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TITLE

Compassion in nursing: findings from a grounded theory study to explore the perceptions of academics and students from adult, child, mental health and learning disability nursing

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<u>ABSTRACT</u>

Compassion is integral to nursing, yet there is limited empirical research exploring it, particularly from a professional perspective.

Aim

To advance understanding of compassion from a professional perspective.

Method

Twelve students and eight academics were theoretically sampled and interviewed to explore their perceptions of compassion in nursing during the period January to August 2018. Interviews were transcribed and analysed using grounded theory techniques.

Results

Four data categories were uncovered: character, competence, culture and connections for compassion. Categories were co-dependent, with each having potential to influence what participants perceived to be representative of compassion- the implementation of humanising approaches to care.

Conclusion

Compassion is complex, influenced by biological, psychological and socio- contextual factors. Further consideration of these factors is needed to support nurses to facilitate compassion through humanising approaches to nursing care. The study findings advance the existing evidence to inform future policy, practice, education and research.

KEY WORDS

Compassion

Education

Grounded theory

Humanising care

Leadership

Nursing

Recruitment

Role modelling

Staffing levels

Systems of care

BACKGROUND

Compassion is traditionally associated with caring roles and synonymous with professional nursing (Straughair 2012). However, patients' have reported experiences of a lack of compassionate care, contributing to a discourse to challenge the reality of compassion as an underpinning philosophy of nursing practice (The Patients Association 2009, The Mid Staffordshire NHS Foundation Trust Inquiry 2010, The Parliamentary and Health Care Ombudsman 2011, Hewison and Sawbridge 2016). Although existing evidence provides some insight to inf,orm compassion, much of this arises from professional opinion, with limited empirical research conducted within the context of contemporary practice.

Understanding compassion is complex, due to the diverse connotations that are associated with the concept (Davison and Williams 2009). Compassion is said to be positioned at the intersection of sympathy and empathy (Lown, Rosen and Marttila 2011) and involve nurses exposing themselves to the suffering of others to provide the impetus for compassionate care (Dewar, Pullin and Tocheris 2011). Personal attributes such as those associated with kindness and understanding are considered vital to compassion (Kret 2011). These attributes can support the nurse to see beyond the patient as a passive recipient, positioning the person at the centre of the care experience (Murray and Tuqiri 2020). Person and relationship centred approaches are pivotal to compassion, supporting nurses to facilitate positive experiences of compassionate care (Bramley and Matiti 2014, Durkin, Gurbett and Carson 2018).

Emerging models from empirical research highlight the complexity of compassion. Kneafsey et al (2015) assert that compassion arises from the development of interpersonal

relationships, which support nurses to make connections with their patients, enable them to recognise individual needs and motivate them to implement compassionate actions. Sinclair et al (2016) also identify interpersonal relationships to be the foundation for compassionate care, proposing a model to support compassion in practice. This model suggests that nurses require appropriate virtues, which facilitate recognition of suffering in others and foster the development of effective relationships. Such relationships can enable nurses to understand the person at an individual level, attend to their unique needs and subsequently promote positive experiences of compassion and compassionate care.

Straughair, Clarke and Machin (2019) propose a tentative grounded theory of compassion, founded on the perceptions of patients who have experienced nursing care. This theory suggests that patients perceive compassion to be underpinned by individual experiences of a humanising approach to care. The study findings also identify that compassion can be negatively influenced by exposure to a range of extrinsic factors (Straughair 2019). Whilst the study offers a more holistic, in-depth understanding of compassion than other research, it is limited to a patient perspective. Within the context of professional nursing practice, it is also important to understand compassion from the perspective of nurses. Therefore, this study addresses this, building on existing evidence to further understand compassion through the perceptions of student and academics.

AIM

To advance understanding of compassion from a professional perspective, specifically through the perceptions of academics and students from adult, child, learning disability and mental health nursing

METHODS

A constructivist grounded theory study was implemented (Charmaz 2014), underpinned by the theoretical perspectives of symbolic interactionism (Blumer 1969) and social constructionism (Berger and Luckman 1966). This approach appreciated that knowledge of phenomena is subjective, constructed through interactions with others and influenced by the context within which these interactions occur. The target sample population comprised academics and students from adult, child, learning disability and mental health nursing in a university in the North East of England. An invitation to participate and study information leaflet was posted on the university's electronic portal for students and emailed to nurse academics. Respondents were invited to complete a sampling questionnaire, providing information on their gender, age, field of nursing and professional status. This information was collated into a sampling matrix, supporting a theoretical sampling strategy which resulted in a sample of eight academics and twelve students (Table 1).

Table 1: The Sample

Participant	Gender	Age	Field of Nursing	Professional Status
P1	Female	30	Adult	1st year student
P2	Female	35	Adult	3rd year student
P3	Female	23	Adult	1st year student
P4	Female	29	Adult	3rd year student
P5	Male	28	Adult	1st year student
P6	Female	48	Adult	Academic
P7	Male	42	Adult	Academic
P8	Female	27	Mental Health	1st year student
P9	Female	21	Mental Health	3rd year student
P10	Female	41	Mental Health	Academic
P11	Male	60	Learning Disabilities	Academic
P12	Female	51	Mental Health	Academic
P13	Female	22	Learning Disabilities	3rd year student
P14	Female	26	Mental Health	2nd year student
P15	Male	28	Learning Disabilities	3rd year student
P16	Female	34	Child	3rd year student
P17	Male	31	Child	2nd year student

P18	Female	52	Learning Disabilities	Academic
P19	Male	51	Child	Academic
P20	Female	36	Child	Academic

Semi-structured interviews were conducted during the period January to August 2018. Interviews were audio recorded and initiated with the primary open question "*can you tell me what compassion means to you, using examples from your professional nursing experience to illustrate this*?", with probing questions inviting elaboration on key points. Interview transcripts were analysed using grounded theory techniques comprising initial coding, focused coding, constant comparison, theoretical memos and diagrams (Charmaz 2014). Data collection and analysis occurred concurrently, until theoretical sufficiency was determined (Dey 1999).

Ethics

Approval was obtained from the faculty research ethics committee before the study commenced. Ethical principles to protect participants were implemented throughout, including ensuring confidentiality, anonymity, informed consent and the right to withdraw.

FINDINGS

Character for Compassion

Compassion was thought to be founded on intrinsic disposition, which participants perceived as a characteristic that was present at birth:

'we all have our own personal traits, some people are born slightly more caring than others… with personality traits that make them more compassionate' (P2)

Intrinsic disposition manifested in personal attributes for compassion, such as being kind, caring and empathetic:

'compassion to me means being kind and caring, just being there for people when they are at their most vulnerable' (P6)

Personal attributes were thought to influence professional interactions, supporting acknowledgement of the patient's perspective to position them at the centre of care:

'professional attributes …being able to put yourself in the person's shoes, being the advocate and all of that under the umbrella of compassion' (P18)

Motivation was essential to compassion, compelling nurses to seek out appropriate opportunities for compassionate care:

'you have to put effort into compassion and that does take motivation' (P15)

In particular, motivation to pursue a nursing career was important to support motivation for compassion:

'when it's something that you are really passionate about…it's easier to deliver the best care' (P9)

Participants suggested that when nurses failed to possess appropriate motivation, they should not be in nursing:

'if the motivation isn't there, they shouldn't be in the profession' (P14)

<u>Competence for Compassion</u>

Socialisation in university and practice contexts was essential to develop competence for compassion. Education was an essential starting point, with nurse academics key to cultivating compassion:

'education is key…compassion should be actually demonstrated in the classroom… so the people around you are…behaving compassionately to each other' (P7)

However, there was reticence as to whether compassion could be taught, with participants asserting that a baseline character from which to nurture compassion further was essential:

'it's not something that you can learn that well…I suppose you can develop on it but I think it has to be there in the first place before you start' (P13)

Despite acknowledging the importance of university education, learning about compassion in practice was considered the most influential context:

'it's like getting instructions on how to ride a bike, but the actual practice of actually doing it are two different things… that's were practice comes in, it's vital to see compassion there' (P14)

Role modelling was essential, with participants perceiving that less experienced nurses could be negatively influenced when exposed to uncompassionate behaviours:

'role modelling is important…they might have come into the ward fresh as a daisy being very compassionate, but then they are falling into that trap to fit in with nurse A, B and C and they just follow' (P17)

<u>Culture for compassion</u>

The culture was significant to nurturing character and competence for compassion, with the ward manager crucial to promoting a shared vision for compassion:

'the ward sister is very influential in creating a compassionate culture' (P6)

Effective leadership was essential and specifically, leading by example was regarded as key to inspiring others:

'it's just leading by example more than anything else… seeing it [compassion] in day to day practice' (P2)

Staffing levels were critical, and in circumstances where staffing levels were low, compassion was thought to be inhibited due to a lack of time for nurses to engage with their patients:

'running around doing 17 different jobs at once…you can't really be that compassionate if you can't spend time with the patient' (P2)

However, despite the challenges of staffing levels, participants were clear that nurses should continue to seek opportunities for compassion:

'staffing levels are always difficult…it is just trying in the moments that you have to sort of give that individual care when you can' (P8)

The systems and processes of contemporary practice were identified as inhibitors to creating a culture for compassion. Participants highlighted that the multiple and complex roles and responsibilities of the nurse were factors influencing time to engage with patients:

'when I am on the ward my mind is sort of racing and there is always something to do…discharge …managing of the teams and things, there is always something …having the time to sit with a patient it is quite limited…other aspects of it like the documentation and things like that so it is just trying to get everything done' (P4)

Advanced clinical care interventions and technology were potential factors impacting time for compassion, with nurses perceived as often focusing solely on clinical tasks rather than engaging with patients:

'the nurses didn't have time, they were too busy doing the meds or IV's or dialysis or wound dressings…they didn't have time to pay attention to the patients really' (P3)

In many practice contexts, task focused systems and processes dominated the approach to care, leading to the potential for a lack of compassion:

'it was just very task orientated, very regimented and if you didn't fit in this box…people were just disregarded' (P2)

Participants sensed a lack of compassion in the organisational infrastructure of some care contexts, due to quality assurance mechanisms that solely focused on targets and clinical outcomes:

'one of the barriers to compassion is that the organisations are not compassionate, they don't value staff or understand the difficulties they face….they're only interested in eliminating risk…the indicators might look great, outcome measures, audits, but the culture isn't compassionate' (P12)

To support a culture for compassion, it was considered vital for organisations to implement appropriate supportive mechanisms for nurses:

'investing in supporting mechanisms…so it doesn't get lost in the system' (P6)

<u>Connections for compassion</u>

Establishing connections at a human level were core to compassion. This involved building relationships with patients, and facilitating actions to support approaches that positioned the person at the centre of care:

'compassion comes from a connection with somebody else…it's all about relationships' (P10)

Establishing relationships was thought to support nurses to engage more effectively with patients, subsequently facilitating opportunities for compassionate care:

'it is just like human nature when you have got a therapeutic relationship with someone, it's easier to engage...close working delivers a lot of opportunities to show a lot of compassion' (P9)

However, it was evident that establishing effective interpersonal relationships required nurses to invest something of themselves at an emotional level:

'a connection between people… they [nurses] just give a little bit of themselves every time and they get truly invested' (P2)

Emotional connections supported human connections, enabling nurses to engage in their patient's distress and enter their world to see the situation from their perspective:

'compassion is about being human isn't it, it's that human connection….being able to engage in people's distress rather than keeping a distance…entering their world (P12)

Compassion was noted to arise from the smallest acts of kindness, often perceived to have the most positive effect on the patient's experience:

'doing what makes the patient feel cared for, even if it's something tiny, like having a chat…it makes such a difference' (P1)

Ultimately, actions for compassionate care were seen to emerge when nurses recognised the humanity they shared with their patients:

'for me it is just doing something that you should just do as a human being …not forgetting that they are human and I am human' (P17)

DISCUSSION

The findings highlight that character for compassion is an essential pre-requisite for nurses. The notion that compassion is influenced by intrinsic personality factors has been suggested by others (Kneafsey et al 2015, Straughair, Clarke and Machin 2019), who also identify disposition and personal attributes to be of fundamental significance to compassion. In support of such controversial claims, evidence in the psychology arena asserts that although people are born with universal attributional traits, individual differences ensue due to their unique position on the continuum of human personality (McCrae 2011). The study findings support this assertion, suggesting that personality factors can influence compassion in nursing. Recruitment strategies should therefore be designed to support selection of the most appropriate candidates for nursing, who demonstrate affinity with a baseline character for compassion. This baseline character for compassion can provide a foundation from which to further develop competence for compassion, which the findings identify to be influenced by exposure to specific learning experiences in the social world.

Competence for compassion can be nurtured through socialisation experiences which are founded on compassion-focused education in the university context and role modelling in the practice context. Education can offer a pedagogical approach which promotes a philosophy for compassion, commensurate with emerging views from others who also suggest that education supports the cultivation of compassion in nursing (Curtis et al 2016). Designing nurse educational curricula that are underpinned by a philosophy for compassion is therefore essential to supporting compassion in nursing. This can be achieved by exposing student nurses to the evidence base underpinning compassion and providing opportunities to learn about compassion through the experiences of service users. However, whilst education has an

important part to play, role modelling in the care context is also vital to nurture competence for compassion. Role modelling behaviours that encourage others to replicate actions for compassionate care are key to this, a claim supported by Straughair (2019). The findings therefore suggest that academics should work with clinical partners to ensure that role models are equipped with the knowledge, skills and character to demonstrate compassion in practice. This may involve supporting ongoing education in the post graduate period and undertaking educational audits to ensure that areas where students undertake clinical placement activity provide an appropriate environment that can effectively nurture compassion.

The findings suggest that a culture for compassion, comprising leadership, resources and the systems and processes of contemporary practice, is crucial. Participants highlighted the importance of care contexts in facilitating a culture within which compassion could flourish, a notion recently supported by West, Bailey and Williams (2020). Appropriate leadership is critical, particularly in terms of promoting a vision that supports replication of compassionate behaviours through shared team goals (Straughair 2019). Human resources and the systems and processes of contemporary practice are also significant influences. Commensurate with the findings of others (Ball et al 2013), low staffing levels and advancing roles were identified as potential factors to inhibit compassion. When poor staffing levels and skill mixes prevailed, there was potential for compassion to be inhibited, due to competing workload priorities. In these circumstances, the focus of care can become task orientated, with technical interventions superseding engagement with patients at a human level. Despite these influences, the findings highlight that it is essential for nurses to sustain compassion, through approaches to care which incorporate small acts of kindness and create effective moments for compassion; a notion proposed by others (Perry 2009, Reimer 2015). Indeed, even in the most complex and challenging conditions of contemporary practice, the findings

identify that nurses should strive to place the patient at the centre of care. The findings therefore highlight several factors with potential to influence compassion in the practice context, and suggest that staffing levels, skill mixes and the systems and processes of contemporary practice require due consideration, particularly in terms of ensuring that they effectively support a culture for compassion.

In this study, compassion was primarily reliant on human connections. Connections for compassion were exemplified through interpersonal relationships, supporting the nurse to see the patient as human and promoting individualised compassionate care. Compassionate care often involved the simplest of caring actions, initiated as a result of the nurse's understanding of the person, ability to see things from their perspective and efforts to position the person at the centre of care. It was evident there was a co-dependency between character, competence, culture and connections for compassion, with each having the potential to influence the patient's experience of humanising care. Humanising care was of central significance to the findings and identified as the fundamental concept embodying compassion in nursing. In the simplest of terms, humanising care was underpinned by a philosophy that regarded the patient as a thinking, feeling person, positioned at the centre of care to assume an active role in the care experience. Fundamentally, humanising care is facilitated when nurses demonstrate character for compassion, are supported to develop competence for compassion, operate within a culture of compassion and are subsequently enabled to establish appropriate connections for compassion (Figure 1).

Figure 1: Humanising for compassionate care
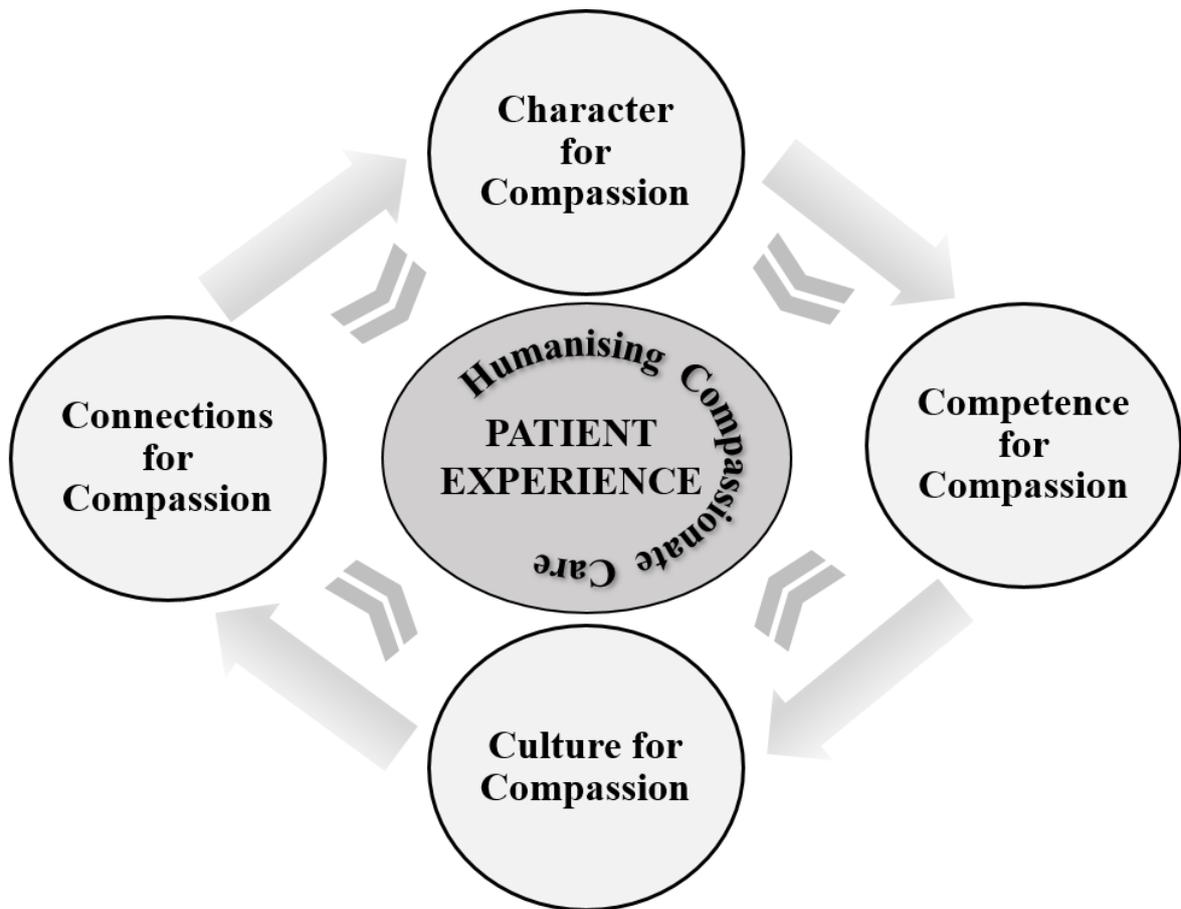
LIMITATIONS

The findings are a substantive representation of the perceptions of participants who were involved in the study. Although they cannot be generalised, they do offer transferability to other similar individuals and contexts.

CONCLUSION

Compassion is a complex concept that is influenced by biological, psychological and socio-contextual factors. These factors require due consideration to ensure that nurses are enabled to implement humanising care, the key concept that this study identifies to be at the core of

compassion in nursing. Primarily, recruitment processes need to select candidates for nursing who demonstrate an appropriate character for compassion. This character requires nurturing through compassion focused education in the higher education setting and role modelling in the practice setting, supporting nurses to advance personal and professional competence for compassion further. The culture of the caring organisation is significant, with leadership, staffing resources and the systems and processes of practice requiring due consideration to create an environment within which compassion can effectively flourish. Ultimately, character, competence and culture can support connections for compassion; connections that are founded on human interactions and which provide opportunities for humanising care. The study offers further original insight into compassion, building on existing evidence to advance understanding and providing a foundation from which to further inform policy, practice, education and research. This is especially pertinent within the context of contemporary practice, whereby the Covid-19 pandemic has raised challenges to sustaining nursing practices which seek to ensure a humanising approach to patient care- identified in this study to be the fundamental embodiment of compassion in nursing.

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