinants of health such as income, social status, social support networks, social environment, personal health practices and coping skills, education, health services, and culture. The model considers the population, the community, the health system, and the patient as elements. Intervention components are volunteerism, interprofessional collaboration, technology, social networks, policy, and engagement. The Triple Aim (Institute for Healthcare Improvement, n.d.) informs the outcome measures of the model, considering patient care experience, improvement in population health, and reduction in healthcare costs. Equity is also added as an outcome in the Health Impact Change Model.

Developing a Compassionate Community Model

Kelley (2023)'s model for Developing a Compassionate Community is a research-informed practice theory which applies a community capacity development approach to the implementation of compassionate communities. This theory stresses that aging, dying, caregiving, and grieving are everyone's responsibility, rather than solely the responsibility of healthcare professionals and palliative and geriatric specialists. Within this approach, compassionate communities are developed *by* the community *for* the community, rather than *to*

the community by healthcare professionals or organizations. The four components of the model are the community environment, the activities in a compassionate community, community values, and the six phases of developing community capacity. The community environment is shaped by 1) individual, family, community, and culture, 2) vision for change, 3) local leadership, 4) empowerment, 5) natural helping networks, 6) collaboration, 7) health and social services, and 8) community infrastructure. The activities of a Compassionate Community as described in the model are promoting community participation and action, strengthening community helping networks, engaging, empowering, and educating community members, building partnerships with health and social services, and championing a social model of end of life care. All compassionate community activities should align with the values of the community. The six phases of community development are 1) becoming inspired to develop a compassionate community, 2) engaging a change team and partners in the work, 3) assessing the communities readiness, strengths, and needs, 4) listening to and respecting the communities priorities, practices, and values in all decisions and actions, 5) creating, promoting, and mobilizing local Compassionate Community initiatives, and 6) championing a social model of care in the community where aging, dying, grieving, and caregiving are everyone's responsibility. Developing community capacity is a process that is nonlinear, dynamic, and ongoing.

All With You Method

The 'All With You' method for developing a Compassionate Community was developed in Spain by a team of community partners who aim to improve the wellbeing of people with advanced illness through integrating health, social, and community care (Librada-Flores et al, 2018). The method involves identifying a leading body, defining the scope of the project, identifying interested parties, identifying desired outcomes, designing, implementing, evaluating,

and following up. The 'All With You' method was first implemented in Seville, Spain and has now been rolled out in several communities in Spain and Columbia, and one community in Argentina (Librada-Flores et al, 2018).

Compassionate Community Implementation Steps

A Compassionate Community developed in Rocinha and Vidigal, Rio de Janeiro, Brazil summarize their implementation process in seven steps. The seven steps are: 1) dialogue in the community/identify community leaders and volunteers, 2) training of community leaders and volunteers, 3) identify health professional and volunteer supporters to compose a project team, 4) identify community members who would benefit from palliative care, 5) establish sponsorship, 6) project management, and 7) integration with the local health network (Mesquita et al, 2023).

Comparing Models

Mesquita (2023) and Kelley (2023) both advocate for dialogue to be initiated in the community prior to implementation. Mesquita (2023) and Librada-Flores et al (2018) express the need to identify individuals in the community to act as a leading body (Librada-Flores et al, 2018). Kelley (2023) and Pfaff et al (2020) recognize the interaction and need to strengthen the link between the individual, patient, population, and health and social care system. Kelley (2023), Mesquita et al (2023), and (Librada-Flores et al, 2018) describe a similar path of starting dialogue and assessing readiness in the community, planning, implementing, evaluating, and following up.

Elements of a Successful Implementation Process

Various elements of success implementation of Compassionate Community initiatives including barriers, facilitators, challenges, and supportive processes have been identified in the literature. Facilitators identified in the literature were organization capacity, stable and engaged

leadership, having a targeted patient population, skillful messaging (Pesut et al, 2022), leadership support, and alignment with existing programs (Bakelants et al, 2024a). Barriers were a lack of guiding principles, fragmented community environment, resource constraints, limited prioritization (Bakelants et al, 2024a), lack of cooperation, lack of transparency, and lack of citizen involvement (Meesters et al, 2024). Challenges identified in the literature were client recruitment (Pesut et al, 2022), building coherence, engaging stakeholders, and assessing the work (Bakelants et al, 2024a). Finally, supportive processes identified in the literature were empowering clients to set an act on personal goals, taking time to address these needs and goals, advocating for services to fill the gaps in health and social care (Howard et al, 2022), recognizing the value of Compassionate Communities, and adapting implementation strategies based on feedback (Bakelants et al, 2024a).

Outcomes

Seven studies discussed the outcomes of various Compassionate Community projects (Abel et al, 2018b; Aoun et al, 2023a; Bakelants et al, 2024b; Gómez-Batiste et al, 2018; Howard et al, 2022; Librada-Flores et al, 2023; Pesut et al, 2022). These outcomes can be organized as program related outcomes, individual outcomes, and system outcomes.

Program related outcomes included high participation among funding organizations and individuals who attended activities, positive interaction between organizations, diversity of activities, active coordination, and commitment to evaluation (Gómez-Batiste et al, 2018). Challenges reported were engaging schools, trade unions, media, and healthcare networks in Compassionate Community activities and concerns about the sustainability of the compassionate community (Gómez-Batiste et al, 2018). Evaluation of a Compassionate Community initiative within a university in Belgium found that there was increased acceptance and integration of

topics such as serious illness, death and bereavement into existing practices, broader support for and formalization of compassionate procedures and policies, emergence of informal networks and internal collaboration, and diffusion of compassionate ideas beyond the university (Bakelants et al, 2024b).

Among individuals who were community members and clients of different Compassionate Community or City initiatives, various studies suggested that Compassionate Community initiatives led to decreased loneliness (Howard et al, 2022; Librada-Flores et al, 2023), improved social connectedness, reduced social isolation, better coping with activities of daily living (Aoun et al, 2022a), decreased caregiver burden (Librada-Flores et al, 2023), improved quality of life (Librada-Flores et al, 2023; Pesut et al, 2022), decreased symptoms of depression or anxiety (Librada-Flores et al, 2023), improvement in feeling they had someone to turn to, improved knowledge of community services, increased involvement in things that were important to them, and increased confidence in managing their own illness (Pesut et al, 2022). In addition, volunteers reported being satisfied in their role (Pesut et al, 2022).

At a systems level, compassionate community initiatives led to decreased hospital and emergency service use, decreased healthcare costs, and increased use of outpatient services (Abel et al, 2018b; Aoun et al, 2023a). A retrospective cohort study conducted by Abel et al (2018b) found that an enhanced model of primary care and Compassionate Communities reduced emergency room admissions and reduced healthcare costs in an intervention group compared to a control group. These findings are consistent with a controlled before-and-after study and cost-consequence analysis conducted by Aoun et al (2023), which found that participants had a lower incidence rate of hospitalization, spent less days in the hospital, had a higher frequency of

outpatient contact, and decreased healthcare costs after the implementation of a Compassionate Community program compared to before the implementation of the program.

Liu et al (2022) and Matthiesen et al (2014) identify the need for further research to fully evaluate Compassionate Community outcomes. It is difficult to draw strong policy or practice conclusions based on existing evidence as much of this evidence is informed by evaluations reporting on preliminary findings (Gómez-Batiste et al, 2018; Howard et al, 2022; Librada-Flores et al, 2023) due to the novelty of the movement. An additional difficulty in evaluation of Compassionate Communities is that quality of life outcomes are likely affected by factors outside of Compassionate Community initiatives, such as care given by other social and healthcare professionals (Librada-Flores et al, 2023).

Summary

The literature summarized in this review speaks to the purpose and function of compassionate communities, knowledge regarding implementation of compassionate communities, and the outcomes of existing compassionate communities. A detailed critical appraisal of the included studies can be found in Appendix A.

There is a growing body of knowledge regarding the implementation of Compassionate Community and City initiatives. The studies included in this literature review provide a beginning foundation of knowledge regarding the ways to implement public health initiatives to build community capacity for palliative care. This body of knowledge could be further advanced by exploring the roles of different team members within the teams that are implementing these initiatives and developing practice guidance. While there is literature speaking to the value of ensuring that healthcare professionals are involved in the planning and implementation of compassionate community initiatives (Abel et al, 2018a; Librada-Flores et al, 2018; Matthiesen

et al, 2014), there is no specific mention or discussion of the role of nursing in these initiatives. There is one article discussing the advance practice of palliative care nurses working in a Compassionate Community context in Brazil (Silva et al, 2023), however, this article mainly describes the clinical practice of these nurses, rather than the role of nurses in implementing a Compassionate Community. None of the literature found describes the different ways that nurses are engaged in the planning and implementation of Compassionate Community or City initiatives. Nurses have the knowledge and skill to be instrumental in the planning and implementation of Compassionate Communities and Cities, yet there is no practice guidance specific for nurses who wish to apply this knowledge and skill to the cause. Practice guidance for nurses to plan and implement Compassionate Communities and Cities will expand nursing's disciplinary knowledge and provide nurses with concrete and usable action guidance to engage in the planning and implementation of Compassionate Community initiatives in Canada.

Research Question

Given that nurses have the knowledge and skill to be instrumental in the development of Compassionate Community and City initiatives and there is no literature discussing their role, the overarching research question that this study addressed was, "What can be learned from nurses and interdisciplinary team members about the different ways that nurses engage in the planning and implementation of Compassionate Community and City initiatives in Canada?"

CHAPTER THREE: METHODOLOGY

This chapter provides a description and rationale of the methodology and methods used in this study. This includes methodology, context, sampling and recruitment, data generation, data analysis, methods to enhance credibility of the study findings, and ethical considerations and risk mitigation.

Design

The overarching methodology used to guide this study was interpretive description (Thorne, 2025). The principles of interpretive description were used to inform all sampling, data generation, and analysis decisions in this applied qualitative health research study. The purpose of interpretive description is to generate disciplinary knowledge to address an issue grounded in the discipline's practice. The issue that this study addressed was the lack of understanding about the different ways that nurses engage in the planning and implementation of Compassionate Communities in Canada. Interpretive description is used in qualitative health research to describe and understand patterns related to individuals' varied experience of social or human phenomenon. Interpretive description draws on the intellectual underpinnings of nursing as a discipline, designing research based on an understanding of disciplinary nursing logic (Thorne, 2020). The philosophical underpinning of interpretive description is that in the world of human experience there are multiple socially constructed realities. While each individual's experience is unique, trends and patterns can be identified across these differences (Thorne, 2016).

Context

In qualitative research, it is critical to describe the varied contexts that influence how the phenomenon of interest being studied may shape participants' experiences. The context of this study comprises the Compassionate Community and City initiatives within Canada. In 2018,

there were 19 Compassionate Community and City initiatives in Canada across Ontario (n=16), British Columbia (n=2) and Novia Scotia (n=1) (Tompkins, 2018). In the last five years this movement has spread rapidly. Today, there are over 223 Compassionate Community and City initiatives across British Columbia (n=>120), Alberta (n=45), Saskatchewan (n=2), Manitoba (n=1), Ontario (n=41), Quebec (n=12), New Brunswick (n=1), and Nova Scotia (n=1) (Tompkins et al, 2023). These initiatives are developed within the national healthcare system in Canada.

In Canada, national standards for the health care system are set through the *Canada Health Act* (Government of Canada, 2023). The federal government is responsible for setting standards through the *Canada Health Act*, providing funding for provincial and territorial health care services, supporting the delivery of healthcare to First Nations people living on reserves, Inuit, serving members of the Canadian Forces, eligible veterans, inmates in federal penitentiaries, and some refugees, and health care data and research. The provincial and territorial governments are responsible for health care policies and programs within their own province or territory. Local governments are responsible for nurturing and encouraging the spread of compassionate community initiatives (Health Canada, 2018). Canadians receive palliative care in home, long-term care, hospital, or hospice (Canadian Institute for Health Information, 2023).

Sampling and Recruitment

Purposeful sampling is a hallmark characteristic of applied qualitative research. Purposeful sampling is a method of sampling where the researcher selects a sample from the population of interest that has the best ability to answer the question being asked by providing a rich description, typically grounded in their experiences of the phenomenon being studied (Palinkas et al, 2015). In this study, two unique data sources were recruited to participate: 1)

registered nurses who have engaged in the planning and implementation of a Compassionate Community initiative in Canada and 2) other members of the interdisciplinary team who have worked alongside a nurse who has engaged in the planning and implementation of a Compassionate Community initiative in Canada.

The rationale for including interdisciplinary team members who are not nurses in this study was to engage in data source triangulation to enhance the credibility of the research findings. Interdisciplinary team members will be defined as any member of a team that is engaged in the planning and implementation of a Compassionate Community. Examples of interdisciplinary team members may include other health or social care professionals such as physicians, social workers, sociologists, or volunteers. Members of the interdisciplinary team may offer insight into the unique support that nurses have to offer the team.

The inclusion criteria for this study were that the individual: 1) is a registered nurse engaged in the planning or implementation of a Compassionate Community initiative in Canada OR 2) an interdisciplinary team member who is working with a nurse in the planning or implementation of a Compassionate Community initiative in Canada; and 3) able to speak and complete an interview in English. 'Planning' was defined as efforts to assess the community's readiness, strength, and needs and the development of a plan to implement a Compassionate Community. 'Implementation' was defined as having put a Compassionate Community into effect.

Maximum variation sampling was used in this study to purposefully seek to select participants that have experienced the phenomenon of interest yet are as different as possible from one another to learn about a phenomenon from a variety of perspectives. The purpose of maximum variation sampling in interpretive description is to identify common patterns across

variations (Palinkas et al, 2015). In this study, maximum variation was operationalized during data generation. As I began to identify themes and patterns, I purposefully sought participants who experienced the phenomenon differently, to determine whether the initially identified themes were true themes experienced in the phenomenon or only true for the current sample. Participants who had differences in geography and stage of planning and implementation were recruited for participation in this study.

Experiential experts (Thorne, 2016) were used to identify participants. In this study, an experiential expert was any member of an interdisciplinary team who was engaged in the planning and implementation of compassionate communities and/or was well connected to nurses and team members engaged in Compassionate Community work. Snowball sampling was used to recruit participants. Snowball sampling involves asking experiential experts to help connect the researcher with potential participants who have experienced the phenomenon of interest (Palinkas et al, 2015). Then, as data generation began, participants were asked if they knew anyone who was a nurse or an interdisciplinary team member working with a nurse who was engaged in the planning and implementation of Compassionate Communities. When additional individuals were identified, participants were asked to connect these individuals with the student researcher through email and invite these individuals to participate in the study. Initial contact with potential participants came from the experiential experts. All potential participants were sent a $50 e-gift card as an honorarium to acknowledge the sharing of their time and expertise.

In this study, Malterud et al's (2016) concept of information power was used to evaluate sample size. Malterud et al (2016) assert that study aim, sample specificity, established theory, quality of dialogue, and analysis strategy have impact on the power of the information generated

with a sample. With these items considered, a sample size of 10 nurses and 10 interprofessional team members were estimated to provide quality data relevant to the overarching research question.

Data Generation

As is the norm in qualitative research, data generation and data analysis occurred concurrently. The primary data type in this study was individual, one-to-one, in-depth semi-structured interviews. Interviewing is a key method that is used to explore how an individual or group experiences a phenomenon. This type of interview allowed for a standardized approach to be followed yet provided the flexibility needed to explore what the participant, who is the expert on the phenomenon, considers important (Jack et al, 2023). Through verbal discussion, nurses and interdisciplinary team members were able to provide a rich description of the different ways that nurses are engaged in this work and provide insight on the topic.

Interviews were conducted online using Zoom (n.d.). The decision to conduct interviews online was made so that geography was not a barrier to participant recruitment and data generation. This also allowed healthcare professionals who choose to participate to be able to participate from home or their workplace. Also, conducting interviews online did not require transportation, minimizing interruptions to the participant's day. Zoom was chosen as the platform because of its recording capabilities and ease of access for both the researcher and participants, as access to Zoom only requires access to the internet. Participants were also offered to participate in the interview using a telephone if they were not comfortable using Zoom, however, all of the participants consented to using Zoom.

Interview questions developed before-hand were used only as a guide rather than a formal structure. Kelley's (2023) six phases of community development for Canadian

Compassionate Communities were used to structure the first part of the interview guide. The rationale for using Kelley's six phases of community development for Canadian Compassionate Communities was that this model was developed through 30 years of research conducted within the Canadian context, specifically within rural, urban, First Nations communities, and long-term care homes. The six phases of community development discuss both planning and implementation of a Compassionate Community. In addition to the six phases of community development, questions were asked about who is involved in the team planning or implementing the compassionate community, and how the health promotion strategies (Public Health Palliative Care International, n.d.c) are operationalized. Two separate interview guides were developed, one for interviews with nurses and the other for interviews with non-nurse interdisciplinary team members. Both interview guides can be found in Appendix B. The interviews with the nurse participants focused on their experiences planning and implementing a Compassionate Community or City initiative. The interviews with non-nursing interdisciplinary team members focused on their experiences working alongside a nurse engaging in the planning and implementation of a Compassionate Community or City initiative.

The interview times were approximately 60-90 minutes, to allow participants to share as much of their experience as they wished. Three pilot interviews took place prior to the start of data generation and were reviewed by members of my thesis supervisory committee. Participants were sent the interview questions prior to the interview to consider their responses. Additionally, demographic information was collected using a demographic form.

Data Analysis

Thorne (2025) advocates for the use of an inductive approach to analysis in interpretive description. In this study, Braun and Clarke's (2006) approach to thematic analysis was used to

analyze the data. The six phases of Braun and Clarke's (2006) approach to thematic analysis are 1) familiarizing yourself with the data, 2) generating initial codes, 3) searching for themes, 4) reviewing themes, 5) defining and naming themes, and 6) producing the report. Clarke and Braun (2017) define codes as the smallest unit of analysis of data which may be relevant to the research question. Clarke and Braun (2017) define themes as patterns of meaning in qualitative data.

The first phase of thematic analysis, familiarization, occurred as I interviewed the participants and then transcribed, cleaned, and read the interview transcripts. My first encounter with the data was during data generation as I interviewed participants. During the interviews, I began to become familiar with and immersed in the data. I kept field notes to jot my initial thoughts down immediately after interviews and capture early analytic insights. I also engaged in reflexive journalling following each interview to capture my initial beliefs, emotions, and assumptions about the interview. My next encounter with the data occurred as I transcribed the interviews. Thorne (2016) encourages researchers to transcribe their own transcripts to slow their attention to hear what the language contains (Bailey, 2008). As I transcribed the interviews, I kept analytic memos (Thorne, 2016) to jot down possible connections, themes, or patterns that I identified during this early stage. I transcribed the interviews first using the cloud recording feature on Zoom and then cleaned the Zoom transcriptions manually (Zoom, 2024). I then read the transcripts a second time to familiarize myself with the data.

Next, I generated initial codes using Dedoose software (Dedoose, n.d.). A broad-based and inductive, generic coding scheme was used as interpretive description analysis should be conducted at the pattern and theme level, rather than being excessively fine-tuned (Thorne, 2016). Data were analyzed with the purpose of engaging in interpretive thinking, rather than

simply to organize and reorganize data (Bazley, 2013). My supervisor SK reviewed all my initial coding and provided support throughout the coding process. The other two members of my master thesis supervisory committee (SJ, MN) read some of the transcripts and provided analytic memos. The committee also engaged in team debriefing to both practice reflexivity and protect the emotional safety of the research team.

Next, SK and I separately searched the data for central ideas and concepts and then met together to generate, discuss, review, define, and name themes. Phases two, three, and four did not occur in a linear fashion, rather they occurred concurrently. Initial thematic insights were documented early on in a thematic memo document and continuously reviewed and revised as new data was generated and coded. Data from each separate interview were compared with one another to identify and understand similarities and differences between the participants experiences. The committee met throughout the data generation and analysis phase of this study to discuss and review themes that were found in the data. Themes that were constructed from the data go beyond topic summaries and capture meaningful patterns found in the data to tell an interpretive story (Braun & Clarke, 2023). After completion of the data generation and analysis phase, I produced a report of the findings. As I wrote the report, I focused on telling an interpretive story that captures the experiences of the participants related to the research question. Next, I shared the report with the committee. The committee reviewed and provided feedback on the report.

Enhancing Credibility

Thorne's (2025) criteria for enhancing credibility considers epistemological integrity, representative credibility, analytic logic, and interpretive authority to promote accuracy and truth of description and interpretation of the research findings. This study was designed in a way that

values that each nurse and each interdisciplinary team member have a different experience of the different ways that nurses engage in the planning and implementation of Compassionate Community initiatives, and yet there are themes and patterns while accounting for these differences. Epistemological integrity is evident in the purposeful sample of nurses and interdisciplinary team members across different Compassionate Communities, the semi-structured interview guide which allows the interviewer to follow the participant's lead in the conversation and hear what the participant wants to share, and in the analysis of the data using a broad-based coding scheme. Representative credibility was promoted in this study through the use of data source triangulation by interviewing members of the interdisciplinary team with different roles. Analytic logic was promoted by using an audit trail including a dense description of all research decisions. Interpretive authority was promoted through engaging in reflexivity. In addition to my reflexivity and positionality piece, I kept a reflexive journal throughout the research process.

Ethical Considerations and Risk Mitigation

Thorne (2025) advocates for the consideration of moral defensibility, disciplinary relevance, pragmatic obligation, contextual awareness, and probable truth when considering study ethics. Privacy, consent, and the emotional safety of the participants were also considered.

Moral Defensibility and Disciplinary Relevance

The intended utility of this study is to provide nurses with practice guidance, grounded in the experiences of nurses who are engaged in the planning and implementation of Compassionate Community initiatives in Canada, for action to be engaged in this work. The intended utility, potential contribution, and disciplinary relevance were shared with participants in the study advertisement, invitation, and consent form.

Pragmatic Obligation and Contextual Awareness

This Master's thesis includes a detailed description of the context being studied and the context to which the research findings may be transferable. This mitigates the risk of readers transferring the research findings to contexts in which it may be inappropriate. The practice guidance for nurses has been developed within Compassionate Community initiatives in Canada and is meant to be applied to practice in Canada. Though the practice guidance may likely have relevance outside of Canada, readers outside of Canada should exercise caution when applying this research to practice and consider the differences of the nursing and healthcare professional population in their own setting and the differences of the communities in which they seek to practice. In keeping with pragmatic obligation, the social determinants of health and the potential vulnerability of persons with serious illness and persons who are grieving must also be considered when seeking to apply the research findings to additional populations.

This study has been designed in congruence with the philosophical underpinnings of interpretive description, which asserts there are multiple socially constructed realities. This study was intended to find themes and patterns across nurses and interdisciplinary team members' experiences of the different ways that nurses engage in the planning and implementation of Compassionate Community initiatives.

Emotional Safety of the Participants

Whitney and Evered's (2022) *Triage Pathway* from their *Qualitative Research Distress Protocol* was used in this study to respond to any emotional distress that occurred before, during, or after the interviews. The Government of Canada's (2024b) *Mental Health Support* website was used to refer participants to province or territory specific resources for additional support.

CHAPTER FOUR: RESEARCH FINDINGS

This chapter shares the findings of this study. It will include a description of the participants, an illustration of the study findings, and a conclusion.

Description of the Participants

Twelve participants were interviewed who were located in Ontario (n=9), Alberta (n=2), or British Columbia (n=1). The ages of the participants ranged from 26 years to 73 years, with the mean age being 58 years. All twelve of the participants identified as women. The disciplinary backgrounds of the participants were nursing (n=10), social work (n=1), and medicine (n=1). In addition, five participants reported being members of faculty at a university (n=5). The participants who were nurses reported having a range of 5 to 47 years of experience in nursing, with the mean years of experience being 28 years. The participants reported working in a variety of specialties prior to becoming engaged in public health palliative care, including palliative care, community home care, community development, primary care, public health, surgery, maternal and infant health, neonatal, pediatrics, medicine, acute care, surgery, oncology, rehabilitation, psychiatric, long-term care, management, research, and education. Most notably, ten of the participants had experience in palliative care prior to engaging in public health palliative care. The participants length of time of experience in public health palliative care ranged from 11 months to 15 years, with the mean length of time being 8 years. Two participants did not report their length of time of experience in public health palliative care.

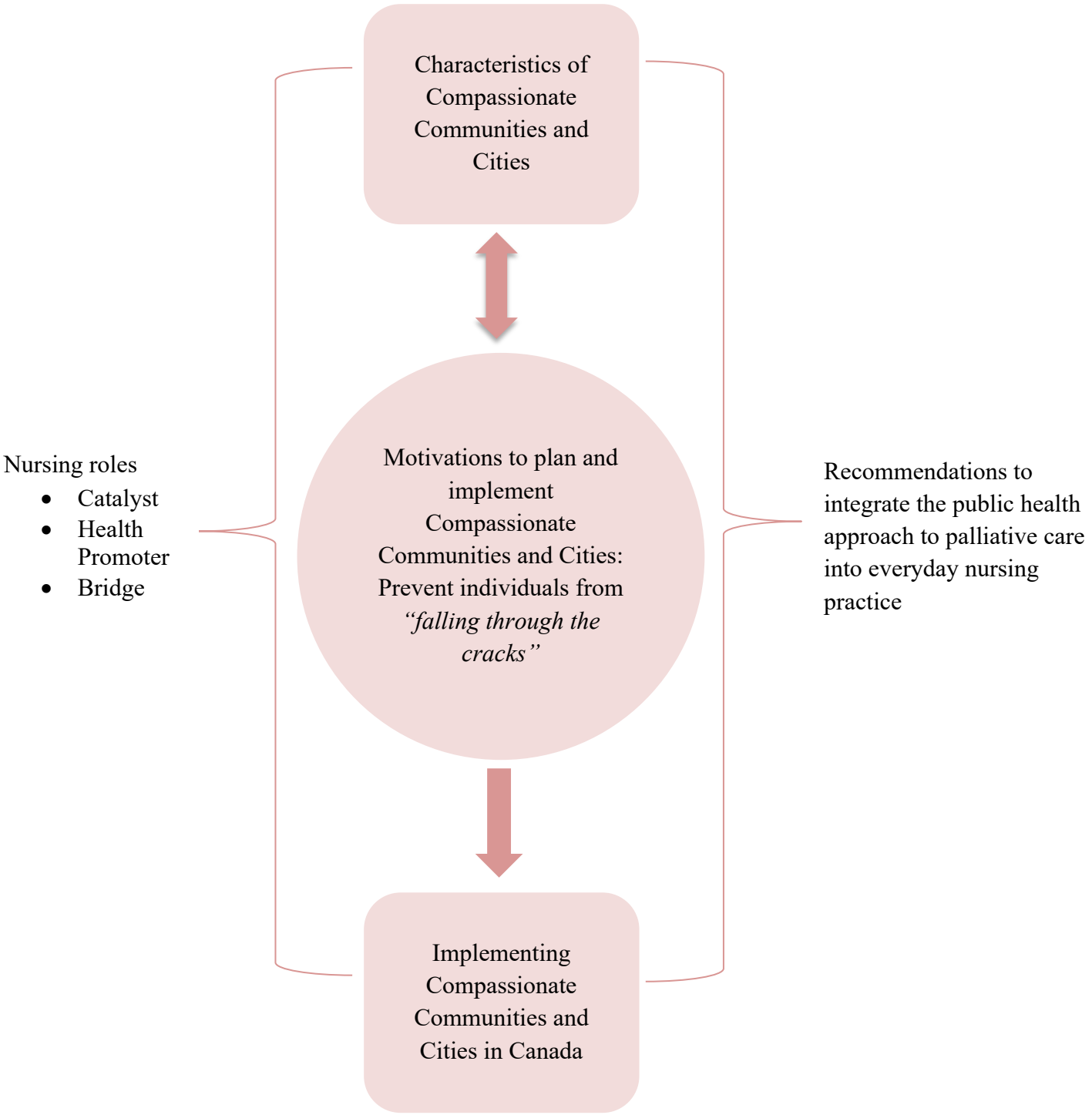
Overview of Findings

The findings of this study describe participants' (a) perceptions of the characteristics of Compassionate Communities and Cities, (b) motivations to plan and implement Compassionate Communities and Cities in Canada, (c) descriptions of how they have been implemented, (c)

understanding of nurses' roles in developing and implementing Compassionate Communities and Cities and (d) recommendations to integrate the public health approach to palliative care into everyday nursing practice. This process is illustrated in Figure 1 below.

Figure 1

Illustration of Study Findings



Characteristics of Compassionate Communities and Compassionate Cities

There were at were at least nine Compassionate Community or City initiatives represented by the participants in this study. Determining the exact number is difficult, as many of the participants supported the nurturing of smaller Compassionate Communities. During the data generation phase and initial data analysis phases of this study, the term 'Compassionate Community initiatives' was used to refer to both Compassionate Communities and Compassionate Cities. As this study progressed, it became clear that it is important to differentiate between these two similar but distinct concepts. The Public Health Palliative Care International (n.d.b) defines Compassionate Communities as neighbourhood or community networks that collaborate to support individuals living with serious illness or grief. Compassionate Cities are defined as municipal jurisdictions that have developed social policy and action based on the Compassionate Cities charter (Abel et al, 2018a; Public Health Palliative Care International, n.d.b).

While the ideas that motivated the participants to implement both types of initiatives were largely similar, there were differences between Compassionate Communities and Compassionate Cities in terms of formation, implementation, and governance. The participants shared that Compassionate Communities may form organically or intentionally but may remain informal, while Compassionate Cities were more formal initiatives. The participants shared that in many cases, well established Compassionate Cities will nurture the formation of formal or informal Compassionate Communities within the Compassionate City. The participants provided examples of how Compassionate Communities formed in pre-existing groups, such as faith communities, ethno-cultural groups, and neighbourhood networks. The participants highlighted that Compassionate Communities require active engagement of community members and

ownership of the initiative amongst the community. They also highlighted that Compassionate Cities have required more formal leadership and governance, often by a committee or a community organization.

Five Compassionate City initiatives were represented in this study by eight of the participants. Three of these Compassionate Cities were reported to be involved in nurturing smaller Compassionate Communities within their city. The participants shared the goals and foci of their Compassionate Communities and Cities. Two of the Compassionate Community initiatives represented in this study focused mainly on advancing equity in palliative care. One Compassionate Community initiative was within a supportive living home, aiming to foster a Compassionate Community among residents, families, and staff within the home. One participant was involved in multiple groups across a province that aimed to connect individuals facing issues associated with serious illness with nature. This involved mobilizing community networks to facilitate activities to support individuals approaching the end of life to be able to go outdoors and implementing group walks in nature to support individuals living with grief using a Compassionate Community approach.

The participants described various activities that Compassionate Community and City initiatives plan and implement. For example, many Compassionate Communities have implemented book clubs to read and discuss books about issues associated with serious illness. Some Compassionate Communities have also organized Death Cafes to facilitate conversations about death and dying. Nurses also facilitated education sessions on topics such as advance care planning, social connectedness, and grief and bereavement. Additionally, awareness had been raised through participation in public events such as community fairs, festivals, and parades. Some compassionate communities collaborated with local schools to educate students about

palliative and end of life issues and to train staff to support students who are dealing with loss. One Compassionate Community initiative also held a palliative care exhibit for the public to learn about available resources in their city. A summary of the Compassionate Community and City initiatives represented in this study is provided in Table 1.

Table 1

Characteristics of the Initiatives Represented in this Study

Province	**Compassionate City/Compassionate Community**	**Goal/Focus**	**Activities**
Ontario	Compassionate City	- Build public awareness of palliative care and community resources - Facilitate connections between community resources - Strengthen and mobilize existing resources - Foster the development of smaller Compassionate Communities within city	- Death cafes - Attend community festivals - Attend community parades - Engage with local high schools - Resource exhibit - Hospice tours
Ontario	Compassionate City	- Build palliative care capacity among the public - Foster the development of smaller Compassionate Communities within city	- Education sessions (advance care planning, grief and bereavement) - Curriculum building with local high school - Speaking at local high school - Professional development with local high school teachers

Ontario	Compassionate Community	- Members of a condo building aiming to support each other through issues associated with chronic and serious illness - Foster discussion about issues associated with aging and death and dying	- Education sessions/worksh ops (advance care planning, falls prevention) - List of helping hands (members sign up to provide practical support such as transport, companionship, emergency contact) for individuals with palliative needs - Regular meetings
Ontario	Compassionate City	- Normalize and foster conversations about death and dying	- Death cafes - Book clubs
Ontario	Compassionate City	- Provide palliative care education for public - Build palliative care awareness and knowledge among the public - Facilitate conversations about death and dying, advance care planning	- Education sessions (advance care planning) - Attend community fair
Ontario	Compassionate City	- Engage community members in supporting individuals facing issues associated with chronic and serious illness - Build palliative care capacity among the public - Foster the development of smaller Compassionate Communities within city	- Education sessions (advance care planning, social connectedness, grief and bereavement) - Support groups - Volunteer check-ins for individuals with practical needs - Volunteer practical support for individuals

			with palliative needs - One on one support with goal forming and healthcare system navigation
Ontario	Education and clinical service	- Address palliative care needs for structurally vulnerable individuals - Equity-focused	- Clinical service
British Columbia	Compassionate Community	- Advocate for improved palliative care services for structurally vulnerable individuals - Equity-focus - Provide palliative care by addressing social determinants of health	- Community action and advocacy team - Clinical service to address palliative needs and social determinants of health
Alberta	Compassionate Community	- Develop a Compassionate Community within a supportive living facility - Facilitate conversations about death and dying and grief among staff and residents - Provide palliative care education to staff - Foster a culturally safe environment	- Education sessions for staff (palliative and end of life care) - Coffee chats with residents - Meet with local Indigenous elders
Alberta	Compassionate Community/Communities	- Nature focused - Mobilize the community to support initiatives to connect individuals approaching the end of their life with nature - Foster companionship and connection with nature among community members living with grief	- Companionship nature walks - Volunteer support to facilitate outdoor connection for individuals approach the end of their life

Each Compassionate Community and City initiative was unique, as each community itself is unique. The participants highlighted the importance of tailoring the community

engagement approach and the goals and foci of Compassionate Community and City initiatives to align with the strengths, values, and priorities of each community. While each community was unique, there were similarities found in the ways that participants described their experiences in planning and implementing their various Compassionate Community or City initiatives.

Motivations to Engage in Compassionate Community and City Implementation

The participants shared their motivations for becoming engaged in the planning and implementation of Compassionate Communities and Cities. The central theme focuses on supporting individuals who are "*falling through the cracks*" and the need to: (a) encourage early conversations, (b) embrace the power of community action, (c) connect social networks and resources, (d) promote equitable access while considering the social determinants, and (e) leverage a community approach to care. These sub-themes contribute to the over-arching motivation of supporting individuals with chronic, progressive, and serious illnesses who have limited access to palliative care.

Supporting Individuals who are "Falling Through the Cracks"

The main over-arching theme was supporting individuals who are *"falling through the cracks."* Many of the participants used the term "*falling through the cracks*" to describe the experiences of individuals living with chronic, progressive, or serious illness in their community that do not receive adequate palliative care throughout the course of their illness. The use of the term "*falling through the cracks*" suggests that there are silos in the community and in the healthcare system that individuals who have palliative needs may fall through. Nurses viewed engaging in the planning and implementation of Compassionate Communities and Cities as an avenue to support these individuals with palliative needs who have limited access to high-quality palliative care. Palliative needs referred to symptom management, practical needs, psychosocial

needs, spiritual needs and needs that arise from issues associated with death, dying, caregiving, grief, and loss. This theme represents the over-arching motivation of nurses to implement Compassionate Communities and Cities – to meet the palliative needs of individuals whose needs are not being met. Each of the sub-themes contribute to this over-arching theme.

Encouraging Early Conversations

The nurse participants identified and discussed the importance of having early conversations about death and dying throughout society. Many of the participants expressed the belief that having earlier conversations about this topic will help address the palliative needs of individuals and improve their capacity for palliative care. This included having conversations about death and dying early in the illness trajectory, but extended beyond the illness experience to encourage conversations about issues associated with death, dying, and illness throughout society. The participants shared their belief that implementing Compassionate Communities and Cities is a way to encourage conversations about death and dying among the public across the living and dying trajectory.

Many participants shared both clinical and personal experiences that led them to recognize the importance of having early conversations about issues associated with death and dying, highlighting the harm that can happen when conversations about end of life are avoided. The participants shared how a lack of these types of conversations can lead to individuals receiving care that is not concordant with their values, wishes, or goals. The participants emphasized how a lack of understanding regarding palliative care can lead to individual's palliative needs not being met.

The participants recognized Compassionate Community and City development as an avenue to support the public in encouraging discussion about the topic of death and dying. The

participants discussed how advanced care planning and early discussion about end of life issues can better prepare community members for the end of life and better equip them with knowledge and skills that are useful in accessing and supporting good quality palliative care. The participants shared how Compassionate Community and City initiatives and the public health approach advocate for early conversations about death and dying to be normalized throughout society so that individuals of the public experience these conversations before they become sick. This way, when an individual presents or is diagnosed with a chronic, progressive, or serious illness, they will have the capacity to initiate conversations with their families and healthcare team about what is important to them to maintain quality of life throughout their illness and experience a smoother transition to end of life.

The participants not only spoke about the inherent value of early discussions about death and dying for individuals who are living with a chronic, progressive, and serious illness, but also about the extension of the benefits to those who are living with grief and loss. The participants shared how earlier discussions about death and dying may better prepare individuals to cope with grief and loss. The participants identified that harm occurs when it is not acknowledged that a person has experienced a loss and is grieving. The participants expressed the belief that many community members do have the capacity to support one another in grief but may not have the knowledge of how to begin. They believed that encouraging discussions about grief and loss can build capacity among the public to support each other through grief.

The recognition of the importance of early conversations about death and dying is a motivation to develop Compassionate Communities and Cities. The participants shared that Compassionate Community and City initiatives often implement activities or programs that aim to engage the public in discussion about death and dying.

Embracing the Power of Community Action

Some of the participants shared that they were inspired to engage in Compassionate Community and City development by previous experiences that taught them the power of community action. These participants first recognized the power of community action and then learned about Compassionate Communities and Cities and believed that community-based initiatives can be a powerful way to engage the public in palliative care. The participants expressed that community engagement may help address palliative needs that exist in the community.

For example, two nurses reflected on their experiences of providing nursing care to individuals with HIV during the AIDS epidemic and their experiences during that time of communities coming together to advocate for improved medical care for individuals with HIV and AIDS and reducing social stigma associated with HIV and AIDS. One of these nurses also reflected on her experiences of community action while advocating for women's reproductive rights. This participant expressed her view that in each of these experiences, it was community who recognized and responded to the issue by collaborating as a group to advocate for change. Another nurse shared that she was inspired by observing effective collaboration between her local hospital and community members on various community projects. These experiences, combined with clinical experiences in palliative care, led these nurses to consider the impact that community action may have to engage the public in palliative care, with the overall aim of addressing palliative needs of individuals facing issues associated with chronic, progressive, and serious illness. These nurse participants expressed the belief that through these experiences they learned that it is often the community that has the power to influence society, rather than healthcare professionals. The significance of the power of community action being a motivator is

that this highlights these nurses' understanding that engagement of the public is critical to a truly successful Compassionate Community and City implementation. The participants identified that community advocacy and action is an effective way of building the momentum that is needed for successful implementation.

The participants highlighted that Compassionate Community initiatives are not an intervention for the community by healthcare professionals, but rather a collaborative effort amongst a group of individuals with shared challenges and values. The participants viewed themselves as members of the community, with valuable knowledge and skills to share, rather than a healthcare professional providing a service to the public. The participants shared that when aiming to shift the culture around the way that the topic of death and dying is approached among the public, it is essential that the concept of community be central to these efforts. The recognition of the power of community action led participants to believe that Compassionate Community and City development will help to address unmet palliative needs among the public and is therefore a motivation to develop Compassionate Communities and Cities.

Connecting Social Networks and Resources

The importance of social connectedness was a motivation of participants to develop Compassionate Communities and Cities to connect social networks and resources. The participants highlighted the importance of social connectedness throughout the interviews. They viewed Compassionate Community and City development as a way to improve social connectedness among the public in their communities. The participants expressed the belief that connecting social networks and resources within the community can improve the public's capacity to respond to palliative needs among their community members.

Many participants shared that they were motivated by values of relationship-building and connection. The participants spoke about how it is important to them to build connections and networks, one participant even shared that connection and rapport-building was the reason she became a nurse. In addition, participants spoke about mobilizing and supporting individual's existing networks. They shared that many individuals living with chronic, progressive, or serious illness have individuals in their "inner circle" who are supporting them through their illness. This reflects a common reality that most palliative care is provided by this inner circle, and health and social care professionals only provide a smaller and more specific part of the ongoing need for support (Kellehear, 2022). The participants shared the belief that it is the responsibility of both the healthcare system and members of the community to mobilize and support these existing networks of care. The participants shared the belief that every person would benefit from being part of a Compassionate Community, whether as a person receiving support, providing support, or both.

The participants spoke about the power of companionship and 'being present.' Volunteer check-ins for individuals living in the community who are in the early stages of chronic, progressive, or serious illness was identified as a powerful way to provide companionship to individuals who have palliative needs. One nurse participant shared that while offering volunteer check-ins may seem to be a small matter, volunteer check-ins were reported by the Compassionate City program clients to be the most effective component of their program. In addition, companionship was identified a powerful form of social connection for supporting individuals at the end of life care and for those who are grieving. The participants shared that relationships and social connection are meaningful and important aspects of palliative care.

The participants also spoke about the importance of connecting with community organizations (e.g., libraries, schools, social service organizations, community care organizations) and fostering collaboration between organizations who have shared interests to support individuals with chronic, progressive, and serious illness. Some participants identified that while there are many organizations in the community that aim to provide support in various ways, there is a lack of collaboration between these organizations for this purpose and they remain under-utilized because of a lack of awareness or ability to access among individuals who would benefit from these programs. Building partnerships with key organizations was identified by the participants as a way to break down barriers to collectively meet needs. In addition, the participants identified that connecting community members with community organizations was important to create awareness among the public of resources that are available for them when they need them. These connections can also foster increased community engagement as community members learn about these resources and offer support where they are able. Fostering connectedness between community organizations is important to strengthen the community and develop a system that is well connected and where services are easily accessible to the public.

Promoting Equitable Access While Recognizing the Social Determinants

Improving access to and the quality of palliative care was another motivation for the participants to implement Compassionate Communities and Cities. Some participants shared that their clinical experiences in palliative care led them to recognize the influence of the social determinants of health on access to and quality of palliative care. For example, participant M7E2E who is a nurse leading a Compassionate Community initiative out of a hospital, shared that, "*good quality palliative care shouldn't be about whether I'm in the right postal code or whether I have, you know, access to you know, healthcare, or whether I have access to clean*

water, but it often is." Having gained a knowledge of the different ways that palliative care is experienced among different groups of people, this nurse came to hold the belief that palliative care is a public health issue which may best be addressed by a community-based public health strategy such as the Compassionate Community model. Similarly, another nurse who is engaged with a community action team aiming to improve palliative care for vulnerable people shared a powerful story of her experiences caring for a man with AIDS during the AIDS epidemic:

> *And what I really found is that nobody wanted to care for this man. And I thought, how must it be when you're dying, and you know, you're... nobody's acknowledging your partner as your life person. How must it? And nobody wants to touch you, and nobody wants to go into your room. How must it be when you're dying? That is the case. And it just, so it really sat with me.* – Participant 5V6EE

For this nurse, this experience early in her career motivated her to engage in community-based work to address the gaps in care that are experienced by people experiencing vulnerabilities.

One physician participant shared that she became motivated to develop a Compassionate Community through the recognition of the ways that the social determinants influence quality of life and how the social aspects of an individual's wellbeing

matter in addition to the medical aspects.

> *As a physician, I think I learned very quickly. I mean, obviously the medicine is important but it is such a small piece of what helps people live and die well. And I think for somebody who treats people at home in their communities you have an open window to the inequities and the suffering that happens, not because of the medicine or lack thereof, but because the lack of social supports and other social determinants of health. So that's the motivation,*

> *is that it's the belief that Compassionate Communities can play a major role in helping people live well all the way up to the end of their life.* – Participant 3C7QE

This participant is motivated to develop a Compassionate City by her belief that Compassionate Cities may address some of the gaps in care that individuals experience and improve quality of life. The recognition of the ways that the social determinants of health influence individual's access to palliative care motivated the participants to develop Compassionate Communities and Cities.

Leveraging a Community Approach to Care

The recognition of the importance of community care is a motivation of the participants to develop Compassionate Communities and Cities. The participants described clinical experiences that led them to recognize that much of what determines health, wellness, and quality of life occurs outside of the hospital and that issues associated with death and dying are widespread and cross the lifespan. Despite this, much of healthcare focuses on acute or reactive care, while healthcare in the community remains under-resourced and is often unable to adequately meet patients' needs. The participants recognized the 'gaps' in the healthcare system and how these gaps become particularly evident in the community setting. Many of the participants expressed that they perceived that community care is under-valued by nursing schools, medical schools, and the government. The value of community nursing was discussed; baccalaureate-prepared nurses are taught community health and public health principles throughout their program but often do not have the opportunity to practice these skills once they enter the clinical setting. Many of the participants expressed the belief that the potential of community nursing could be optimized to meet palliative needs in the community by strengthening and valuing nursing skills such as advocacy, therapeutic communication, and

community assessment and care equally to hands-on practical skills. Community nurses are well positioned to 'meet patients where they are' or 'meet communities where they are' by tailoring their approach to the uniqueness of each community and individual. The recognition that the community plays an important role in the wellbeing of individuals who are facing issues associated with chronic, progressive, and serious illness motivated the participants to engage in the development of Compassionate Communities and Cities.

How Implementation Teams Form

Both nurse participants and non-nurse participants spoke about the various ways that they became involved in teams aiming to implement Compassionate Communities and Cities. Typically, participants were first introduced to the concept of Compassionate Communities and Cities through mentorship, webinars, information sessions, or through professional networks such as residential hospices or palliative care associations. The participants became motivated to implement Compassionate Communities and Cities by listening to others in the field speak about their motivation and the aim of Compassionate Communities and Cities and finding that the ideas around this concept aligned with their own personal beliefs. For example, participant ZA1XF who has engaged in the implementation and evaluation of a Compassionate City organization stated that as she was listening to a presentation about Compassionate Cities at a hospice, *"it just resonated with what I believe about community and the moral imperative of society to be caring for people at end of life."* The participants spoke about their experiences learning about Compassionate Communities and Cities and how this vision inspired them as they understood Compassionate Communities and Cities to be an articulation of an approach that aligned with personal beliefs they had based on their clinical and personal experiences.

The participants spoke about how teams formed to collaborate to move towards shared visions that they had about implementing Compassionate Communities and Cities. Many participants shared that their teams formed organically and informally. After participants became inspired to implement a Compassionate Community and/or City, they reached out to other individuals in their network who had similar beliefs. Some participants reached out to well established Compassionate City initiatives for support in connecting with others in their own area. As individuals began to join to form a team, teams collaborated to discuss their priorities to develop a vision, and from there discuss their capacity to implement an initiative in their community. Participants spoke to the importance of having a clearly defined vision to work towards. They also spoke to the importance of having a formal steering committee, especially in the context of a Compassionate City, to provide leadership and maintain momentum.

As community members engaged with formal Compassionate City events, many were motivated to initiate their own informal Compassionate Communities within their personal networks. This inspiration stemmed from various sources: some were moved by presentations about the Compassionate Communities model, while others were personally impacted by the support they received during experiences with chronic or serious illness. These encounters deepened their commitment to the cause. One participant described a unique pathway: a group that initially formed through a research project continued to meet after the project concluded, finding strength and purpose in their shared vision. Overall, the establishment of Compassionate Community and City teams catalyzed the broader implementation of Compassionate Communities and Cities.

Implementing Compassionate Community and City Initiatives

The participants spoke about their experiences of implementing a Compassionate Community and/or City and shared recommendations for implementing additional Compassionate Communities or Cities. This section is divided into two to reflect the key similarities and differences between implementing a Compassionate City and implementing a Compassionate Community.

Compassionate Cities

The participants shared that Compassionate City implementation requires a team-based approach. Diversity in both age and discipline were identified as team strengths, allowing for a more diverse range of ideas to be developed. Developing a Compassionate City implementation team involved networking with individuals who share a similar vision and engaging in discussion to clearly define the vision and discuss the team's capacity to plan and implement an initiative. Some of the participants highlighted that when aiming to plan a Compassionate City initiative, it is crucial to develop literacy around the definition of Compassionate Community and City and have a clearly defined vision. In addition, they highlighted the importance of having clearly defined roles and responsibilities within the team. It was necessary to have identified individuals who are responsible for leadership and are committed to moving the initiative forward. Some participants shared that while it is important for community members to be actively engaged, it is essential to have a formal organization take ownership of the program to provide structure, funding, physical space, and volunteer coordination. The participants spoke about how it is important to have team members responsible for championing the initiative, as well as team members responsible for building connections. While there can be overlap, the

participants highlighted that it is important that responsibilities are made clear to keep momentum and maintain sustainability of the initiative.

The participants emphasized that each community is unique and will require an approach to development that is grounded in their own strengths, values, and priorities. They shared that it is essential to engage the public early in the planning process to learn about their strengths, values, and priorities for building palliative care capacity in the community. The participants felt that many members of the public are hesitant to talk about matters of death and dying, therefore communicating the importance of Compassionate City to the public is important when seeking their engagement. The participants discussed strategies to connect with the public. While engaging the public was identified as a struggle for many of the participants, they shared some strategies that have been successful, highlighting the importance of creativity in developing these strategies. The participants shared that the implementation of any successful Compassionate City or Community initiative is a pragmatic process; it is important to seek feedback regularly and embed evaluation into all activities. Some participants shared that implementation does not follow a linear process that occurs in steps, rather implementation has taken the form of an iterative loop where feedback is regularly sought and responded to.

The participants shared that connecting with other community organizations early in the planning process is an important action when aiming to develop a Compassionate City. Connecting with key organizations was identified as particularly beneficial as they may have existing relationships with the public and may assist in promoting community engagement. In addition, sharing resources, such as space or time, can be an efficient way to connect with the public. Some participants emphasized that collaboration with existing organizations who share a similar aim is more efficient than aiming to create a new service that may overlap with existing

resources. Since one of the aims of Compassionate Cities is to bridge gaps in community resources to support individuals who are vulnerable and have less access to these services, connecting with existing resources is useful to bridge these gaps. Strengthening these bridges may lead to a more robust social net. While there were many similarities between the experiences of the participants in implementing a Compassionate Community and implementing a Compassionate City, there were also some key differences.

Compassionate Communities

The participants discussed that each community is unique and there is no one way to approach implementation, however, there are several key elements to consider. First, it is essential that the community has ownership of the initiative. The participants highlighted that each member of a Compassionate Community has a role to play in its development and sustainability. While nurses or other healthcare professionals could provide gentle and non-intrusive leadership, the participants emphasized that community members must be at the centre of the initiative. The participants pointed out that while nurses are well positioned to support Compassionate Community implementation, Compassionate Community implementation does not require a nurse or healthcare professional. Any member of the community can initiate a Compassionate Community. Second, the participants spoke about how Compassionate Communities can be as formal or informal as the community wishes. Some Compassionate Communities prefer to have a structured leading body that meets regularly, while others prefer to meet regularly with a less structured approach. Third, the participants discussed that each community requires a unique approach that is tailored to the values, wishes, and capacity of that community. The participants emphasized the importance of taking a pragmatic approach to implementation; what works for one community may not work for another. Strategies for

development should closely align with the goals and capacity of the community. Nurses engaged in planning and implementation throughout each stage.

The Nursing Role

The participants shared many ways that nurses engage in the planning and implementation of Compassionate Communities and Cities. While each participant shared unique ways in which they themselves or other nurses contribute to their respective teams, there were three main types of nursing roles in implementing Compassionate Communities and Cities, including as: (1) catalysts who move initiatives forward, (2) health promoters who apply the health promotion principles to palliative care, and (2) bridges who form connections between community partners, researchers, and the healthcare system. The relationship between these three roles is not linear but rather they occur simultaneously throughout the planning and implementation stages of development. For example, a nurse is not catalyst before a health promoter, nor a bridge before a catalyst.

Nurses As Catalysts

Nurses are catalysts for Compassionate Community and City implementation. Throughout the interviews, the participants discussed the various ways that nurses act as catalysts to initiate and facilitate the implementation of Compassionate Communities. In this context, a catalyst is a person who moves an initiative forward. The participants spoke about how nurses provide leadership and expertise in community development, health promotion, and palliative care. The participants shared the ways that nurses collaborate with interdisciplinary teams to develop ideas, create a vision, and move the vision forward. The participants shared that nurses develop creative strategies to engage the public in Compassionate Community or City activities and mobilize research knowledge. In addition, the participants shared that nurses use

their competency as advocates to share the importance of Compassionate Communities with the public and stakeholder organizations to move initiatives forward. Additionally, nurses championed Compassionate Community and City initiatives by embodying and promoting the vision in the community, teaching, *"cheerleading"*, and sharing research, evidence, and experience.

The participants spoke about the ways in which nurses engage in leadership using a non-intrusive leadership style to provide guidance and training. Some participants discussed how the nurses' role, particularly in Compassionate Community implementation, depends on whether they themselves are a member of that community. One participant noted that the nurse's role in a smaller Compassionate Community would differ based on whether they are an 'insider' or an 'outsider' in the community. An 'insider' was defined as a natural member of the community themselves. An 'outsider' was defined as someone who is not a natural member of the community but engages with the community to provide guidance from the outside. The participants shared that in the case that the nurse is not a natural member of the community, they may provide a gentle and non-intrusive approach to guidance, which may involve providing resources and education. If the nurse is a member of the community, their role was described as providing resources and education in addition to a more heavily engaged participation in the activities of the Compassionate Community. The participants identified that many communities do have the potential to support one another through chronic, progressive, and serious illness; the role of nurse can be to gently provide support to mobilize the potential of the community.

It was also discussed how it is important to have champions who are active members of the community to share the vision and catalyze change within the community. While nurses are

often champions, the participants highlighted the importance of having a diverse champion team that may include health and social care professionals and members of the public.

Nurses As Health Promoters

Nurses who are planning and implementing Compassionate Community and City initiatives are health promoters. The nurse participants shared that they use their knowledge of health promotion and community development to collaborate with interdisciplinary teams to plan and implement Compassionate Communities. The nurse participants sought to assess their communities' knowledge, comfort, and skill in discussing sensitive topics such as serious illness and end of life and build their capacity to support individuals dealing with these issues. Nurses engaged with interdisciplinary teams to facilitate initiatives and activities that aim to proactively improve quality of life and wellbeing in the context of serious illness. Their skills in health promotion and community health were employed to enable and support communities to engage in improving their own wellbeing in this context. The health promotion principles of prevention, early intervention, harm reduction, and sustainability were used as guiding principles to develop strategies to build capacity and advance equity in palliative care in the participant's local communities.

Prevention, Early Intervention, and Harm Reduction

The nurse participants viewed the health promotion principle of prevention in this context to be focused on efforts to prevent distress from issues associated with serious illness. The nurse participants explained their ideas that by implementing Compassionate Community and City initiatives to build awareness and knowledge of palliative care and available resources among the public, many community members will have this knowledge and awareness before these issues arise. When they do become affected by issues associated with chronic, progressive, and serious

illness, they will have been equipped with knowledge and skills to address and manage these issues.

The nurse participants identified that many members of the public are already facing issues associated with serious illness. Most individuals have experience with death and loss. For this reason, the nurse participants explained that the health promotion principle of early intervention was used as a guiding principle to plan and implement Compassionate Community and City initiatives. Building awareness, knowledge, and capacity of palliative care and community resources were viewed as strategies for early intervention in the illness trajectory to prevent crises later. The nurse participants explained that building capacity for palliative care among the public prepares community members to recognize when an individual needs palliative support earlier on in the illness trajectory and equips them with skills to support these individuals.

The nurse participants discussed that it is not realistically possible to prevent all suffering and distress, leading some participants to find harm reduction to be a particularly relevant health promotion principle in this context. While there is no way to escape the distress that accompanies the experience of living with serious illness or losing a loved one, the nurse participants believe that this distress can be reduced by equipping communities to support one another through these experiences. In addition, the nurse participants discussed that increased awareness and knowledge of palliative care and available resources may alleviate some uncertainty and uneasiness.

Sustainability

The nurse participants described the ways that they use their knowledge and skill in the health promotion principle of sustainability to plan and implement Compassionate Community

and City initiatives that will sustain throughout time. The Compassionate Community and City initiatives represented in this study were each at different stages in planning, implementation, and sustainability, meaning the participants were able to offer varying insights into how to develop a successful initiative that is sustained over time. The participants identified community engagement, research and evaluation, and mobilizing and strengthening existing resources as strategies for successful implementation.

The nurse participants spoke of the importance of Compassionate Community initiatives being led by the community. While each of these initiatives also included involvement from other healthcare professionals, the nurse participants noted it was important to seek engagement of community members and stakeholders early on in planning and implementation. As communities become engaged, they identified that it was important that communities took ownership and became self-sustaining. Some of the participants shared examples of clients of the program becoming volunteers themselves and continuing to be involved and sustain the initiative. In these cases, it was through positive experiences with the initiative that the clients were inspired to continue the work. The nurse participants spoke about how momentum was built in the community when its members gained an understanding of the importance of this work.

In the context of Compassionate Cities, a way of supporting communities to be self-sustaining was to nurture smaller Compassionate Communities within the city. The nurse participants gave examples of how this might involve the nurse or another healthcare professional initiating a Compassionate Community in their own small community, such as in a geographic location (i.e., condo building, neighbourhood network) or a faith-based community such as a place of worship. The nurse participants also gave examples of how this could also

involve reaching out to other faith-based communities or ethno-cultural groups who are interested in becoming a Compassionate Community. Some Compassionate Community organizations found that smaller Compassionate Communities formed organically or informally. The nurse participants spoke about how their approach to leadership in a small Compassionate Community was an approach that provided gentle and non-intrusive guidance, without taking over control of the initiative. They described themselves as resources to provide training, education, information, and consultation. One participant referred to this approach as a *"light touch approach."*

Nurses used their knowledge and skills in health promotion and planning to assess their communities' strengths and needs and learn about their priorities and values by embedding evaluation throughout planning and implementation. The nurse participants described various methods of evaluation that they used to assess communities' strengths and needs such as in-person discussion, questionnaires, surveys, townhall meetings, and qualitative research. One nurse participant shared that she participated in a SWOT analysis to assess the strengths and weaknesses of her community in terms of palliative capacity, identify opportunities for growth in capacity, and threats to Compassionate Community development. Evaluation was considered an essential component to making planning and implementation an iterative and pragmatic process. There is also some assessment that happens informally – the nurse participants identified that nurses can assess needs and values and respond by being flexible and adapting their approach to the needs and values of the community or individual. The nurse participants also spoke about the importance of research and evaluation of Compassionate Communities and Cities to demonstrate their importance and impact to policy-makers and funding bodies.

Many of the participants identified a lack of funding as a barrier to sustainability. Some of the nurse participants shared ways that they try to acquire funding. For example, one nurse participant who is a university professor in a School of Nursing successfully acquired funding from a philanthropic organization by making connections in the community. Another nurse participant shared that she has written grant proposals to the hospital organization that she works for to acquire funds to be able to engage in more Compassionate Community activities. Some participants shared that a lot of Compassionate Community work happens through volunteer efforts, both from nurses, other healthcare professionals, and community members.

Some nurse participants also spoke about how they mobilize and strengthen work that is already happening. These participants spoke about how there are many resources in their city available to support individuals who are dealing with issues associated with chronic, progressive, and serious illness, but that because of a lack of awareness of these resources among the public and a lack of engagement and collaboration, these resources remain disconnected and under-utilized. Many participants spoke to the importance of collaborating with other community organizations. Examples of these organizations included mental health associations, social services organizations, emergency services, colleges, universities, community health centres, family health teams, local libraries, and local news broadcasters. The nurse participants shared that they collaborated with other community organizations to help to break down barriers, identify and address gaps in their community, and provide physical space.

Advancing Equity

The nurse participants engaged in Compassionate Community and City development as a way to advance equity. The participants identified that a strength of nurses in Compassionate Community and City work is their knowledge and understanding of the ways that the social

determinants of health influence an individual's experiences and access to palliative care. Nurses used this knowledge and understanding to inform the ways that equity considerations are integrated into the planning and implementation of Compassionate Community initiatives. Some nurse participants spoke about the importance of developing creative strategies to include vulnerable individuals. For example, one nurse hosted education sessions about the importance of social connectedness in a location where there are also food services for individuals with low socio-economic status and food insecurity. One nurse who leads a program aiming to improve palliative care services for individuals with intersecting vulnerabilities noted the importance of including this population in the planning and implementation of community initiatives. She shared that an essential component of their program is their community-action team which includes people with lived and living experience of substance use, homelessness, mental illness. The team also includes people who work in harm reduction, shelters, and low-barrier housing. Some of the nurse participants also promoted equity by reaching out to various ethno-cultural groups to offer support in building their capacity for palliative care or by connecting with different organizations that serve newcomers to Canada. The nurse participants spoke about the importance of ensuring that initiatives have ethno-culturally specific approaches to ensure inclusion. One nurse participant who is developing a Compassionate Community within a supportive living facility shared how they are collaborating with their local Indigenous elders to ensure that care for Indigenous residents is culturally safe.

Nurses As Bridges

Many of the nurse participants used the term 'bridge' as an analogy to describe the ways that nurses function within a Compassionate Community or City team. Throughout each of the interviews, examples of how nurses form connections to strengthen the implementation of their

respective Compassionate Community initiatives were shared. Nurses made connections between individuals, community partners, different professions or disciplines, social care and healthcare, research to practice, and the public and healthcare system. Many of the nurses shared how they enjoy networking and making connections. The non-nurse participants shared that they value the strength of nurses in forming connections and building relationships.

Nurses bring a holistic perspective to the interdisciplinary team that is essential for Compassionate Community and City development. The nurse participants discussed this holistic perspective as a way of looking at the whole person rather than just their physical or medical issues. This included the physical, emotional, psychological, social, spiritual, and cultural components of both individuals and communities. This holistic nursing perspective closely aligns with the principles of the public health approach to palliative care and therefore with Compassionate Community development. Some participants spoke about how nursing is a holistic profession and acts as a bridge between the different professions and disciplines that collaborate to implement Compassionate Community and City initiatives, helping to facilitate team-based care. While each profession comes with its particular strength and focus, a strength of the nursing profession was described as nurses' ability to act as a bridge to foster interdisciplinary collaboration so that each unique strength and perspective is included to inform the implementation and sustainability of Compassionate Community and City initiatives. The nurse participants spoke about how they bring a perspective that ensures that Compassionate Community and City initiatives' strategies and actions are in alignment with the various components of holistic care. The nurse participants spoke about how nurses act as a bridge between social care and health care in both the acute care setting and the community.

Both the nurse participants and non-nurse participants spoke about how nurses are strong communicators, which enables connection-making in Compassionate Community and City work. Therapeutic communication is a standard of nursing practice that is embedded throughout nursing education and is operationalized in practice. Nurses consistently described their communication practices as client-centred; nurses use their communication skills to ensure that their patient's care is in alignment with their values, goals, and wishes. This skill was transferrable to caring for communities in the Compassionate Community context. The nurse participants described how they communicate with communities to develop strategies that are uniquely tailored to the uniqueness of each community and are informed by the communities' wishes and values. In this way, nurses function as a bridge between the healthcare system and the public. Nurses come prepared with evidence-based knowledge and clinical skills and can communicate in creative ways to transfer and disseminate knowledge among the public to build capacity for palliative care.

The nurse participants also spoke about how nurses act as a bridge between research and practice. Nurses mobilize research knowledge by using research evidence to inform their practice in Compassionate Community and City activities. For example, one nurse participant who conducts research around the topic of connecting individuals dealing with issues associated with serious illness with nature is involved in various initiatives to act on this research knowledge. This nurse participant is involved in initiatives that involve community members in improving access to the outdoors for individuals approaching the end of life and Compassionate Community initiatives implementing 'grief walks' where individuals in the community who are grieving can connect with each other and nature while walking together in the outdoors. Another nurse, who has a background in community development, conducts research around integrating

palliative approaches to care for individuals who are facing intersecting vulnerabilities such as housing precarity, homelessness, substance use, and mental illness. Her research has been mobilized to develop and implement mobile palliative care services for vulnerable individuals. This research has informed the development of both clinical services and a community-action team that has advocated to move this mobile palliative care service for vulnerable individuals forward. Continued advocacy and research have led to increased referral and uptake of these services and the implementation of mobile palliative care services for vulnerable individuals in other cities in Canada. In addition, the nurse participants spoke about the ways that they engage in research mobilization by sharing research evidence with community members, organizations, and other stakeholders by leading education sessions, providing educational resources, and presenting research findings. Presenting research findings to stakeholder groups has been an impactful way to inspire community members to become involved in Compassionate Community activities. Sharing research findings with relevant organizations has also been an effective way to form partnerships. Forming these partnerships was useful to create opportunities and provide space for gathering and provide a volunteer pool.

Nurses also bring a duality of perspectives which is beneficial to addressing community level gaps. At the micro level, nurses come with an understanding of the palliative needs of individuals in a community. At the macro level, nurses zoom out and view the community holistically. This perspective is particularly useful in Compassionate Community work because it helps fill gaps in individual's existing networks of care and supports integrated care for smoother transitions. Nurses come prepared with skills to assess the health and capacity of a community when it comes to supporting individuals facing issues associated with chronic, progressive, and serious illness and engage in strategies to build capacity at a population level. The nurse

participants and one non-nurse participant expressed that while the role of the nurse in planning and implementing Compassionate Community and City initiatives is important, nurses across the system have an important role in the public health approach to palliative care.

Participant Recommendations for Integrating a Public Health Approach to Palliative Care into Everyday Nursing Practice

The participants in this study expressed the view that all nurses have a role in applying a public health approach to palliative care. The participants encouraged all nurses in every setting to consider the role that they have in contributing to healthy aging and dying in their own setting. Many of the participants expressed their belief that there is a need for nurses in all settings to gain competency and literacy in the palliative approach and the public health approach. One nurse participant who is a faculty member of a School of Nursing and is engaged in a community-based palliative care program aiming to improve palliative care for vulnerable individuals expressed this belief:

> *And I think this is what public health palliative care is trying to do you know, with a new name is basically to shift that thinking away from palliative care as a service which it never was? You know it never was thought of like, conceptualized as... it was conceptualized as an approach, a philosophy, a way of, you know, working in and with people. But it's been operationalized as a service.* – Participant 5V6EE

This nurse participant discussed how the potential of palliative care is much broader than what happens within traditional institutions and care settings. Another non-nurse participant expressed that she hopes to see more nurses working across the system understand the importance of the role of community care. While many nurses will never work in community settings, the participants expressed that they still have a role in supporting the work that happens in these

settings. In addition, some nurse participants also expressed that even within traditional healthcare settings across the system, nurses have the knowledge, skill, and ability to care for their patients in ways that help them to connect with what matters most to them. Additionally, one nurse participant who works in an equity-oriented community-based program encouraged nurses in every setting to apply a trauma-informed approach to care that acknowledges that each of their patients have a past and come from an environment that influences their health and wellness. Participants shared that the public health approach to care is applicable in every setting, to foster a healthcare system and further a society that acts on compassion towards individuals facing issues associated with chronic and serious illness.

The participants shared their recommendations for nursing education to support nursing students in building the knowledge and skills they would need to support or lead Compassionate Community and City work. It would be beneficial for nurses working to plan and implement Compassionate Communities and Cities to come prepared with knowledge of the palliative approach to care, public health approach, community health nursing assessment, community development, and capacity building. The participants also shared the importance of Compassionate Community and City nurses having a deep understanding of the social determinants of health and the ways that a person's environment affects their health. In addition, it would be beneficial for these nurses to learn skills such as communication, advocacy, and relationship-building. Some participants also recommended that nursing students be given the opportunity to participate in clinical placements in the community to learn about community health assessment and nursing strategies to build capacity within a community.

While the participants discussed recommendations for education and training to support nursing students to be able to do Compassionate Community work, the participants also provided

recommendations for education of nursing students generally to integrate the public health approach to palliative care across the system. Even though many nurses will work with patients who are at risk of developing chronic and serious illness, the participants felt that many nursing students graduate with a limited understanding of when and how to apply a palliative approach to care. The participants expressed that nurses who are working outside of palliative care also have a role in supporting healthy aging and dying. Many of the participants expressed the view that nursing education must include more discussion about death and dying. The participants also identified the importance of educating nursing students about the palliative approach to care and supporting students to build skills in advance care planning and serious illness communication. Participants shared the view that generally there is a very narrow perspective of the potential of palliative care within healthcare and it is important that nursing students be educated with a much broader perspective of the potential of palliative care. One participant summarized this view well:

> *We need to be able to educate nurses with a much broader perspective of what the potential is for palliative care beyond, you know, the everyday kind of care that happens in a unit, in an institution, even in a home care setting.* – Participant 5V6EE

Since much of healthcare happens outside of traditional health care settings, there is a need for nurses in all settings to understand the potential for palliative care in the community. The participants expressed that it would be beneficial for nursing students to develop an awareness of resources in their community that are available to support palliative needs. In addition, they felt that nursing students should receive education that allows them to recognize that communication, advocacy, and relationship building are important nursing skills. The participants also expressed that nursing students should also be prepared with education regarding the social determinants of

health, trauma informed care, and the ways that grief and loss affect individuals throughout their lifetime. Some nurse participants also felt that it is important for nursing students to have clinical placements in traditional palliative care settings and the community broadly, even if they do not intend to work in these settings following graduation, in order to build their understanding of the role of a palliative approach providing a more seamless transition throughout aging and living with chronic, progressive, or serious illness to end of life.

Summary of Findings

In conclusion, nurses become motivated to develop Compassionate Communities and Cities through their recognition of the importance of (a) encouraging early conversations about death and dying, (b) connecting social networks and resources, (c) embracing the power of community action, (d) promoting equitable access while considering the social determinants of health, and (e) leveraging a community approach to care. From this motivation, nurses engage in Compassionate Community and City team formation and Compassionate Communities and Cities are planned and implemented. Nurses engage in planning and implementation throughout the entire process as (a) catalysts, (b) health promoters, and (c) bridges. Nurses are instrumental in forming strong and sustainable Compassionate Communities and Cities, yet there is potential for the nursing role to expand to integrate a public health approach to palliative care into everyday nursing practice across the healthcare system.

CHAPTER FIVE: DISCUSSION

This chapter provides a discussion of the study findings including a summary of key findings, discussion of the findings in relation to existing literature, and reflection of the methods used in this study, highlighting key strengths and limitations. This chapter highlights the contributions of this study in advancing nursing disciplinary knowledge regarding the implementation of Compassionate Communities and Cities.

Summary of Key Findings

This study is the first to explore how nurses engage in different ways in Compassionate Community and City planning and implementation in Canada. Nurses have demonstrated strong leadership skills by identifying issues in access to palliative care in Canada and addressing these issues by facilitating the development of Compassionate Communities and Cities. Nurses catalyze the implementation of Compassionate Community and City initiatives by applying health promotion principles and forming connections to move initiatives forward. Although many challenges in embracing palliative care were identified, strong nursing leadership demonstrates the potential to address these challenges. Despite often working with limited resources, nurses utilize their health promotion and relationship building skills to form connections within communities to catalyze the implementation of Compassionate Communities to support individuals who have palliative needs that are often overlooked in mainstream healthcare services.

Key Findings in Relation to Existing Literature

This section will discuss the key findings of this study in relation to the existing literature. First, the aim of Compassionate Communities and Cities will be discussed in comparison with existing literature and then implementation briefly. Then, the role of nursing in

implementing Compassionate Communities and Cities will be discussed in comparison with existing literature regarding nursing's role as leaders, health promoters, and bridges. Finally, the need for nurses across the system to adopt a health promotion approach and a palliative approach will be discussed and compared with previous literature.

The Aim of Compassionate Communities and Cities

The participants shared their motivations and visions for their Compassionate Community and City initiatives. The participants spoke about how their experiences led them to identify that many Canadians do not have adequate access to palliative care. The aims and visions that they shared were consistent with existing literature regarding the purpose and function of Compassionate Communities. Several purposes and functions of Compassionate Communities have been reported in the literature, such as to build awareness of palliative care (Librada-Flores et al, 2023; Matthiesen et al, 2014), change social attitudes towards palliative care (Gómez-Batiste et al, 2018; Mesquita et al, 2023), foster collaboration within health and social care sectors to strengthen integration of care for individuals with chronic and serious illness (Abel et al, 2018a; Aoun et al, 2022b; Gómez-Batiste et al, 2018; Librada-Flores et al, 2018; Liu et al, 2022; Matthiesen et al, 2014), educate the public about palliative care (Kelley et al, 2018; Librada-Flores et al, 2018; Liu et al, 2022; Paul, 2016), engage community members in palliative and end of life care (Aoun et al, 2022b; Librada-Flores et al, 2018; Liu et al, 2022; Matthiesen et al, 2014; Mesquita et al, 2023; Pesut et al, 2022) and engage policy-makers (Abel et al, 2018a; Kelley et al, 2018). The foci of the Compassionate Community and City initiatives represented in this study were to build public awareness and knowledge of palliative care and community resources, foster collaboration within the healthcare system and community resources to strengthen and mobilize existing resources and reduce fragmentation, build capacity

for community members to support one another through issues associated with chronic, progressive, and serious illness, and normalize conversations about aging, death, dying, and grief, facilitate advance care planning conversations, and advance equity and cultural safety in palliative care.

This study adds to existing literature by highlighting the aim of Compassionate Communities and Cities to normalize conversations about death and dying to increase preparedness for facing issues associated with death and dying. Furthermore, these findings build on existing literature by highlighting the role of Compassionate Communities and Cities in building the community's capacity to support one another through issues associated with chronic, progressive, and serious illness by building skill and knowledge among the public. Communities have the ability to take care of one another, yet this ability is not always actioned; the public can benefit from support to mobilize and build capacity. Participants in this study emphasized the importance of connectedness and collaboration in the community to reduce fragmentation within the healthcare system and community.

Implementation

The findings of this study strengthen findings from existing studies regarding the successful implementation of a Compassionate Community. Existing models describe a process of implementation that begins with dialogue to assess readiness in the community, followed by planning, implementing, evaluating, and following up (Kelley, 2023; Librada-Flores et al, 2018; Mesquita et al, 2023). Many of the participants in this study discussed the importance of early community engagement to inform the planning of the initiative, as well as the importance of seeking feedback from community members to inform the evaluation of the initiative and following up on evaluation to promote sustainability. In addition, the importance of having an

established leadership team committed to sustaining the initiative was identified as an essential element of successful implementation, which supports previous findings in existing literature which identifies stable and engaged leadership as a facilitator of successful implementation of Compassionate Community innovations (Pesut et al, 2022).

The Role of Nursing

The findings of this study add to existing literature by highlighting the value of having a nurse on Compassionate Community and City teams for their action as catalysts, health promoters, and bridges. This section discusses each of these roles in comparison to the existing literature.

This study highlights the role of nursing in catalyzing Compassionate Communities and Cities. The role of nursing as leaders in Compassionate Community and City implementation has not yet been discussed in the literature. While there have been calls to promote nurse leadership in palliative care in general (Dahlin, 2019; Hagan et al, 2019; Lopez et al, 2022), there is limited literature discussing this leadership role. Baskiewicz et al (2024) conducted a diagnostic survey to assess the leadership competency potential of palliative care nurses in Poland and found that palliative care nurses in the study rated their leadership competencies very highly but desire to develop their leadership competencies further. This study helps to address this gap in the literature by providing examples of nursing leadership in palliative care and providing practice guidance for nurses to be leaders in palliative care.

This study also highlights the role of nursing as health promoters. Health promotion in palliative care is a relatively new concept, and the role of nursing in health promoting palliative care is only beginning to be explored. Leclerc-Loiselle et al (2024) conducted an integrative review to explore literature regarding nursing activities for health promotion in palliative home

care and compared these activities to Kellehear's (1999) five strategies for health promoting palliative care. The scoping review found that nursing health promotion activities in the palliative home care context focused mainly on palliative care for individual. The literature included discussed how nurses provided education to their patients about death and dying and involved personal and community social supports but there was no discussion of the reorientation of palliative care services towards a health promoting perspective nor activities to combat death-denying health policies and attitudes (Leclerc-Loiselle et al, 2024). The participants in this study did engage in reorienting palliative care services towards a health promotion approach to palliative care. The nurse participants provided examples of how they champion a health promotion approach to palliative care through various activities such as public education sessions and workshops about advance care planning and the importance of social connectedness, public awareness initiatives, and community engagement in palliative care. The nurse participants engaged in reorienting palliative care services towards a health promotion approach at a population level rather than an individual level. They also engaged in combatting death-denying policies and attitudes by engaging in activities to encourage conversations about death and dying (e.g., death cafes, advance care planning workshops) and evaluating the impact of Compassionate Community and City initiatives for quality improvement purposes and to demonstrate the importance of theses initiatives to policy-makers.

In addition, the nurse participants in this study engaged in strategies to advance equity in palliative care. While there is an established need to advance equity in palliative care identified in the literature (Canadian Institute for Health Information, 2023) there is minimal empiric literature discussing the role of nursing in advancing equity in palliative care specifically. There is literature discussing the role of nursing in advancing health equity (Kett et al, 2025). A mixed-

methods study conducted in the United States to explore the health equity competencies and training needs of public health nurses found that public health nurses who participated in the study cited nurses' clinical knowledge and skill, ability to understand the big picture to address needs in a community, and nurse-specific tools (e.g., the nursing process, motivational interviewing) as intersecting components of nursing work that equips nurses to advance equity (Kett et al, 2025). These findings are consistent with the findings of this study. The nurse participants in this study discussed the ways that nurses' clinical knowledge and skill equips them to assess communities with a macro lens at a population level to develop strategies that meet the palliative capacity needs of their community. Together these findings suggest that nurses have strong potential to embrace palliative care within a public health approach.

Additionally, this study highlights the role of nursing as a bridge between community partners, researchers, and the healthcare system. The participants in this study discussed the ways that nurses form connections to strengthen the implementation of Compassionate Community and City initiatives. The role of the nurse as a bridge was a strong pattern throughout this study, present in each interview, yet there is not discussion of this role in the literature. This study demonstrates this role of the nurse in implementation – nurses' communication, networking, and relationship building skills were a vital role on their Compassionate Community and City teams.

The participants in this study discussed the need for nurses across the system to integrate a public health approach to palliative care into their everyday practice. While this study focused on the public health approach to palliative care, the participants frequently mentioned the lack of understanding of palliative care among nurses across the system despite their crucial role in promoting healthy aging and dying. The participants spoke about the need for nursing education

to include a more robust palliative care curriculum to prepare nurses for their role in caring for individuals with chronic, progressive, and serious illness. The participants spoke about how nurses across the system have a role in embracing an early palliative approach to care to support individuals across the entire illness trajectory and support a smooth transition to end of life. This is consistent with the findings of an empirical and policy literature review conducted by Rosa et al (2022). Rosa et al (2022) conducted this review with the aim of identifying emerging nursing roles and promoting nursing leadership to enhance universal access to palliative care. They concluded that promoting policy, education, capacity building, and research that advances palliative nursing care has the potential to advance access to palliative care and relieve suffering on a global scale (Rosa et al, 2022). This is also consistent with the palliative care competencies for nurses in all practice settings outlined by the Ontario Palliative Care Network *Competency Framework* (2019a). The Competency Framework posits that nurses across the system should have competency in understanding the principles of palliative care and communicating about palliative care with their patients and their families (Ontario Palliative Care Network, 2019a).

The findings of this study integrated with existing literature support the role of the nurse as health promoters and leaders in palliative care and has implications for these roles to be strengthened across all healthcare settings. This study has several implications for nursing practice, education, policy, and research.

Methodological Reflection

In reflecting on the methods employed in this study, several key strengths and limitations are evident. Limited diversity in geography and limited non-nursing participation are limitations of this study. Methodological and philosophical congruence is a key strength of this study in

addition to strategies used to promote trustworthiness and rigor, mitigate ethical risk, and protect the emotional safety of both the research participants and the researcher.

Limitations

This study has two limitations with respect to the sample size and variation. When designing the protocol for this study, I aimed to recruit two unique data sources: 1) nurses who have engaged in the planning and implementation of a Compassionate Community initiative in Canada and 2) other members of the interdisciplinary team who have worked alongside a nurse who has engaged in the planning and implementation of a Compassionate Community initiative in Canada. Using Malterud et al's (2015) concept of information power, it was estimated that ten nurses and ten non-nursing interdisciplinary team members would provide quality data to address the research question posed. Ten nurses (n=10) and two non-nurse interdisciplinary team members (n=2) participated in this study. Additionally, nine (n=9) of the twelve participants were recruited from Ontario, two (n=2) were recruited from Alberta, and one (n=1) was recruited from British Columbia. Therefore, the limited geographical diversity of the participants and Compassionate Communities and Cities represented in this study, as well as the limited non-nursing participation in this study are limitations.

The purpose of this study was to describe and understand the different ways that nurses engage in the planning and implementation of Compassionate Communities in Canada. There are over 223 Compassionate Community initiatives across British Columbia (n=>120), Alberta (n=45), Saskatchewan (n=2), Manitoba (n=1), Ontario (n=41), Quebec (n=12), New Brunswick (n=1), and Nova Scotia (n=1) (Tompkins et al, 2023). While over half of Compassionate Community initiatives in Canada are located in British Columbia, only one (n=1) participant was successfully recruited from this province. Although recruitment strategies were extended to

additional potential participants throughout British Columbia, Quebec, Alberta, New Brunswick, and Nova Scotia, there was limited expression of interest. With nine of the twelve participants representing Compassionate Community and City initiatives in Ontario, Ontario is strongly represented in this study. While quality and relevant information was learned about the nursing role in Compassionate Community and City implementation in Ontario, there is not enough data from additional provinces to conclude that the findings of this study are transferrable across Canada. The two (n=2) interviews from Alberta and one (n=1) interview from British Columbia generated data that was unique yet shared themes with the interviews from Ontario, suggesting that the findings of this study are transferrable to additional settings outside of Ontario, across Canada.

The rationale for aiming to recruit ten non-nursing interdisciplinary team members was to enhance credibility by employing data source triangulation. Two (n=2) non-nursing interdisciplinary team members did participate, one (n=1) participant was a physician and one participant (n=1) was a professor of social work and gerontology. Data source triangulation of the non-nursing perspective of implementing a Compassionate Community or City alongside a nurse provided data that supported and strengthened data generated from interviews with nurses. While the nurse participants generated relevant, quality data regarding their experiences of the different ways that they implement Compassionate Communities and Cities, the interviews with non-nursing interdisciplinary team members generated relevant, quality data regarding their experiences of implementing Compassionate Communities and Cities and the ways that nurses strengthened the implementation team and why they, as members of the team who are not nurses, valued having nurses on the team. Both non-nursing participants shared different ways that nurses on their team acted as catalysts and bridges and applied the health promotion principles to

their work. One non-nurse participant shared that she valued having a nurse on the team particularly for her nurse colleague's relationship building, communication, and networking skills as well as her ability to move the initiative forward. The other non-nurse participant identified nurses' knowledge, skill, and ability to be leaders, facilitators, and connectors to move implementation forward and promote sustainability. In addition, she valued nurses' holistic perspective and shared different ways that the nurses she works with apply the health promotion principles to Compassionate Community and City development. While the two interviews with non-nursing interdisciplinary team members did generate quality data and these interviews did support and strengthen the themes that were found in interviews with nurses, the non-nursing perspective of the phenomenon of interest could have been further explored through interviews with additional non-nursing interdisciplinary team members.

Limited participation from non-nurses and limited diversity in geography were a result of minimally successful recruitment strategies. Although nurses and non-nursing team members from British Columbia, Quebec, and Alberta were invited to participate, there was either limited or no response. Despite these limitations, this study has several key strengths.

Strengths

Several strategies were employed to enhance the credibility of this study, mitigate ethical risk, and protect the emotional safety of the study participants and the student researcher. These strategies strengthen the methodological rigor and safety of this study.

Thorne's (2025) criteria for enhancing credibility was used to promote trustworthiness and rigor in this study. A number of strategies were used to promote accuracy and truth of description and interpretation of the research findings. For instance, reflexivity was practiced on an ongoing basis throughout this study. Prior to the commencement of research activities, I

engaged in critical reflexivity by journalling about my relationship with the topic of death and the healthcare system and society's responsibility to support and provide palliative care. I identified my assumptions and beliefs about Compassionate Communities and nursing's role in them. In addition, I practiced reflexivity by identifying and exploring my philosophical position and theoretical allegiance in terms of research and advancing knowledge. As well, I identified and explored my position in the world as a white, female graduate student at a research-intensive university and how this position may influence my relationship with the participants and the members of the public who may benefit from the findings and implications of this study. I demonstrated this reflexivity by writing a reflexivity and positionality piece. In addition to practicing reflexivity and positionality prior to research activities, I practiced reflexivity throughout the research study by keeping a reflexive journal. I journalled after conducting each interview and throughout data analysis in order to stay aware of my evolving understanding of the research findings and to identify any personal assumptions or beliefs that may influence my interpretation of the findings. In addition to practicing reflexivity, data source triangulation was used to enhance the credibility of this study. Data source triangulation was employed to purposefully sample participants who were nurses who are engaged in the planning and implementation of Compassionate Cities and Communities, in addition to two interdisciplinary team members who were recruited to triangulate data by providing an additional perspective. Additionally, an audit trail was kept throughout study activities to keep a dense description of all research decisions and actions. Finally, I was supervised by a masters thesis committee comprised of nursing faculty who are experienced in qualitative research methods and experts in palliative care, community nursing, and public health. The supervisory committee supported decisions regarding the design of the study by engaging in discussion during committee meetings

and providing written feedback. Additionally, the supervisory committee supported and strengthened data analysis by providing supervision of the initial coding and providing insights and feedback regarding patterns and themes. Each of these strategies strengthened the epistemological integrity, representative credibility, analytic logic, and interpretive authority to enhance the credibility of this study.

Thorne's (2025) principles of moral defensibility, disciplinary relevance, pragmatic obligation, contextual awareness, and probable truth were used to guide the ethical considerations of this study and the development of strategies for risk mitigation. As outlined in Chapter Three, the intended utility, potential contribution, and disciplinary relevance were shared with the study participants during study recruitment and in the consent form. In addition, a detailed description of the study context was provided in Chapter Three to mitigate the risk of research findings being applied inappropriately.

An additional strength of this study is the use of strategies identified and used to protect the emotional safety of both the research participants and the researcher. Whitney and Evered's (2022) *Triage Pathway* was used as a protocol to respond to any emotional distress of the participants that occurred before, during, or after interviews. The use of a distress protocol strengthens qualitative research by minimizing the risk of harm from emotional distress experienced because of the interview. It is essential for qualitative researchers to use strategies to protect the emotional safety of participants, as the participants are sharing their experiences with the researcher to address a practice issue where they often have personal stake. In addition, the emotional safety of the student researcher was protected through debriefing with the thesis supervisory committee. Regular debriefing occurred between the thesis supervisor and student researcher to discuss any methodological challenges that arose and any emotional difficulty that

was experienced. In addition, debriefing occurred with the thesis supervisory committee as an opportunity for the committee to support the student researcher in any methodological or emotional challenges that arose. In qualitative research the emotional wellbeing of the researcher may influence the quality of the research findings in the absence of reflexivity. The practice of debriefing with the committee strengthened the student researcher's reflexivity practices through support from experienced researchers in exploring previously held beliefs, assumptions, and emotions about the research topic and how these may influence my evolving understanding of the phenomenon of interest.

CHAPTER SIX: IMPLICATIONS

This chapter provides a discussion of the implications of the study findings. This includes implications for practice, education, policy, and research. This chapter is followed by the conclusion of this study.

The intended utility of this study was to provide nurses with practice guidance rooted in the tacit knowledge and experiences of nurses who engage in the planning and implementation of Compassionate Communities. The findings of this study yield various implications for practice, education, policy, and research.

Implications for Practice

This study yields various implications for the implementation of Compassionate Communities and Compassionate Cities broadly and for nurses specifically. Further, this study has led to wider implications for nursing practice throughout the healthcare system.

Implementing Compassionate Communities and Cities

This study led to the development of practice guidance for nurses to engage in the implementation of Compassionate Communities and Cities. These recommendations are summarized in Tables 2 and 3 below. These recommendations are general practice guidance. Each community and city require an approach to implementation that is uniquely rooted in their strengths and priorities.

Table 2

Recommendations for Implementing a Compassionate City

Recommendations for Implementing a Compassionate City
For everyone: - Adopt a team-based approach to planning, implementation, and sustainability

- Define the term Compassionate City early on in the planning process - Develop clear goals related to the focus and structure of the initiative as well as intended outcomes - Define roles and responsibilities of the team members - Engage the community early on - Assess the strengths, values, and priorities of the community/city - Embrace the uniqueness of each city; develop an approach that is tailored to the values and wishes of the community/city - Seek feedback from the community regularly - Connect with other community organizations For nurses: - Build relationships with community members - Build partnerships with community organizations - Provide a holistic view - Develop health promotion activities - Provide information and guidance - Develop creative strategies to engage the public

Table 3

Recommendations for Implementing a Compassionate Community

Recommendations for Implementing Compassionate Communities
For everyone: - Use a gentle and non-intrusive approach to guidance

- Embrace community ownership of the initiative
- Embrace the uniqueness of the community
- Provide with information and resources when requested
- Align strategies for development with the goals and capacity of the community

For nurses:

- Consider your role based on whether you are a natural member of the community or not a natural member of the community; base level of engagement on this role
- Support community members with gentle and non-intrusive guidance as requested

These recommendations were developed and informed by the study data as well as nursing disciplinary knowledge related to palliative care, community health, and public health. Although these recommendations were developed through a nursing disciplinary lens, they may be transferrable to other disciplines as well as the general population. In addition, it is important for nurses to consider their own role in a community based on whether they are a natural member of the community or if they are providing guidance as an outsider.

Integrating a Public Health Approach to Palliative Care into Everyday Practice

While this study provided useful practice guidance for nurses who wish to become engaged in Compassionate Community and City implementation, it also yields a broader implication – opportunities should be made available for nurses to integrate a public health approach to palliative care into their everyday practice. Nurses across the healthcare system have a role in taking a public health approach to embrace palliative care. Since most nurses care for individuals who have or are at risk of developing chronic, progressive, or serious disease, the quality of care that nurses provide can be enhanced by improving nurses' competency in

providing a palliative approach to care. Based on the findings of this study, there are opportunities for nurses to be able to apply competency of a public health approach to palliative care in their everyday practice. All our patients, regardless of their age or health status, will face issues associated with aging, death, and dying, if they do not already. Every human life is touched by the reality of human mortality, and all nurses have a role in promoting healthy aging and dying. In practical terms, integrating a public health approach to palliative care into everyday nursing practice involves embracing palliative care and being able to support our patient's communities to be engaged in their care.

Embracing palliative care in everyday nursing practice involves being mindful of the way we talk about palliative care. This includes nurses having a clear understanding of a palliative approach to care and ability to explain and discuss the palliative approach with their patients (Ontario Palliative Care Network, 2019a). Although the topic of death is often avoided across the healthcare system, we must address when the word "palliative" is used with a negative connotation. It is never too early to talk about palliative care; when patients and families share their concerns about their future, embracing palliative care simply gives a name to an approach that relieves suffering and improves quality of life. It is important to approach this topic in a positive and realistic manner. Every nurse has a role in encouraging conversations about death and dying throughout society by embracing the topic in their own practice.

Nurses have a role in supporting our patient's communities, however defined, to increasingly adopt a more proactive role in their care. Many individuals already have their own community, whether it is their family, friends, faith community, ethno-cultural community, or another type of group with whom they have a sense of belonging and fellowship. When an individual's life becomes affected by chronic, progressive, or serious illness, most interventions

and care plans focus on what the healthcare system can offer them, yet 95% of their time is spent apart from formal healthcare (Abel & Kellehear, 2022). The individuals who form a community around the individual who is sick often do have potential to engage in palliative care by helping to address practical and social needs, but they do not always know how. Nurses can mobilize this community by assessing who is in an individual's community and their capacity to provide support. Offering reassurance and health teaching can be a powerful way of mobilizing communities. When acknowledging the role of community in addressing social and practical palliative needs, the way we plan care can fundamentally change. While nurses have the potential to integrate a public health approach to palliative care into their everyday practice, this potential is not always optimized.

Implications for Education

Given that nurses' potential to integrate a public health approach to palliative care into practice is not always optimized, there is opportunity to integrate this concept into nursing undergraduate and continuing education. The findings of this study include recommendations for nursing education.

The concept of a public health approach to palliative care can be integrated into nursing education to prepare nurses for action in their communities to build capacity for palliative care and to prepare nurses to apply the public health approach to palliative care in their everyday practice. Many of the participants in this study shared the feeling that community nursing is undervalued in nursing education and within the system. While communicating about serious illness is one of the most difficult skills for a nurse to acquire, little attention is given to preparing nursing students to engage with this topic in their practice. While the topics of public health, health promotion, and end of life care are commonly addressed in nursing education,

there is opportunity to expand this education to include a more comprehensive curriculum regarding a palliative approach and the ways that health promotion can be applied to a palliative approach. The Canadian Association of Schools of Nursing's (2012) *Palliative and End-of-Life Care: A Faculty Guide for Nursing Education* can be updated to include education regarding a palliative approach and a public health approach. This would help prepare undergraduate nursing students to meet the entry-to-practice competencies of their provincial regulatory bodies, such as the Entry-to-Practice Competencies outlined by the College of Nurses of Ontario (2019), the British Columbia College of Nurses and Midwives (2021), the College of Registered Nurses of Alberta (2019), and others which each state that entry level registered nurses must be able to provide nursing care to meet palliative needs.

Given the novelty of the concept of a public health approach to palliative care, many nurses currently in practice may be unaware or have limited knowledge regarding the concept. While many palliative care nurses have become aware of the concept through continuing palliative care education, social media, and palliative care networks, it is likely that nurses working in other settings remain unaware of the concept. The findings of this study imply that there is a need for palliative care education to be extended beyond palliative care settings, not only to the public, but also to healthcare professionals in other healthcare settings. Nurses working in other settings may have concerns about quality of life among their patients but be unaware of the ways they can apply a public health approach to palliative care in their practice. Opportunities for furthering education and training are recommended for all nurses to integrate a public health approach to palliative care into their practice across the system. As these findings suggest, nurses can be involved in different ways to promote awareness and advocacy at

different levels; examples of this may include engaging in advance care planning or health teaching about a palliative approach in various settings.

Implications for Policy

This study has implications at both the government and organization level. Health Canada's (2018) *Framework on Palliative Care in Canada* posits that organizations and local governments have a role and responsibility in palliative care. The framework states that organizations have a responsibility to listen to the needs of the populations they serve and advocate for individuals with serious illness and that local governments have a responsibility to nurture and spread local Compassionate Community initiatives (Health Canada, 2018). The participants of this study spoke about how mainstream healthcare services in Canada often do not adequately meet the palliative needs of individuals facing issues associated with serious illness. This has broader implications that deserve attention from the provincial government. The *Framework on Palliative Care in Canada* also posits that provincial governments have a responsibility to foster the development of a culture that promotes the framework (Health Canada, 2018). There is opportunity for both local and provincial governments to collaborate with Compassionate Cities to develop and adopt policies that nurture the development and sustainability of Compassionate Communities. In addition, there is opportunity for the public health sector to collaborate with palliative care professionals to promote public health initiatives for palliative care and Compassionate Cities.

Healthcare and community organizations also have a role in promoting a compassionate society. There is opportunity for healthcare and community organizations to collaborate with each other and Compassionate Communities and Cities, but also to foster compassion within their organizations through supportive policy.

Implications for Research

There is a need for further research to explore the experiences of specific initiatives in terms of implementation and quantitative measurement of their impact. In addition, further research should compile quantitative and qualitative evaluation of Compassionate Cities, Compassionate Communities, and other public health palliative care initiatives to demonstrate their value. For example, observational studies may be conducted to measure the palliative care capacity of communities who are engaged in Compassionate Communities compared to communities where there are no Compassionate Community initiatives. The Death Literacy Index may be used to measure palliative care capacity at a population level (Leonard et al, 2022). Additionally, pre-post test studies may be used to evaluate the impact of specific public education interventions.

To advance the field forward, further research should be done to explore how collaboration between the public health and palliative care sectors may optimize their potential to work together to build palliative care capacity among the public. Finally, further research should explore the ways that nurses and other healthcare professionals can integrate a public health approach to palliative care into their everyday practice. A qualitative approach such as qualitative description may seek recommendations from nurses on how to integrate this approach into their everyday practice and later research may evaluate these recommendations using designs such as a randomized control trial or observational study.

CONCLUSION

Nurses apply their health promotion and relationship building skills to form connections within communities to catalyze the implementation of Compassionate Communities and Cities to support individuals with palliative needs who are often overlooked in mainstream healthcare services. Nurses' education and experience uniquely positions them to be leaders in the initiation, implementation, and sustainability of Compassionate Communities and Cities. Nurses' have knowledge, skill, and ability in leadership, health promotion, and relationship building that strengthens the implementation and sustainability of Compassionate Communities and Cities. Nurses have a key role in facilitating and strengthening the spread of the Compassionate Community movement to improve the quality of life of individuals facing issues associated with chronic, progressive, and serious illness.

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APPENDICES

Appendix A

Chart with Appraisal of Included Studies and Characteristics

Author and Year	Country	Method/Article Type	Purpose	Findings	Critical Appraisal
Abel, J., Kellehear, A., & Karapliagou, A. (2018). Palliative care - the new essentials	United Kingdom	Journal article	Propose a model for palliative care service delivery.	This model proposes the integration of the processes and operations of specialist palliative care, generalist palliative care, compassionate communities, and civic end of life care to make palliative care delivery sustainable.	The concepts and the relationship between the concepts are clearly defined and logically represented with a model. The origin and development of the model is not discussed in the article.
Abel, J., Kingston, H., Scally, A., Hartnoll, J., Hannam, G., Thomson-Moore, A., & Kellehear, A. (2018). Reducing emergency hospital admissions: a population health complex intervention of an enhanced model of primary care	United Kingdom	Retrospective cohort	Evaluate a model of primary care and compassionate communities in terms of population health improvement and reduction of emergency room admissions.	There was a significant reduction in emergency room admissions in the intervention group compared to the control group during the study period.	The study question is clearly focused. Quantitative data was collected using hospital statistics regarding unplanned emergency admissions. Regression models were used for data analysis. The researchers state that it is not clear how generalizable the results are.

and compassionate communities.					
Aoun, S. M., Bear, N., & Rumbold, B. (2023). The Compassionate Communities Connectors program: Effect on healthcare usage.	Australia	Controlled before-and-after study/Cost-consequence analysis	Assess the effect on healthcare usage of a community-based palliative care program.	The intervention group had a lower hospitalization incidence rate ratio per month and spent less days in the hospital per month and a higher frequency of outpatient contact. Net savings of $AUD 518,701 are estimated if the program were to be adopted given an enrollment number of 100 patients over a 6 month participation period.	The study addressed a clearly formulated study objective and the results were reported comprehensively. The study results indicate that implementation of a compassionate community initiative may lead to decreased acute care usage among individuals living with advanced illness and increased community care as well as positive economic impact.
Aoun, S. M., Rosenberg, J., Richmond, R., & Rumbold, B. (2023). The Compassionate Communities Connectors programme: experiences	Australia	Qualitative study	Explore experiences and views of patients and family carers who received support from the compassionate community initiative	Patients and families reported that the program volunteers acted as advocates and that the program increased social connectedness	The aim of the study is clearly stated and a dense description of methods is provided. Congruence between method and aim is demonstrated.

of supported families and referring healthcare providers.			program and their referring healthcare providers.	and took the pressure of off families. Referring healthcare providers reported reduced social isolation, increased capacity of the service, and that the program filled a gap in service provision.	Study findings support a growing body of evidence for the positive impact of compassionate community initiatives.
Aoun, S. M., Richmond, R., Gunton, K., Noonan, K., Abel, J., & Rumbold, B. (2022). The Compassionate Communities Connectors model for end-of-life care: implementation and evaluation.	Australia	Mixed-method	Evaluate a compassionate community initiative called the Compassionate Communities Connectors.	Patients, family carers, connectors, caring helpers, and referring health professionals reported improved social connectedness, reduced social isolation, better coping with activities of daily living, and an increase in supportive networks.	The study aim is clearly identified. A dense description of study design and methods is provided. Aim and designs are congruent. This pilot evaluation adds to a growing body of preliminary findings regarding the outcomes of compassionate community initiatives.
Aoun, S. M., Richmond, R., Noonan, K., Gunton, K., & Rumbold, B. (2022). 'The more you give, the	Australia	Qualitative Study	Explore the experiences and views of connectors implementing the model of care of the Compassionate	The volunteer connectors shared that the program benefited everyone involved, including volunteers, in	The objective and relevance of the study was clearly stated, and a qualitative method is well suited to answer the

better it is for you. You know the reward is greater than the effort': the Compassionate Communities Connectors' experience.			Communities Connectors programme with a focus on feasibility and acceptability.	terms of connection and reciprocity, and helped foster a sense of community.	research question posed. Deductive content analysis was appropriate for this study design and question. Research findings reported six themes that emerged from participant interviews. This study demonstrates feasibility and acceptability of a program based on the compassionate communities model.
Bakelants, H., Van Droogenbroeck, F., De Donder, L., Chambaere, K., Deliens, L., Vanderstichelen, S., Cohen, J., & Dury, S. (2024). Developing a compassionate university: Insights from a longitudinal process evaluation.	Belgium	Longitudinal Case Study	Examine the underlying processes and contextual factors contributing to the development of a Compassionate University.	Leadership support, establishment of the Compassionate Schools Learning Network, and alignment with existing university programs were facilitators for successful implementation. Lack of guiding principles, fragmented university	The study aim is clearly stated. A dense description of study design, methods, and context is provided and is congruent with the study aim. Reflexive journalling, member checking, and peer examination enhance the rigor of this study. Normalization

				environment, resource constraints, and limited prioritization were barriers. Recognizing the value of compassionate universities and adapting implementation strategies based on feedback for evaluation were supportive cognitive and social processes. Building coherence, engaging stakeholders, and assessing the work were challenges to the development process.	Process Theory (May & Finch, 2009) and a Consolidated Framework for Advancing Implementation Science (Damschroder et al, 2009) were used to guide data analysis and findings. Research findings contribute to literature body regarding successful implementation of compassionate communities.
Bakelants, H., Dury, S., Chambaere, K., De Donder, L., Deliens, L., Vanderstichelen, S., Marynissen, S., Cohen, J., & Van Droogenbroeck, F. (2024). Mapping the ripple effects of a	Belgium	Qualitative/Ripple Effects Mapping	Investigate the activities and outcomes of a compassionate university initiative.	Outcomes were increased acceptance and integration of topics such as serious illness, death and bereavement into exiting practices, broader support for and formalization of compassionate procedures and	Study aim was clearly stated and methods were clearly described. The findings demonstrate that culture shift within a university environment is possible.

compassionate university for serious illness, death, and bereavement.				policies, and emergence of informal networks and internal collaboration on the topics, and diffusion of compassionate ideas beyond the university.	
Gómez-Batiste, X., Mateu, S., Serra-Jofre, S., Molas, M., Mir-Roca, S., Amblàs, J., Costa, X., Lasmarías, C., Serrarols, M., Solà-Serrabou, A., Calle, C., & Kellehear, A. (2018). Compassionate communities: design and preliminary results of the experience of Vic (Barcelona, Spain) caring city.	Spain	Mixed-method	Describe the principles, aims, initial phases, initial activities, and preliminary results of a compassionate community in Vic, Barcelona, Spain.	Quantitative data collected shows 19 activities were implemented and 1470 community members attended or participated. SWOT analysis showed high participation and positive interaction and collaboration between groups. Identified challenges are involving schools, trade unions, media, and healthcare professionals, and incorporating multicultural visions, and sustainability.	Aim, mission, vision, values, and method for evaluation were clearly described. Results are preliminary but add to a growing body of pilot studies evaluating outcomes of compassionate community intiatives.
Hasson, N., Urtaran-Laresgoiti, M., Nuño-	Spain	Participatory Action Research Model	To present a social innovation example to	Social innovation project collaborated	Aim of article and aim of project were both clearly

Solinís, R., Moreno, I., Espiau, G., Grajales, M., & Fonseca, J. (2022). Community Based Participatory Research For The Development of a Compassionate Community: The Case of Getxo Zurekin.			develop a compassionate community.	with community members and utilized active listening and co-creation strategies. Aim to establish a shared vision, co-create and model pilot initiatives, and evaluate initiatives. Recognize unique strengths of community partners.	stated. Participatory action research method and design were congruent with method and purpose. Findings are clearly stated and contribute to literature regarding innovative methods to develop a compassionate community.
Howard, M., Pfaff, K., Sattler, D., Dolovich, L., Marshall, D., Zwarenstein, M., & Upshur, R. (2022). Achieving holistic, quality-of-life focused care: description of a Compassion Care Community initiative in Canada.	Canada	Mixed-method	Evaluate a compassionate community initiative pilot project aimed at identifying and addressing upstream and downstream risks to physical and mental health through the use of community volunteer one-on-one visits.	Volunteers are able to collect information to assess quality of life.	Research aim was clearly stated. A mixed-method design was described. The RE-AIM framework (Glasgow & Estabrooks, 2018) was used for evaluation. Paired t-test was used to compare mean differences in the survey at base-line and follow-up. Coding of qualitative data was completed by a nursing research team. Research

					findings are clearly stated and discussed and are valuable to support volunteer engagement in compassionate community efforts.
Kelley, M. L., Prince, H., Nadin, S., Brazil, K., Crow, M., Hanson, G., Maki, L., Monture, L., Mushquash, C. J., O'Brien, V., & Smith, J. (2018). Developing palliative care programs in Indigenous communities using participatory action research: a Canadian application of the public health approach to palliative care.	Canada	Participatory action research.	Create local palliative care programs.	A palliative care workbook, policy recommendations, and policy framework to guide palliative care development were created.	Clear statement of the aim and method of research. Methodological congruence between aim and design are evident. The research findings are actionable and transferable to develop palliative care programs in additional communities.
Kelley, M. L. (2023) Developing a compassionat	Canada	Community-based participatory action research	Describe the Developing a Compassionate Community	The Developing a Compassionate Community model.	The origins of this model are rooted in research and practice. The

e community: a Canadian conceptual model for community capacity development.			model. Provide a theory of change to guide practice in community capacity development.		concepts are clearly defined and logically represented in a model. The model is applicable to communities wishing to build community capacity for aging, dying, caregiving, and grieving within Canada. The model has been used in practice by the author. The model has evolved through scholarly inquiry, having multiple published versions (Kelley, 2007; Kelley et al, 2018; Kelley, n.d.)
Librada-Flores, S., Molina, E. H., Osuna, J. B., Vargas, R. M., & Vicuña, M. N. (2018). All with You: a new method for developing	Spain, Colombia, and Argentina	Journal article	Describe the experience of implementing the "All With You" method to develop compassionate communities in various cities.	The "All With You" method was developed by the New Health Foundation team in Sevilla, Spain and local community partners. The method led to the successful implementation	The objectives and methods of the project are clearly stated. Project results were evaluated through the use of structure, processes, and results indicators for

compassionate communities - experiences in Spain and Latin-America.				of a compassionate community in Sevilla. The method has been rolled out in eight other cities in Spain, Columbia, and Argentina.	compassionate communities at the end of life developed for the All With You program.
Librada-Flores, S., Pérez-Solano Vázquez, M. J., Lucas-Díaz, M. Á., Rodríguez Álvarez-Ossorio, Z., Herrera-Molina, E., Nabal-Vicuña, M., & Guerra-Martín, M. D. (2023). "Compassionate City" in Patients with Advanced Illnesses and at the End of Life: A Pilot Study.	Spain	Longitudinal descriptive	Evaluate the impact of the Compassionate City pilot experience in Sevilla, Spain on participant's quality of life, loneliness, anxiety, depression and caregiver's burden and family satisfaction.	The data showed improved loneliness and decreased caregiver burden. Some participants also experienced improved quality of life and improved mood.	The study purpose and method was clearly stated. Scales used to measure quality of life, loneliness, anxiety, depression, caregiver burden, and family satisfaction are listed in the article. Descriptive analysis was used to analyze the data.
Liu, C.-J., Huang, S.-J., & Wang, S. S.-C. (2022). Implementation of Compassionate Communities: The Taipei	Taiwan	Report	Discuss the implementation of a compassionate community.	The Life Issues Cafe brought together university students and senior individuals to explore attitudes towards death, addressing life	The core values and strategies of Compassionate Communities in Taipei are discussed.

Experience.				and death matters, and the ability to face death calmly. Stakeholders collaborated to link organizations and social groups. University students visited with senior individuals. Education and training programs were held for hospital staff and community volunteers. The compassionate communities movement has spread to 20 different communities in Taipei.	
Matthiesen, M., Froggatt, K., Owen, E., & Ashton, J. R. (2014). End-of-life conversations and care: an asset-based model for community engagement.	England	NA	Describe the processes and features of a community engagement approach that facilitates community awareness of end of life care and identify community priorities.	Communities have existing resources but often do not know how to begin to engage. This assets-based model mobilizes communities to begin to engage in matters of death and dying.	This article applied McKnight and Kretzmann's asset-based model community development approach (McKnight, 2017) to the matter of death and dying.

Meesters, S., Ohler, K., Voltz, R., Schulz-Nieswandt, F., Eichberg, S., Strupp, J., & Kremeike, K. (2024). How can a community be successfully empowered to deal with death, dying, and bereavement? —formative evaluation of the Caring Community Cologne using focus groups.	Germany	Qualitative focus group study	Report on the implementation of a compassionate community initiative and assess the views of compassionate community members.	Study participants reported adequate structure of the compassionate community but a lack of cooperation, transparency, and citizen involvement. Support of federal institutions was identified as a key factor.	Study aim and methods were identified and sufficiently described. A model was used to organize study findings and report results. The findings contribute understanding of successful implementation strategies and areas where improvement is needed.
Mesquita, M. G. da R., Silva, A. E., Coelho, L. P., Martins, M. R., Souza, M. T. de, & Trotte, L. A. C. (2023). Slum compassionate community: expanding access to palliative care in Brazil.	Brazil	Experience report	Describe the implementation of a compassionate community in Rocinha and Vidigal, Rio de Janeiro, Brazil.	Coordinators worked to identify community members who would benefit from palliative care and community members who were willing to engage in palliative care. Community members received training for palliative care. Healthcare professionals volunteered	The report is written from the perspective of a physician and professors who were a part of the project management of the compassionate community. There are not yet any qualitative or quantitative studies evaluating the outcomes of these

				their services.	compassionate communities.
Noonan, K., Rumbold, B., & Aoun, S. M. (2023). Compassionate community connectors: a distinct form of end-of-life volunteering.	Australia	Qualitative Study	Describe the motivations, experiences and characteristics of compassionate community volunteers in a compassionate community initiative.	Individuals who volunteered as a compassionate community connector often had previous community volunteering experience and a pre-existing understanding of end of life community supports.	The study aim and method are clearly stated in methodologically congruent. The methods are clearly described. The findings contribute useful information for volunteer recruitment and thus compassionate community implementation for future compassionate community initiatives.
Patel, M., Hundt, G. L., & Slowther, A. (2023) End-of-life care at home as a therapeutic landscape within a compassionate communities approach.	United Kingdom	Case study	Explore the lived experiences of compassionate communities at the end of life from the perspectives of patients with a prognosis of at least 6 months, their families, volunteers, and healthcare professionals.	Living at home was important to all of the primary participants. Most of the primary participants had healthcare assistants and all had healthcare professionals to provide scheduled, formal care. Most primary participants had family members or support from	The study purpose and method was clearly stated and methodologically congruent. Ontological position is stated. Data generation (individual interviews, focus groups, and diary logs) were used to answer the research question. Thematic analysis was

				faith communities as informal care. Volunteer befrienders were an important aspect of the compassionate community approach. They provided companionship and acted as a link between informal and formal caregivers.	guided by Braun & Clarke (2006). Discussion of limitations and strengths is included. Small sample size of primary participants and lack of ethnic diversity in the sample were identified limitations. The study findings add to knowledge regarding aspects of compassionate communities.
Paul, S. (2016). Working with communities to develop resilience in end of life and bereavement care: hospices, schools and health promoting palliative care.	United Kingdom	Participatory action research	Explore, implement, and evaluate models of practice between a hospice and two elementary schools.	The health promoting activities that arose out of the research were focused most on mobilizing individuals caring for elementary aged children to provide support and education about death, dying, and bereavement.	The study aim and method are clearly stated and methodologically congruent. Focus groups and interviews were used to generate data. Thematic analysis was used to analyze data. The researcher engaged in reflexivity by stating her position in relation to the study participants. The study

					findings are clearly stated, evaluation of the practice innovations is ongoing. The author states that research findings from evaluation will be reported in the future.
Pesut, B., Duggleby, W., Warner, G., Ghosh, S., Bruce, P., Dunlop, R., & Puurveen, G. (2022). Scaling out a palliative compassionate community innovation: Nav-CARE.	Canada	Mixed-method	Evaluate the feasibility, acceptability, sustainability, and impact of a volunteer navigation compassionate community intervention.	Organizational capacity, stable and engaged leadership, a targeted client population, and skillful messaging influenced successful implementation. Client recruitment was a significant implementation barrier. Quantitative findings revealed improvement in clients feeling they had someone to turn to, knowing community services were available to them, increased involvement in things that were important to them, and	Study aim and method are clearly stated and congruent. The findings contribute to a growing body of knowledge regarding successful implementation of compassionate community initiatives.

				increased confidence in managing their illness. Volunteers reported being satisfied in their role. Qualitative findings revealed improvements in clients' quality of life.	
Pfaff, K. A., Dolovich, L., Howard, M., Sattler, D., Zwarenstein, M., & Marshall, D. (2020). Unpacking 'the cloud': a framework for implementing public health approaches to palliative care.	Canada	Model	Introduce and describe the Health Impact Change Model (HICM) and its development and evaluation.	The HICM was developed by combining The Population Health Model, Accountable Communities for Health, and the Chronic Care Model. The outcomes were developed by applying the Triple Aim Framework (Institute for Healthcare Improvement, n.d.). The purpose of the model is to be operationalized to implement and evaluate compassionate communities, dementia-friendly communities or other population health level	The concepts are clearly defined and logically represented with a model. The framework is transferable to be applied to additional communities. The authors identify limitations such as conceptual complexity, the requirement of volunteerism and community service, and the focus, time, and commitment that collective cultural change requires.

				strategies.	
Pfaff, K., Krohn, H., Crawley, J., Howard, M., Zadeh, P. M., Varacalli, F., Ravi, P., & Sattler, D. (2021). The little things are big: evaluation of a compassionate community approach for promoting the health of vulnerable persons.	Canada	Applied qualitative approach	Evaluate implementation of a compassionate community initiative for vulnerable persons.	The program acted as a safety net to support people who are falling through the cracks. Help clients set personal goals and preferred interventions. Taking time, advocacy, and empowerment were identified as three key processes to effectively address the needs of the CC clients.	The research aim was clearly identified and the selected method was appropriate. Learning about the experiences of program clients and stakeholders contributes valuable evidence for the positive effects of a CC program.
Prince, H., Nadin, S., Crow, M., Maki, L., Monture, L., Smith, J., & Kelley, M. L. (2019). "If you understand you cope better with it": the role of education in building palliative care capacity in four First Nations communities in Canada.	Canada	Participatory action research	Assess and address palliative education needs of First Nations communities to improve community capacity for palliative care.	Participants identified barriers to dying at home and expressed the wish to have increased palliative educational resources available.	The aim of the research and qualitative methodology were clearly stated and congruent. The sample of four different First Nations communities was appropriate for the study aim. Research findings are clearly stated and discussed. The research findings provide actionable knowledge to

					build community capacity among First Nations communities.
Silva, A. E., Almeida, A. R., Martins, M. R., de Oliveira, T. M., da Rosa Mesquita, M. G., & Trotte, L. A. C. (2023). Advanced practice nursing in palliative care within the compassionate favela community: an experience report.	Brazil	Experience report	Describe the advanced practice of palliative care nurses working within a compassionate community context.	Nurses provide holistic care to relieve suffering through clinical reasoning, problem-solving skills, and engaging with the interdisciplinary team.	The aim of this study is clearly stated, however, the design and methods are not identified or clearly described. This article mentions that advanced practice nurses had a role in implementing the compassionate community in Favela, but does not provide much description of this role.
Stjernswärd, J., Foley, K. M., & Ferris, F. D. (2007). The Public Health Strategy for Palliative Care.	England	Journal article	Describe the World Health Organization Public Health Strategy for Palliative Care.	The Public Health Strategy for Palliative Care addresses policy, drug availability, education for policy makers, healthcare workers, and the public, and implementation of palliative services at all levels.	A public health approach to care is defined and the need for a public health strategy is described. Each concept of the World Health Organization model is clearly defined. Immediate, intermediate,

					and long term outcomes are discussed.

Appendix B

Figure 1 - Interview Guide for Interviews with Nurses

Planning

1. How did you become inspired or come to be involved in the development of a compassionate community?
2. Who are the team members in your team?
    a. How were they selected?
    b. What are their backgrounds/disciplines?
3. What is your role in the compassionate community?
4. How did you engage in the team?
    a. With community partners?
    b. How is this engagement compared to other team members?
5. How did you participate in assessing the community's readiness?
    a. How did you participate in assessing the community's strengths?
    b. How did you participate in assessing the community's needs?
6. How did you listen to and respect the community's priorities, practices, and values, in all decisions and actions?
7. How did you participate in planning or creating local compassionate community initiatives?
8. What are key steps that need to be planned in order to successfully implement a compassionate community initiative?

Implementation

1. How did you promote and mobilize local compassionate community initiatives?
2. How do you apply the health promotion principles (prevention, harm reduction, early intervention, and sustainability) to your work?
3. How did/do you champion the compassionate community model?
4. What is your role in the development or implementation of the compassionate community?
5. How do you promote and support sustainability in this compassionate community initiative?
6. Is there anything that you would do differently?
7. What education or training do you think is necessary to prepare nurses to assume a leadership role in compassionate community work?
8. Is there anything that you would do differently?
9. Before we finish today, is there anything else that you think is important to know about this topic?

Figure 2 - Interview Guide for Interviews with Non-nurse Interdisciplinary Team Members

Planning

1. How did you become inspired or come to be involved in this compassionate community?
2. What is your role in this compassionate community?
3. Who are the team members in your team?
    a. How were they selected?
    b. What are their backgrounds/disciplines?
    c. What is the role of the nurse(s) on the team?
    d. What type of nurse? What organization are they employed by?
4. How do nurses you work with engage the team? Community partners?
5. How do nurses participate in assessing the community's readiness?
    a. How do nurses participate in assessing the community's strengths?
    b. How do nurses participate in assessing the community's needs?
6. How do the nurses listen to and respect the community's priorities, practices, and values, in all decisions and actions?
7. How do the nurses participate in planning or creating local compassionate community initiatives?
8. What are key steps that need to be planned in order to successfully implement a compassionate community initiative?

Implementation

1. How do nurses promote and mobilize local compassionate community initiatives?
2. How do nurses apply the health promotion principles (prevention, harm reduction, early intervention, and sustainability) to your work?
3. How do nurses champion the compassionate community model?
4. How do nurses engage in the development or implementation of the compassionate community?
5. How do nurses promote and support sustainability in this compassionate community initiative?
6. What unique strengths, knowledge, skills, or abilities does the nurse bring to the team that is important in compassionate community work?
7. Is there anything that you would do differently?
8. Before we finish today, is there anything else that you think is important to know about this topic?