An Exploration of the Concepts of Compassion in the Care of Older People amongst Key Stakeholders in Nursing Education: Pre-Qualifying Nursing Students, Nurse Educators and Clinical Mentors—a Qualitative Study

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Abstract

**Background:** Older people, the focus of this thesis, are amongst those in most need of compassionate care. Compassion, which can be demonstrated in 5 levels is defined as the ability to appreciate and empathise with an appropriate action to ease suffering. Earlier research studies have explored patients’ and/or qualified nurses’ perspectives of compassion in nursing. This study is the first to explore compassion from the nurse educators’ (NEs), clinical mentors’ (CMs) and pre-qualifying nursing students’ (PQNSs) varying perspectives.

**Aim:** To explore, discuss and evaluate views of compassion in the care of older people amongst nurse educators, pre-qualifying nursing students and clinical mentors.

**Methods:** A generic qualitative research approach was adopted using purposive sampling to recruit 39 participants (NEs=8, CMs=8 and PQNs=23). Semi-structured interviews yielded data that were analysed using framework analysis and NVivo. Data collection was completed between July 2013 and February 2014.

**Findings:** Seven themes emerged: role modelling, working practices, care philosophy, clinical leadership, staff attitudes, quality care and nature and nurture. Role modelling was the dominant theme.

**Discussion:** This study adds to the literature by exploring multiple perspectives. Whilst pre-qualifying nursing students and clinical mentors favoured compassion from the perspective of humanistic role models, nurse educators valued compassion as a means to demonstrate work practices, including competence.

Participants suggest that whilst enhancing quality care, compassion can speed up patients’ recovery. This study proposes that while compassion is difficult to teach, it can be nurtured, provided the individual has an aptitude for compassion in the first place.
**Conclusion**: These findings show three stakeholders’ perspectives and identify in what circumstances compassion is expected to flourish and when problems are likely to occur. From the accounts of these stakeholders, it is argued that compassionate care should be incorporated within practical sessions in the pre-qualifying curriculum and within care of the older person. In clinical practice, the perspectives on compassionate care identified by this study, can be embedded in its culture at all levels through nurse education and clinical leadership.

**Key words**: compassionate care, pre-qualifying nurse education, clinical practice and older patients.
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**Declaration**

Whilst registered as a candidate for the above degree, I have not been registered for any other research award. The results and conclusions embodied in this thesis are the work of the named candidate and have not been submitted for any other academic award.
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<td>Allied and Complementary Medicine</td>
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<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>BBC</td>
<td>British Broadcasting Corporation</td>
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<td>BNI</td>
<td>British Nursing Index</td>
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<td>BNU</td>
<td>Buckinghamshire New University</td>
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<td>CASP</td>
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<td>CINAHL</td>
<td>Cumulative Index to Nursing and Allied Healthcare Literature</td>
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<td>CM</td>
<td>Clinical Mentor</td>
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<td>CQC</td>
<td>Care Quality Commission</td>
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<td>Emotional Intelligence</td>
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<td>GMC</td>
<td>General Medical Council</td>
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<td>HCW</td>
<td>Health Care Worker</td>
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<td>HEI</td>
<td>Higher Educational Institution</td>
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<td>HEE</td>
<td>Health Education England</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HSO</td>
<td>Health Service Ombudsman</td>
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<td>IRAS</td>
<td>Integrated Research Application System</td>
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<td>MEDLINE</td>
<td>Medical Literature Analysis and Retrieval System Online</td>
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<td>NE</td>
<td>Nurse Educator</td>
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<td>NET</td>
<td>Networking for Education in Healthcare</td>
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<td>NHS</td>
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<td>Nursing and Midwifery Council</td>
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<td>NPSA</td>
<td>National Patient Safety Agency</td>
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<td>Office of National Statistics</td>
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<td>PHSO</td>
<td>Parliament and Health Service Ombudsman</td>
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<td>PQNS</td>
<td>Pre-Qualifying Nursing Student</td>
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<td>RCN</td>
<td>Royal College of Nursing</td>
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<td>Registered Nurse</td>
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<td>SEHD</td>
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Chapter 1: Introduction

The study underpinning this thesis explores, discusses and evaluates views of compassion in the care of older people amongst three key stakeholders in nursing education, namely pre-qualifying nursing students (PQNSs), nurse educators (NEs) and clinical mentors (CMs). Whilst exploring some of the integral components of compassion, such as caring, empathy, self-compassion, communications and compassionate care, a literature review was undertaken to explore current evidence on the views of compassion in the care of older people amongst these stakeholders. The key issues arising from the literature review were critically analysed with implications for practice considered. At the time, there was a dearth of evidence in regards to comparing and contrasting three stakeholders’ perceptions of compassion in contemporary context. Therefore, with little previous knowledge revealed, a qualitative research methodology appeared to be appropriate to answer the question of ‘what are the perceptions of PQNSs, CMs and NEs of compassion in the care of older people’. The overall approach that was taken to complete this study was the generic qualitative methodology (section 3.4). Semi-structured one to one interviews were used as the means of data collection. The processes of how generic qualitative approach and semi-structured interviews were achieved are explored in more depth in Chapter 3. The findings of this study are thereafter analysed with contemporary literature.

1.1 Context to chapter 1

This chapter introduces the concepts of compassion, compassionate care, and poses questions around measuring compassion and its relationship to older people. It explores the background to compassion and compassionate care. It examines some of the policies relating to compassionate care. An overview of the older population is given. An outline of the generic qualitative approach and a brief account of the role of the researcher as a nurse educator are provided.
1.2 Overview of compassion

There are theoretical models of caring, which incorporate compassion as a vital component (Benner & Wrubel, 1989; Eriksson, 1992; Roach, 1992 & Watson, 1997). As from 2008, compassion seemed to be describing the value of the NHS (DH, 2008d). The King’s Fund Point of Care Programme also adopted the word compassion (Goodrich & Cornwell, 2008). Roach (2002, p.14) states that “compassion is a gift”, it is inborn and cannot be acquired by advanced skills and techniques. Other authors have stated that compassionate care can be developed, enhanced and nurtured (Goetz et al., 2010; Lutz et al., 2008; Kalish et al., 2011 & Kramer, 1974). Compassion should be the business of every health care worker, but what is meant by this common unassuming, complex word is yet to be fully understood.

1.2.1 Defining compassion

It seems that the term compassion has been gradually introduced in some of the main NHS documents (Manley & McCormack 2008). Previously, instead of the term compassion, dignity was commonly used in most NHS policy documents (Darzi, 2008; Dewar, 2011 & Maben & Griffiths 2008). However, both dignity and compassion have been used recently as there has been media condemnation revolving around poor care in many Trusts (see sections 1.3, 1.5.1 &1.5.3). At the same time, it appears that the word ‘compassion’ has also been associated with related terms such as ‘sympathy’, ‘empathy’ and ‘kindness’ (Brunero et al., 2010 & Goetz et al., 2010) and terms person-centeredness, holistic care, and relationship-centred care (Dewar et al., 2011).

Compassion as stated by Schantz (2007, p.3) is “a necessary result of being human beings who feel insulted when they are accused of lacking compassion because it implies that they are non-human beings”. Schantz’s concept analysis reveals that the definition of compassion is neither transparent in nursing curricula nor widely endorsed in nursing practice. She further states that in nursing research articles, terms such as ‘caring, empathy, sympathy, compassionate care and compassion’ are interchangeably used, creating some confusion.
In the literature, the word compassion is defined differently by authors such as Perry (2009), Schantz (2007), Kret (2011) and Mohan (2002). Whilst the Oxford Dictionary (2010, p. 232) defines compassion as ‘sympathetic pity and concern for the sufferings or misfortunes of others’, it can also be traced in Latin: “cum” refers to with and “patrior” to suffer (Patterson et al., 2011). It can be argued that the emphasis on the definition from the Patterson et al. (2011) is on feeling or emotion for someone else, but fails to identify any action in tackling the suffering (Straughair, 2012a). Compassion is stimulated by a profound understanding of someone else’s suffering (Chochinov, 2007). Youngson (2008) and Chochinov (2007) define compassion as a caring feature of comprehending pain in others and wanting to help.

Compassion has many dimensions to its meaning. Some authors emphasise on strong emotion or to pity (Jormsri et al., 2005 & Snow, 1991). For instance, it is claimed that compassion is “a relatively intense emotional response to the serious misfortune of another and the response is a suffering with the other and include a concern for the other’s good” (Snow, 1991, p. 197). It is also suggested that compassion can be described as “having pity for the suffering of others and a desire to free the sufferers from the pain” (Jormsri et al., 2005, p.587). Mohan (2002, p.67) suggests that “compassion encapsulates not only the emotional willingness to enter into another’s feelings and express empathy and solidarity; it also involves the active will to share and help alleviate the plight of others.”

Nussbaum (1996, p.27) defines compassion as “the painful emotion caused by the awareness of another person’s undeserved misfortune.” She further elaborates that compassion has three conditions, mainly the pain is grave, the person does not merit the pain and the purpose of the provision of compassion is commendable. The contentious issue in this definition is about the word “undeserved”, which can be considered as anti-compassion. Nussbaum seems to suggest that compassion is only for people who did not bring the pain on themselves. However, if someone was at fault for the pain incurred then they are undeserving of compassion. As an example, Nussbaum seems to propose if someone has lung cancer following years of smoking, this misfortune is desired
and therefore not worthy of a compassionate response. This condition that Nussbaum postulates, goes against the very ethos of the NMC Code, which states that a nurse should “act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment” (NMC, 2015, p. 15).

Providing care with compassion is not given based on whether a patient is a “deserved or underserved” one. Judging patients is not part of the nurses’ role. Van der Cingel (2009 & 2014) argues that as far as health care is concerned, compassion should not include being judgemental. Van der Cingel (2014) further stipulates that if compassion is to be recognised as a significant element of care, compassion needs to be accessible to everybody who suffers, irrespective if the pain originates from good or bad behaviour. Curtis (2014) suggests that the right to equal care is part and parcel of all healthcare professional codes of conduct.

Perry (2009) and Schantz (2007) argue that compassion in its complete meaning, not only signifies sympathy and empathy, but compels and empowers people to recognise and act towards relieving someone else’s anguish. Dewar (2011) and Mohan (2002) suggest three dimensions, which comprise of identifying that someone is suffering; understanding that person and then aiming at alleviating the suffering. Many definitions, namely, Mohan’s (2002), Perry’s (2009) and Schantz’s (2007) emphasise on “active will”, which is particularly pertinent to the older patients, who might be confused and lonely or even reluctant to ask for help.

Fundamentally, compassion gives rise to a great drive mainly dedicated to others, resulting in superior social connectedness (Jazaieri et al., 2012). “Compassion is about the very way in which we relate to others”, (Dewar & Mackay, 2010, p.301). A compassionate person helps selflessly for the well-being of others without any thought of reward. This means that compassion moves people from the emotional realm to the realm of ethics; from the world of what people sense and want to do, to the world of what we are and what we are destined to do (Schulz et al., 2007 and Turkel & Ray, 2004). Based on the above premises, kindness, trust, respect, dignity and compassionate care are demonstrated through relationships (DH and NHS Commissioning Board, 2012).
As stipulated before, the ability to recognise the sufferer and a willingness to help is shared with most of the definitions of compassion. Cole-King & Gilbert (2011) state that compassion is more than that. Cole-King & Gilbert (2011) define compassion as “a sensitivity to the distress of self and others with a commitment to try to do something about it and prevent it” (p. 30). In an attempt to break down the definition, they imply that sensitivity is about awareness, attention and motivation. Actively doing something requires commitment, courage and wisdom. Cole-King & Gilbert (2011) suggest that if suffering or distress is the prime motive, then all characteristics of the person’s (family’s) suffering (psychological or physical) need to be seen to. In a healing profession like nursing, compassion will undoubtedly be pertinent because of the vulnerability of patients and clients, be it the sick, children, adults, mentally ill or elderly (DH, 2008d and Turkel & Ray, 2004).

Many words or even terms have been used to describe compassion (Crawford et al., 2013). Table 1.1 gives a list of attributes to compassionate mentality (Crawford et al., 2013). Whilst the list is comprehensive, it fails to acknowledge the ‘action’ element of being compassionate. It can be argued that some of the attributes that can be added to the list are ‘action to help with courage, commitment to relieve suffering’. Compassion is seen as a central part of dignity (RCN, 2008) and nurses’ compassion is a pivotal part in the provision of that dignified care to patients.
Table 1.1: Attributes of a ‘compassionate mentality’

<table>
<thead>
<tr>
<th>Kind</th>
<th>Gentle</th>
<th>Warm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loving</td>
<td>Affectionate</td>
<td>Caring</td>
</tr>
<tr>
<td>Sensitive</td>
<td>Helpful</td>
<td>Soothing</td>
</tr>
<tr>
<td>Concerned</td>
<td>Empathetic</td>
<td>Friendly</td>
</tr>
<tr>
<td>Tolerant</td>
<td>Patient</td>
<td>Supportive</td>
</tr>
<tr>
<td>Encouraging</td>
<td>Non-judgemental</td>
<td>Validating</td>
</tr>
<tr>
<td>Considerate</td>
<td>Sympathetic</td>
<td>Comforting</td>
</tr>
<tr>
<td>Reassuring</td>
<td>Calming</td>
<td>Open</td>
</tr>
<tr>
<td>Understanding</td>
<td>Giving</td>
<td>Respectful</td>
</tr>
</tbody>
</table>

(Crawford et al., 2013)

1.2.2 Measuring compassion

Nurses’ ability to demonstrate compassion whilst communicating and dealing with patients politely and showing a caring disposition towards colleagues is important (Santry, 2010). Compassion is appropriately regarded as an essential component of the nursing process; nevertheless, nursing cannot be viewed solely in these terms (Sturgeon, 2008). Compassion is difficult to quantify and challenging to measure. To address poor standards of care in several hospitals, namely the Mid-Staffordshire NHS Trust and how to boost levels of patient satisfaction, the then Secretary of State for Health, Alan Johnson, drew up plans to develop a set of metrics (compassion index) that would assess the effectiveness and safe level of nursing care and how compassionate care would be delivered (Johnson, 2008a).

The emphasis on ‘compassion index’ proved to be testing within the Department of Health. Mr Johnson wanted the achievement of all nursing team in every ward across England to be measured, with the outcomes advertised on an approved website (Carvel, 2008). Mr Johnson argued that a smile on the nurses’ faces, suggested by Clout (2008) and compassionate care were as vital to patients’
recovery as the skilled operating theatre doctors. Whilst nobody can argue that a caring attitude is essential for nurses to have, measuring compassion by the smiles on their faces (Clout, 2008) is concerning. The thought of having a template for a “compassionate nurse” seems a rather daunting prospect to contemplate.

It can be debated that it is easier to measure some aspects of care, like infection control and falls than others, namely compassionate care (Bailey, 2008). Initial suggestions were that the metrics for compassion would predominantly emphasise on the reported patient’s experiences of communication and care (Mooney, 2009). This concurred with inferences drawn by Sanghavi (2006), who suggested that despite that compassionate care itself cannot be meaningfully quantified (it is challenging, he suggested to quantity ‘small acts of kindness’), the significance of such care can be measured in the form of prospectively tracking patient satisfaction, health knowledge and health outcomes in terms understandable to patients. Examples of small acts of kindness can be a light touch or even an essential telephone call. Olshansky (2007) argues that if compassion is not clearly defined; nurses will find it difficult to integrate it as an essential element of their professional practice.

There are tools designed to measure compassion. However, there is no standardised tool that is being consistently used across the NHS (Papadopoulos & Ali, 2015). Pommier’s (2011) tool which provides a compassion scale calculates how one would normally act towards others (Appendix 1). Six aspects for compassion, namely, ‘kindness versus indifference, common humanity versus separation and mindfulness versus disengagement’ are used to calculate how compassionate one is (p. 262). Whilst this scale seems simple to use, it can however make an assessment, whereby compassion is also being measured time consuming. Burnell & Agan (2013) developed the Compassionate Care Assessment Tool (CCAT) to measure compassion. In their research, inpatients used four subscales; meaningful connection, patient expectations, caring attributes and capable practitioner to rate how compassionate nurses were. This tool seems
to be more appropriate to assess nurses’ level of compassion by inpatients in clinical practice.

1.3 Focusing compassion within the care of older people

There are many reasons why this study focuses compassion on older people. The ageing population is increasing faster than ever, and it is expected that the number of people over the age of 80 years will triple by 2050 (Joseph Rowntree Foundation, 2012 & ONS, 2010). According to the DH (2001a & 2001b) two thirds of hospital beds are used by older people, who make up the main patient group in care homes (Taylor, 2011). Nurses on average spend most of their time looking after this patient category (Pope, 2012). Complex needs, chronic illness and disability seem to be a recipe making the older people more vulnerable (Baillie et al., 2009).

Of nearly 9,000 complaints made to the Ombudsman about the NHS in 2010, 18% were around care of the older people. Approximately half of people with disability are aged 65 or older (DH, 2001a). Whilst this figure of 18% of complaints from the older people is small, one can question the real representation of this value. Many older people are aware of the way that the healthcare was before the introduction of the NHS and the modern welfare state and hence reluctant to complain (DH, 2001a). This can compromise the very nature of raising a complaint. Of the cases investigated by the Ombudsman, the highlighted concerns were based on fundamental care such as maintaining dignity, a clean environment, support with feeding and assistance with personal care (PHSO, 2011).

Whilst exploring the care of older people, it was emphasised that some staff members were patronising or were even being contemptuous (CQC, 2011a). There were fears that staff members were not treating patients in a respectful manner, for example feeding them without any engagement, openly discussing patients’ care and personal information, compromising confidentiality and privacy (CQC, 2011a). It was even stated that patients were being left unfed in the report ‘Hungry to be Heard’ (Age Concern, 2006). Fundamental care, such
as communication, respect and dignity were being compromised (Goodrich, 2011 & Webster and Bryan, 2009). It was agreed that the older people needed to be valued and listened to and that there was a need for compassionate care (DH, 2013b). Poor treatment and compromised quality of care of the older people were not confined to an area, but were reported to be across all sectors, namely acute, community and primary care (Parliamentary and Health Service Ombudsman, 2011).

It is stated that the more registered nurses (RN) there are on a ward; the better would be the quality of care, enhanced patient safety and better patient experience (RCN, 2010a). Nevertheless, older people, who frequently have the most complex needs of all, seldom benefit from a favourable skill mix (RCN 2010a). Not only the overall care is compromised with a poor skill mix, there is also a risk that care giving may be inappropriately delegated. The implications of poor skill mix also suggest inadequate time to reasonably deliver fundamental nursing care (RCN, 2010a). Ageism is a way of portraying types of biases apprehended about older people based on their age (Ray et al., 2006). Ageism is firmly embedded within the social fabric of the British culture and older people are often stereotyped as ‘bed blockers’ that is, unnecessarily occupying hospital beds (Hewstone, 1989).

Wards that care for the older people normally find it more difficult to recruit and retain staff nurses, compromising the patient-to-nurse ratios (skill mix) (Ball and Pike, 2009). In addition, in hospital and private homes, most staff members providing the care for older people have fewer qualifications, are not paid well and work in poor conditions (Dunkley and Haider, 2011). This may be because what the media portrays and some nurses perceive that caring for the older people is labelled as basic, often suggesting that it necessitates little knowledge or skill (Maben et al., 2012).

It is claimed that looking after older people is not as exciting as working in the acute settings, such as Accident and Emergency (Centre for Workforce Intelligence, 2011). For example, despite the care of the older people being the largest medical speciality, the increase in the number of medical consultants in
this field has not been as great as in other specialties (Centre for Work Intelligence, 2011). In essence, with the increased demands in the care of the older people, the UK needs around 50 per cent more geriatricians (Centre for Workforce Intelligence, 2011). This suggests that the skill mix in the elderly setting will be poor, leaving both patients and staff members vulnerable. Patients will not receive individualised care and feel unhappy, whilst staff members can face a high level of burnout or even compassion fatigue. Hooper et al. (2010) make the correlation between high levels of nurse compassionate care and compassion to patient satisfaction, and high levels of nurse burnout with patient dissatisfaction.

Other significant areas for improvement recognised by the “Dignity in Care” report were in patients’ independence, pain reduction, end of life care and social inclusion (Help the Aged, 2007 & 2008 & Levenson, 2007). Over the last fifteen years, there have been more reports concentrating on the poor care of the older people in acute hospitals and the community settings.

1.4 Compassionate care

Whilst exploring compassion and its manifestation in nursing, Dietze and Orb (2000) express a need to view compassionate care not merely to take away another person’s pain and ease suffering as defined by many dictionaries, but to enter into that person’s experience to capture an understanding of their problem and to share some of it with them. It was suggested that three main values were vitally important when considering patients’ needs for compassionate care from the nurses’ perspectives (Bradshaw 2011a). These were the “character of the nurse, competence in knowledge and skill and ward leadership”, (Bradshaw, 2011a, p.1798). These will be further discussed in chapter 2 (see section 2.3).

From this viewpoint, Bradshaw (2011a, p.1798) defines compassion as “suffering together with another as more than an emotion or feeling but as a precursor to practical help.” Bradshaw (2011b) claimed that compassionate care is not a measurable skill and should be provided with authenticity. She further suggested that the only incentive for a compassionate act is for the
benefit of the patient. In other words, the carer or the nurse acts selflessly, which is part of their role.

1.4.1 Compassionate care post The Francis Report

The 290 recommendations made on the NHS and independent sectors involved each and every person helping patients to participate in a safe, committed as well as a compassionate and caring organisation (Francis, 2013). Below is an exploration of some of the recommendations relating to nursing, but most importantly to compassionate care.

It is acknowledged that there is a correlation between suitable staffing levels and safe, compassionate care (Francis, 2013). Insufficient nursing staff levels were highlighted as a causative reason in the shortcomings at Mid Staffordshire hospital NHS Trust, in areas such as care of the older people (Francis, 2013). However, the Francis Report did not approve a minimum staffing level; bearing in mind that different speciality (critical care, care of the older person, surgical or medical) will have a different ratio. Instead Francis suggested that NICE would develop a framework for ‘establishing the staffing needs of each service’ (Francis, 2013, p.69). There is a discrepancy of qualified nurse staffing levels in hospitals across Britain. For instance, in some NHS Trusts the ratio of qualified nurses to patients is one to five and in others it can go up to one to eleven (Ball, 2012).

The shortcomings in care at Mid-Staffordshire hospital NHS Trust were related to older patients, predominantly those suffering from dementia. Some patients suffering from dementia have limited cognitive aptitude and thus are not able to cope in hospital environment (Hermann et al., 2015). This makes them vulnerable, not only as they can get confused, but also, they can get depressed and be aggressive (Hermann et al., 2015). Therefore, dementia care is linked with higher nursing needs. The Alzheimer’s Society (2013) suggested five ways to develop the care of people suffering from dementia. To deliver appropriate care, staff members need to be trained in dementia care and hospitals should become dementia friendly. Senior clinicians should take the lead in the
enhancement of dementia care. Better equipment is needed to properly
diagnose dementia once a patient is admitted and to prevent hospital admission,
patients with dementia should be well supported in the community. To meet the
needs of this category of patients, a personalised “dementia ward” was
proposed (Thorlby et al., 2014). It was also suggested that a policy of having
one-to-one nursing ratios for people with dementia should be considered
(Thorlby et al., 2014). Whilst the above proposals seem ideal, they pose
financial challenges to Trusts.

1.5 Putting compassion into context

Nursing can be defined as “the use of clinical judgement in the provision of care
to enable people to improve, maintain, or recover health, to cope with health
problems, and to achieve the best possible quality of life, whatever their disease
or disability, until death”, (RCN, 2003, p.3). Hooper et al. (2010) go further by
stating that nursing is synonymous with caring and compassion. Turkel and Ray
(2004) state that the soul of nursing is the quest of doing good through
compassionate caring. Compassion is the ability to receive satisfaction from
caring, for an intrinsic reward (Simon et al., 2005). Compassion is recognised as
a nursing feature that influences patient care (Kret, 2011). From the above
perspectives of nursing it is clear that compassion and compassionate care are
very much part of the nurses’ roles. The compassionate nurse is therefore
confronted to share the pain of the patient. As the nurse, has more direct contact
and spends more time with the patient, the nurse/patient relationship is
important. Dietze and Orb (2000, p. 172), argued if this relationship is of
“confidence and trust”, holistic care can be provided.

1.5.1 Reports on compassion and compassionate care

The profile of provision for compassionate care has been raised by the RCN
(2008) and in DH (2009) reports. There has been a plethora of reports
articulating undesirable patient experiences mainly due to an absence of
compassionate care (PSHO, 2011 & RCN, 2012b). Some of the reports, mainly
from the Health Ombudsman (PSHO, 2011) and the Patient’s Association
(Patients’s Association, 2011), described stories of patients’ experiences of unacceptable levels of care. The Patients Association is a healthcare charity which recommends enhanced access to precise and autonomous information for patients and the public; high quality care for patients and patient involvement (Patients Association, 2011). It was also reported that between 2005 and 2009, 400 patients had been "dying needlessly". Researchers from London School of Economics (LSE) suggested that more than a million over-65s a year are poorly treated while in hospital, including not being assisted to eat (Campbell, 2015).

Professional bodies such as the RCN, Nursing and Midwifery Council (NMC) and General Medical Council (GMC) all identify with the need for urgency in the provision of compassion within the health care arena. NMC (2015, p.4) states that a nurse should “treat people with kindness, respect and compassion”. Other documents confirm that the delivery of nursing care with compassion has apparently been lost (CQC, 2011b, 2012; Francis, 2010 & PHSO, 2011). The Health Service Ombudsman (2011) gives accounts of how the NHS provision is inadequate in meeting the needs of the older people with care and compassion. Common in all the stories is “the experience of suffering unnecessary pain, indignity and distress” (HSO, 2011, p.7).

1.5.2 Policy context

Policies emphasising care, compassion and person-centeredness emerged between 2005-2012 (CQC, 2011b; Darzi, 2008; DH 2005; DH, 2008b; DH, 2008c; DH, 2008d; DH, 2012; PHSO, 2011; RCN, 2012a; SEHD 2006a; SEHD 2006b & SGHD, 2007). One of the main aims emphasising compassion has been that ‘high quality care should be as safe and effective as possible, with patients treated with compassion, dignity and respect’ (Darzi, 2008, p.11). The Francis publications (2010 & 2013) portrayed limitations in the NHS by evidencing alarming reports of lack of compassion at the Mid-Staffordshire Hospital NHS Trust. These resulted in compassion entering the political agenda as the Next Stage Review stated that compassion would become one of the tenets of the Health Service and was embedded in the NHS Constitution. It stated “we ensure that compassion is central to the care we provide and
respond with humanity and kindness to each person’s pain, distress, anxiety or need” (DH, 2013a, p. 5).

It was mentioned that patients should anticipate compassion as an essential part of their day-to-day nursing care (DH, 2010a). The Prime Minister’s Commission on the Future of Nursing and Midwifery in England (DH, 2010b) reinforced the commitment for good quality compassionate nursing care emphasising nurse’s role and nurse leaders. However, this report fails to elaborate or provide any detail as to what it entails or even translates to practice. As far as RCN (2010b) is concerned, out of the eight principles it outlined, principle A explores compassion. It states: ‘nurses and nursing staff treat everyone in their care with dignity and humanity- they understand their individual needs, show compassion and sensitivity and provide care in a way that respects all people equally’ (RCN, 2010b, p.3). More information on the prominence of compassion is entrenched in the document Standards for Pre-Registration Nursing Education (NMC, 2010b). These standards ascertain the essential competence level that PQNSs must have before embarking on the professional NMC register. The NMC Code, Standards of Conduct Performance and Ethics for Nurses and Midwives was originally published in 1983 and revised in later editions. It provided a legal and ethical set of principles for UK nurses (NMC, 2008). It is worth noting that revised Code (NMC, 2015) The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives, the words ‘compassion’ or ‘compassionately’ are emphasised.

1.5.3 Looking at compassion in health care

The impetus to look at compassion in the health care arena is by a series of rather unprecedented events in care. Some well-broadcasted cases of abuse were reported at the Winterbourne View, a privately own care home and at the Mid-Staffordshire National Health Service (NHS) Foundation Trust, where the Francis Inquiry concluded that there was an absence of compassion amongst many other failures (Francis, 2013). In a seminal article, the Patients Association (2011) reported some patients’ experiences, namely elderly patients being denied pain relief, denied help when eating or access to toilet facilities. It
was reported that at the Mid-Staffordshire NHS Trust Hospital, patients were left crying and demeaned by uncompassionate staff members (Francis, 2013).

A survey undertaken by the RCN (2008) pointed out the many problems in health care organisations, from the bureaucratic management style to the setting of unrealistic targets compromise compassion. This can lead to staff members being uncompassionate (Francis, 2013). It is debated that working in an environment where staff members demonstrate compassion encourages students to pursue and promote the same (Pence, 1983). Roach (2002) stipulates that patients should not be exposed to uncompassionate nurses.

From the healthcare practitioners’ viewpoint, it is perceived that front-line staff members, mainly nurses, are blamed (Smith, 2013). “People must always come before numbers, statistics, benchmarks and action plans are tools not ends in themselves” (Francis, 2010, p. 4). These should be looked at in the context of patients being treated in a conveyor belt style, the ‘production-line mentality’ (Crawford & Brown, 2011, p.5). British Broadcasting Corporation (BBC) also elaborated on several examples, which were televised projecting poor nursing practice and sparked off a public outcry (Patients Association, 2009).

It seems that patients are increasingly being discontented with their care. The Nursing and Midwifery Council (NMC) purports that patients’ complaints about nurses are increasing. The NMC (2009) suggests that the number of claims has increased from 1032 in 1997/1998 to 1487 in 2007/2008 – an increase of 44 percent. Campbell (2011), the Guardian newspaper health correspondent, analysed online patients’ opinions and concluded that out of the 11,982 comments it received between 2005 and 2010, 2,537 were adverse. Some of the areas highlighted by participants were staff members being rude, a general lack of compassion in the respect that patients were left uncomfortable, patients not being kept up-to-date with information and requests not being met. The Patient Association (2009) goes further by suggesting that this is only part of the problem.
Due to the increasing number of complaints about lack of care, dignity and patients’ fundamental human rights being violated, patients, carers, relatives and staff should increase their awareness about how to promote compassionate care (DH, 2005 & SEHD, 2006a). Patients are purported to being denied some of the most fundamental nursing care, such as nutrition, respect, personal hygiene and information. In a report the “NHS is failing to meet even the most basic standards of care for older people”, the Health Service Ombudsman (2011, p.1) reveals that there is a problem with attitude, ‘both personal and institutional’, which fails to appreciate and acknowledge patients at the fundamental and individual level and to respond to them in a compassionate, thoughtful and professional manner.

1.5.4 Compassion fatigue (CF)

Compassion fatigue is defined as, “a unique form of burnout” (Joinson, 1992, p.116). It can be argued that high levels of care with compassion have been associated with patient satisfaction and high levels of fatigued nurses have been connected to patient discontent (Hooper et al., 2010). Consequently, nurses’ compassionate ideals and values become compromised (Maben et al., 2007). This certainly cannot be ideal for the nurses, patients or the image of the organisation. Nurses caring attitudes can be maintained by providing supportive practice areas, identifying the signs and symptoms of CF and burnout and finding appropriate interventions (Hooper et al., 2010) (see section 4.2.5). Some of the coping strategies identified by Yoder (2008) are both work related (debriefing staff, change of work situations) and personal (spiritual or religious). Emotional labour is where the likes of nurses find it important to overpower their emotion to make sure that the patient feels reassured and safe (Hochschild, 1983). This is further explored in section 2.7.

1.5.5 Self-compassion

A lack of compassion towards oneself (self-compassion) can also contribute to stress and ultimately a lack of compassion towards patients (Gilbert, 2009). Authentic caring in nursing must be grounded in self-care suggested Watson
Self-compassion can be defined as “being open to and moved by one’s own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding, non-judgmental attitude toward one’s inadequacies and failures, and recognising that one’s own experience is part of the common human experience” (Neff 2003a, p. 224). Self-compassion is significant as people need some form of nurturing, but it is also important for nurses to be able to show empathy towards patients. One of the main issues of being selflessly concerned is about not being able to look after oneself, to be kind to oneself, self-compassion as Neff (2003b) describes. For instance, it will be difficult for a nurse who cannot look after herself to start providing compassionate care to a patient. Neff (2003b) further explains that self-compassion entails knowing one’s own suffering and the desire to make it better. Excessive compassion can end up in self-sacrifice (Van der Cingel, 2009).

1.6 Background to nurse education

Some studies have argued that compassion can be instilled, that teaching or inducing compassion is possible (Goetz et al., 2010 & Lutz et al., 2008). This is perhaps why recommendation 187 of the Francis Report (Francis, 2013) suggests that prior to commencing the pre-qualifying nursing course; PQNSs should work in the care sector as a nurse assistant. Initially it was stated that the aspiring PQNSs should work three months under supervision and preferably in the care of the order people (see section 4.2.4). The timescale was later reviewed and increased to “up to a year”. In one sense this approach can be helpful as these potential PQNSs will get the experience of looking after vulnerable patients, whilst providing fundamental nursing care. Attending to the very basic needs of patients washing, dressing, feeding and dealing with confused patients can be challenging and beneficial (Algoso et al., 2015). It can be debated that it will be easier to thereafter get into the role of the PQNS. Algoso et al. (2015) argue that working as a nurse assistant prior can help in the preparation of potential PQNSs recruits, offering a real picture of what it entails to be a nurse whilst instilling basic nursing principles, such as compassionate care. The problem with this condition is that it could have consequences on
recruitment and selection of PQNSs as in essence the length of course could be increased from three to up to four years. Hypothetically, this can prevent potential candidates from applying on the BSc in Nursing degree course.

Another potential problem that can have negative consequences on PQNSs’ recruitment and selection is the NHS Bursary Reform Policy (DH, 2016). From 1 August 2017, NHS bursaries for nursing, midwifery and a number of other allied health students will be discontinued, but instead student loans through the student loans system will be made available (DH, 2016). While the Government states that this funding reform will enable universities to offer more training places on pre-registration programmes, there is inadequate evidence to substantiate such a claim. Instead, it can be suggested that this funding reform will be damaging to nursing on a whole. It is claimed that less students will apply for nursing courses when they start paying tuition fees (Sayburn, 2016). For instance, mature students, especially those with dependents are unlikely to apply.

It is important to note that prior to entering the Nursing and Midwifery Council register, nurses need to go through a process, from recruitment and selection from Higher Educational Institutions (HEIs) to completing the nursing course (NMC, 2010). Whilst this process seems simple, it necessitates the cooperation of several people, namely, Clinical Mentors (CMs) from practice and Nurse Educators (NEs) from the HEIs. Pre-Qualifying Nursing Students’ (PQNSs) recruitment and selection are vital to guarantee the suitability of interviewees. Following the aftermath of care failings at Mid-Staffordshire Foundation NHS Trust, the need to recruit nursing candidates with suitable values and attitudes (values based recruitment) were identified (DH, 2013a; HEE, 2014; Willis Commission, 2012).

1.6.1 Current recruitment practices

At the institution where this research study was conducted, recruitment and selection include a formal maths and an English test as well as a group and one-to-one interview. All the four elements of the assessment have their own
functions. The maths test assesses the level of basic calculations to ensure PQNSs can adequately administer drugs. The English test uses a narrative whereby a mother loses her son who suffers from a mental health condition and the written response is evaluated to see whether the candidate displays emotional intelligence (EI), can offer empathy and compassion to the mother. It also assesses their command of the English language. This therefore acts as an evaluation of the applicant's capacity for compassion. The group interview assists in assessing whether the interviewees can work in a team as well as respecting each other. The one-to-one interview gives the interviewer a chance to review the interviewees. One of the questions asked explores the qualities of an effective nurse, whether the interviewees have an insight into nursing and whether they view the 6Cs (see section 1.6.3) important. The interviewees on the other hand get an opportunity to ask any questions to the interview panel, which consists of a NE, a CM and a service user in the form of an expert patient. Each member of the interview panel offers perspectives on education, practice and user of healthcare respectively.

1.6.2 Including service users in the recruitment process

Increasingly there is evidence supporting the inclusion of service users in the interview process of pre-qualifying nursing students (O'Boyle-Duggan et al., 2012). Service users’ involvement at the interview is important as they offer their perspectives on the compassion and caring aptitudes of the potential candidates. Whilst compassion should be at the heart of teaching PQNSs, assessing interviewees at the point of recruitment and selection can be challenging. Despite numerous initiatives to establish compassion is at the heart of nursing, how it translates to practitioners is yet to be clearly defined. Compassion is not only complex, but can be idiosyncratic in nature too.

As compassionate care is being considered in the nursing arena (care of older people for this project), skills, competence and professionalism are some of the important qualities that practitioners should have (DH, 2010b). Valuing as well as respecting older people whilst enhancing compassionate care is important (Taylor, 2011). In a profession, such as nursing, whereby evidence based
practice is high on the agenda, it is also important to consider competence and professionalism when looking at compassion. 'Truly compassionate care is skilled, competent, value based care that respects individual dignity. Its delivery requires the highest levels of skills and professionalism.' (DH, 2010b, p. 3).

Compassion without competence can be worthless or unsafe (Roach, 1997).

1.6.3 Screening for compassion

One of the recommended schemes was to screen for compassion at the selection point to the nursing course (Johnson, 2008b & Francis, 2013). The screening for compassion is an encouragement to create a patient-centred and compassionate provision for patients. Recommendation 188 of the Francis report (Francis, 2013, p.1695) considers the introduction of an “aptitude test for compassion and caring”. It has been suggested that few NHS Trusts test potential nurse recruits on their aptitude (Ford and Stephenson, 2011). Introducing a test to measure prospective PQNSs’ level of compassion and caring at the recruitment and selection events seems challenging and time consuming (see section 1.2.2).

In her first study, Roach attempted to answer the question: What is a nurse doing when he or she is caring? Five groups were acknowledged, which were known as the ‘Five C’s’ (commitment, conscience, competence, compassion and confidence). Pusari (1998), described the elements of caring as 8 Cs: Compassion, Competence, Confidence, Conscience, Commitment, Courage, Culture and Communication. The Government proclaimed a three-year Compassion in Practice strategy in 2013. This comprised a plan that prospective nurses should be employed using the '6Cs': ‘Care, compassion, Competence, Communication, Courage and Commitment’ campaigned by the Chief Nursing Officer (DH, 2012a, p. 13). Obviously, the standards and behaviours that are encapsulated by the 6Cs are not new. Whilst unacknowledged, it seems undisputable that the Chief Nursing Officer’s 6Cs, is influenced by the work of Roach’s (1984 & 1992) attributes to caring, the 5 Cs and Pusari’s 8 elements of caring.
1.6.4 Nurse curricula: preparation to care

Conduct and interpersonal aspects of care are now secondary (Johnson, 2008b). PQNSs are no longer part of the workforce they are classed as supernumerary. However, it is important to make sure that this is complemented by practice skills that emphasise the staff–patient experience (Hanna & Hins, 2006). Nurses are now qualifying with higher qualifications, a Bachelor of Science (BSc) at least, and seem to be moving away from the compassionate and basic nursing care. In addition, several skills e.g. intravenous cannulation, medication prescribing, previously carried out by junior doctors are now performed by nurses (Sturgeon, 2010). It can be argued that this takes away some of the precious times that nurses would otherwise spend with patients.

Compassion has been used in nursing theory and practice for a long time (Van der Cingel, 2014). Van der Cingel, (2011) argues that there is the urge to embrace compassion as a guiding principle for healthcare practices. However, it seems that the reason that the nursing curricula is yet to reflect on the above, is because the significance of compassion to nurses is yet to be fully understood (Van der Cingel, 2014). Over the past few decades, there has been a gradual decline in the provision of compassionate care, eroded mainly due to the adoption of evidence-based practice (Johnson et al., 2007, Miers et al., 2007 & Pearey & Draper, 2008). It is suggested that the fact that there is so much concentration on acquisition of knowledge, the curriculum has shifted its emphasis away from the caring with compassion (Bray et al., 2014).

It is considered that many nursing students join the profession because they want to improve healthcare (Wear & Zarconi, 2008). However, during their training and after they complete the course, some nurses tend to experience a level of frustration, burnout due to stress and a level of compassion fatigue (see section 1.5.4) (Brewin & Firth-Cozens, 1997). Some have even alleged that nurses are now ‘too posh to wash’ (Wright, 2006, p.20). This means that nurses are moving away from completing the fundamental care procedures in nursing, which are washing, dressing, feeding, communicating and giving adequate time to patients, that is, providing compassionate care. But a perceived absence of
this quality care in the current profession has generated new efforts to make sure nurses embrace it as an essential principle (Mooney, 2009).

Maintaining compassionate care is not only the role of nurses, it requires an inter-professional approach (see section 4.2.3). Despite the use of case studies, vignettes, simulations, and clinical laboratory experiences as conventional approaches to teaching to assist students in developing a holistic approach to patient care as Harrison (2006) stipulates, nurses are completing these courses and still deemed as uncompassionate. Douglas (2010) states that delivering care without compassion is ‘simply wrong’. Therefore, exploring the reasons why some nurses lack compassion is important.

Hem and Heggen (2004) question whether compassion is essential to nursing practice. Due to increasing patient demand, lack of time and inadequate resources, Hem and Heggen (2004, p.28) postulate that compassion is challenging in practice and is a “radical idea, with a critical potential”. In their study, Hem and Heggen considered patients suffering from psychosis. They suggested that to maintain patient safety, the psychiatric nurses acted in a paternalistic way, refraining the patients from taking leaves to visit their homes. The patients felt that they were not being listened to, hence they felt that the nurses were being uncompassionate. On the other hand, the nurses felt that they had to maintain patient safety.

1.7 Personal beliefs and values

The approach adopted for this research study is a generic qualitative one which, as its name suggests, tends to make use of some or all the features of qualitative methodology. It endeavours to either combine several qualitative methodologies or asserts no specific methodological perspective at all (Caelli et al., 2003). The main emphasis of the study is on understanding the experiences of PQNS, CMs and NEs in relation to compassionate care. Making use of field notes, interviews and conversations in a natural setting, generic qualitative research is informed by the interpretative paradigm to make sense of the world (Denzin and Lincoln, 2011).
I felt that a reflexive approach was important to adopt, as I perceived myself as part of the study rather than separate from it (Ritchie et al., 2013). At the same time stating personal and professional influences at the beginning of any research improves its credibility by allowing the reader to contextualise the results (Pope & Mays, 1999). Professionally, I have worked as a supervisor, health and safety officer, nurse and nurse educator. To inform this study, I managed to draw on some of my previous knowledge and experiences, but also reflected on some moments when I required compassionate care as an inpatient (see section 1.7.2).

Being brought up in a family whereby values underpinning compassionate care for each other were always maintained, I attempted to promote the same professionally, in my role of a supervisor, a nurse or a nurse educator. I felt that it was important to listen and appreciate colleagues’ strengths and weaknesses and support them as much as I could. I felt that I could always associate with them and their problems and would offer support. I endeavour doing the same all throughout my life.

Originating from my life experiences and my upbringing, my principles and beliefs impacted on the research study. As a supervisor, I believed that supporting colleagues with work and their professional development were important. As a health and safety officer, I made sure that safety of anyone, be it an employee, employer or a member of the public was not compromised at any point. As a charge nurse, I always tried to make sure that patients and colleagues as well as students were looked after and cared for.

1.7.1 The researcher’s personal view of compassion

Based on the above-recognised definitions, compassion is a universal concept, not only for the deserved or undeserved. In contrast to other positive feelings, such as happiness and contentment, compassion surfaces as selfless behaviours and kindness (see section 1.2.1). Everyone warrants compassion, be it the patient or nurse. Compassion is what nurse leaders described as a feature of a “good nurse” (see section 1.2.1).
My painful encounter as first year student whereby my clinical mentor ill-treated me in front some parents in a paediatric ward enthused me to become an example of competence and compassion to junior members of staff. Instead of emulating that mentor and coercing PQNSs, turning them away from the profession, I chose to become their mentor. Experience can influence how compassionate one becomes in later life. In my view and based on the definitions explored, empathy (see sections 2.3.3 & 4.3.2) is the main ingredient of compassion. First and foremost, empathy, which is treating someone the way that a person wants to be treated (Bray et al., 2014), needs to be understood. The issue with empathy, which can be situational and/or appropriate, is that it is at times difficult to be understood. For instance, in a moment of sorrow, a person might want to be left alone or be comforted and be in the company of many people. Empathy in this instance and many other instances might be tricky to be understood, but should be appropriate. On the other hand, empathy can be situational as one can argue that in a crowd, a person might want to be treated differently to when they are alone.

1.7.2 Personal reasons for undertaking this research project

The reason for undertaking this research study is both general and personal. Despite compassion being central to nursing practice, indeed the moral compass of a nurse should revolve around this important trait, several reports, namely the Francis Report, those from the Health Service Ombudsman and the Care Quality Commission suggested that patients, especially the old and vulnerable are not receiving compassionate care (CQC, 2011b., Francis, 2010 & 2013 & HSO, 2011). These are the very people requiring the utmost humane and caring attitude from the ones looking after them. Needless to add most health care workers want to provide good care, the same that they would endeavour for themselves or their loved ones (Goodrich & Cornwell, 2008). There are several reasons for some of these appalling findings, for instance staffing levels and skill mix and targets (see section 2.5.1). For many staff, including myself, the main motivational force to enter the nursing profession is to be able to provide care with compassion. Thereafter, I joined the HEI as a NE to
impart this knowledge to PQNSs. Patients’ satisfaction enhancement through their journey is highlighted in the objectives of key policy documents (DH, 2008d). Early in my nursing career, I thought that the media attention about nurses, lacking compassion was mainly anecdotal and that most nurses were caring in nature.

However, as an inpatient it came as a shock when I encountered first hand a systematic lack of care including being persistently uninformed about my care plan whilst also witnessing uncaring and condescending attitudes towards elderly patients. It is evident in research that compassion affects the efficiency of treatment (Epstein et al., 2005). I felt isolated, neglected, sad, depressed and even angry at one point. I thought that I failed as a nurse and a nurse educator. Despite my small contribution in raising the provision of good quality care, here I was as a patient and yet denied of all the very things that I preached. In the middle of the first night of my stay, I saw some elderly patients being spoken down to in the most patronising way. Not only did I think that the nurse lacked interpersonal skills, but she presented herself as someone who ‘could not be bothered’ and lacked empathy and compassion. In that hospital gown, I felt vulnerable and weak due to the medication that was administered at that time that I could hardly intervene and advocate for those patients. Before I was discharged I made sure that I did speak to the people in charge sharing my concerns and offering some constructive feedback. Despite this personal experience of mine, I still think that for most nurses’ the main desire to enter this profession is for goodwill and humane reasons.

Whilst I did not explore the reasons why those nurses lacked or at least failed to use those fundamental nursing skills, I was completely incredulous and taken aback by such dismal attitudes. Reflecting upon this experience made me realise how some nursing practices might be so ‘cut and dried’, without any feelings and task orientated. This obviously was not how I was taught to nurse, how I nurse and how I teach students to nurse. I therefore decided to develop my research question focus around care and compassion (see section 2.1).
1.8 Chapter summary

In summary, compassion is very important, especially in the healthcare settings. Demonstrating compassion can be as simple as holding someone’s hand or as complex as recognising whether someone is critically ill and intervening to relieve pain. Applying the above in health care, one can suggest that in the case of holding someone’s hand, any health care worker should be able to provide. The patient may feel comforted that someone understands them. Compassion with competence is required in the case whereby one needs to recognise a critically ill patient and thereafter act. One can argue that the latter example is task orientated and compassion might not be needed. However, even whilst performing a task, one can still appreciate and understand the concerns of the sufferer and have the will to help.

This chapter has outlined compassionate care in the contemporary National Health Service (NHS). It introduced compassion, compassionate care and why the focus of this is related to older people. It puts compassion and compassionate care into context and gives insight into the background of nurse education. Many definitions of compassion are explored. The notion of measuring compassion by the number of smiles on a person’s face is debated. A couple of tools to measure compassion are explored. Several policies as well as compassionate care post the Francis Report are discussed. The concepts of compassion fatigue, which is a form of burnout and self-compassion, which is compassion towards oneself are introduced. Compassion in relation to nurse curricula and the current recruitment practices are discussed. This chapter also outlined how integral compassionate care is to the nursing profession, which is further explored in chapter 2.

1.9 Aim and Objectives of the study

The aim of this study is to explore, discuss and evaluate views of compassion in the care of older people amongst three key stakeholders in nursing education namely PQNSs, CMs and NEs, and how these views can be embedded into practice.
The main objectives are:

1. To explore first year pre-qualifying nursing students’ (PQNSs) understanding of compassion in the care of older people,

2. To explore second and third year pre-qualifying nursing students’ perceptions of compassion in the care of older people,

3. To explore university nurse educators’ (NEs) and clinical mentors’ (CMs) perceptions of compassion in the care of older people and factors that influence its development or inhibition in the academic and clinical environment,

4. To compare and contrast the views on the development or inhibition of compassion in the care of older people amongst the three key stakeholders; pre-qualifying nursing students, nurse educators and clinical mentors.

Chapter 2 explores the literature related to this field. It provides the approach employed to choose the literature. This is preceded by some of the key dimensions of compassionate care identified referring to what patients, CMs and NEs view to be significant. Drawing on research literature and expert views, some pertinent problems in response to compassionate care are emphasised, with particular interests on aspects that influence its application in practice (both in the clinical areas and the university). The conceptual and methodological dimensions of compassion from the perspectives of PQNSs, CMs and NEs are explored. It also offers a brief insight of the decline of compassionate care and contributory factors associated with lack of compassion such as targets and excess paperwork. The main themes that emerged following the literature review are “Compassion as a commendable trait, Compassion and communication, Why compassion may be lacking, Competence versus compassion, Compassion and emotional labour and Compassion and attention to details”.

Chapter 3 sets out a justification for the research approach adopted and explains in detail how the study was conducted. Little has been written about the use of the generic qualitative approach, and some researchers state that this approach might be superficial and loose (Merriam, 1998). This chapter
elucidates the aims and objectives of the research study, the methods used and the participants who were involved. Ethical considerations, such as the importance of seeking consent, validation of participants and the researcher as well as confidentiality and anonymity are discussed. It further explores the data collection activities and the method of data analysis, framework analysis.

Chapter 4 details the findings that draw on data from the framework analysis. The seven main themes that emerged are role modelling, working practices, care philosophy, clinical leadership, staff attitudes, quality care and nature and nurture. All participants suggested that role modelling is the best way to demonstrate compassionate care. This chapter concludes by offering an updated definition of compassion following the findings by describing the levels of compassion.

Chapter 5 draws together a critical analysis of the findings in relation to the literature and explores what this study contributes to knowledge of compassion and compassionate care in adult nursing.

Chapter 6 explores the significance of this research study and offers a personal reflection in relation to the completion of the Doctoral Programme in Nursing. It explores the limitations and strengths of the research. This chapter further makes suggestions about implications that this research study will have on practice (both in academia and clinical practice).
Chapter 2: Literature Review

A literature review was undertaken aiming to explore and analyse the research literature regarding compassion in the care of older people amongst the key stakeholders in nursing education e.g. pre-qualifying nursing students (PQNSs), clinical mentors (CMs) and nurse educators (NEs). There is a comparatively extensive literature on compassion fatigue and compassion in health care, whereby researchers explore the value of compassion within the multi-professional team. Numerous studies on compassionate care were found which focus on nurses, mainly in accident and emergency units (A&E), oncology and intensive care units (ICU).

This review attempts to demonstrate an awareness of the contemporary state of knowledge on compassion in the care of the older people, synthesise the articles used by identifying and analysing their strengths and limitations (Ellis, 2013) (see sections 2.3 to 2.8). Several research articles have investigated compassion satisfaction, lack of compassion amongst health care professionals (mainly doctors), and the likelihood of nurses suffering from compassion fatigue. In contrast, there is rather restricted consideration of compassionate practice within higher education. One study concentrated on the importance of demonstrating compassion to students as an indispensable component of nurse education (Georges, 2011). That was a philosophical article, which used non-fictional stories to illustrate the effect of compassion on nursing in both the academic and clinical settings. Using mixed methods, the role of professional education in developing compassionate practitioners was explored (Bray et al., 2014). Adam and Taylor (2013) describe an evaluation of a teaching approach that can improve students’ aptitude to provide care with compassion. A framework for compassionate interpersonal relations was developed using perspectives of key stakeholders on compassion (Kneafsey et al., 2015). Christiansen et al. (2015) used mixed methods to explore the barriers and enablers in delivering compassionate care.

Some research studies focus mainly on the limitations of professional bodies, such as NMC, HEIs (Higher Educational Institutions) and the training that they
provide (Bradshaw, 2011a). Bradshaw further states that the emphasis being laid is predominantly on individual nurses, their character, competence and leadership skills rather than the organisations. From the theoretical perspectives described in section 1.2, compassion is associated with terms such as ‘sympathy’, ‘empathy’, ‘kindness’, holistic care, and relationship-centred care (Dewar et al., 2011). Conceptual and methodological dimensions of compassion are explored (see sections 2.2.1 and 2.2.2). A possible conceptual framework for compassion is identified and compared with the Donabedian’s conceptual framework for quality (see figure 2.2).

2.1 Search Strategy

A broad search of the literature encapsulating the best and most suitable search engines was carried out. Available online through the Buckinghamshire New University (BNU), a search of five electronic research and professional bibliographic databases was conducted. This included Medical Literature Analysis and Retrieval System Online (MEDLINE), Cumulative Index to Nursing and Allied Healthcare Literature (CINAHL Plus with Full Text), British Nursing Index (BNI), Allied and Complementary Medicine (AMED), Information Science & Technology Abstracts. In addition, hand searches of pertinent journals and bibliographies were also undertaken.

A wordlist mapping exercise gave a hierarchical list of most frequently used subject headings related to the topic of research. Descriptors used included compassion, care, caring, dignity, compassionate care, patient-centred care, older people, nurse education and nursing. The search generated more than 8,300 items on compassion in the above databases from 2000-2015. The same search was conducted, but instead of compassion, the word care was used. It uncovered more than 1,727,600 items, some of which overlapped. It is suggested that undertaking literature reviews in health and social sciences are more and more overwhelming due to the sheer volume of research studies carried out (Evans, 2003). The number of hits for different terms is presented in Table 2.1.
This literature review aimed to uncover relevant papers to answer the following focused questions: What are the perceptions of PQNSs of compassion in the care of older people? What are the perceptions of CMs of compassion in the care of older people? What are the perceptions of NEs of compassion in the care of older people? What are the similarities and differences in these perceptions? Why is compassion lacking in the care of the older people? What circumstances promote or compromise compassion care in clinical practice? How can compassion be taught in HEIs?

2.1.1 Hand Searching

Hand searching requires a focus. With the progression in Information Technology and its increasing number of users, Polit and Beck (2010) propose that hand searching of bibliographic resources to be old fashioned. However, Sculthorpe (2014) states that several commendable sources of worthy research may not yet be available electronically. Bell (2012) adds that hand searching can be untrustworthy when seeking current information due to delays in publication. It is however argued that material found using this method can be helpful with background material facilitating a more in depth comprehension of the subject (Bhattacharya, 2014). Together with the electronic, a hand search was also carried out. Relevant journals that did not appear on the databases used included Journal of Action Research. However, no relevant article was found using the hand search strategy.
Table 2.1: Example of search terms from MEDLINE, CINAHL Plus with Full Text, BNI, AMED and Information Science & Technology Abstracts

<table>
<thead>
<tr>
<th>Key terms</th>
<th>Hits from 2000- November 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion</td>
<td>8351</td>
</tr>
<tr>
<td>Care</td>
<td>1,727,679</td>
</tr>
<tr>
<td>Caring</td>
<td>45,311</td>
</tr>
<tr>
<td>Dignity</td>
<td>6,464</td>
</tr>
<tr>
<td>Compassionate care</td>
<td>852</td>
</tr>
<tr>
<td>Patient centred care</td>
<td>1,331</td>
</tr>
<tr>
<td>Older people</td>
<td>30,321</td>
</tr>
<tr>
<td>older people or older adults or elderly</td>
<td>222,105</td>
</tr>
<tr>
<td>Nurse education</td>
<td>5,318</td>
</tr>
<tr>
<td>Nursing</td>
<td>1,011,855</td>
</tr>
</tbody>
</table>

The search was eventually condensed to a grouping of pertinent search terms with Boolean operators used such as OR to broaden the search and the use of AND to narrow the search instead. An example of grouping of terms using Boolean operators is shown in Appendix 2.

2.1.2 Inclusion criteria of literature

The identification of inclusion and exclusion criteria helped to recognise quality information and literature (Gorman & Sacherek, 1998 cited by Conn et al., 2003). The literature was restricted to published works written in the English language. Using limits such as publication year from January 1, 2000 to November 30, 2015 research studies then further refined to the literature search.

The reason for starting the search from 2000 was due to the influx of articles published on compassion and to capture contemporary developments of this concept. Note that vital references acknowledged before 2000 were identified by snowballing search strategy, which makes use of the reference list of a paper.
to identify supplementary papers (Greenhalgh & Peacock, 2005). Other inclusion criteria were that studies should be published in a peer-reviewed journal and significantly about compassion. Conceptual papers were also used.

2.1.3 Exclusion criteria of literature

The exclusion criteria included non-English language studies and studies published before the year 2000. At the same time, studies including other stakeholders other than PQNSs, CMs and NEs were also excluded. Articles which predominantly focussed on compassion fatigue or children’s nursing were also excluded. A variety of sources were rejected in this phase, for instance, those which only briefly mentioned compassion or those which hardly consider the care of the older people. The search was restricted to peer-reviewed literature, excluding a large body of editorial papers. The preliminary search was undertaken from January 2000-November 2015. Later work would appear in the discussion of the findings (Chapter 5). See appendix 4 for full search.

2.1.4 Key articles and analysis

More than 300 articles were read and reviewed. Based on the above inclusion and exclusion criteria, thirty-five pertinent articles were used for this literature review. All primary research studies (n=23) were critically appraised using the Critical Appraisal Skills Programme (CASP) tool, appropriate to the research design of the articles. CASP provides a structured and individualised approach (CASP for qualitative and quantitative studies are slightly different as not all criteria are common to both research approaches) (Appendix 3 shows an example of a qualitative research CASP tool used). Once selected, abstracts were reviewed for relevance. In order to analyse the themes for discussion in relation to compassion, a critical analysis of the subsequent material was undertaken.

The following segment filters revealed related terms to compassion, and others emerged regarding perceptions of compassionate care by older people. Note that 22 of the research studies (13 qualitative, 1 quantitative, 2 mixed
methodologies and 6 conceptual) were conducted in the UK, 7 (2 qualitative, 1 quantitative, 1 mixed method and 3 conceptual) in the USA, 1 qualitative in Canada, 3 (1 qualitative and 2 conceptual) in the Netherlands, 1 conceptual in Australia, 1 qualitative from Malawi (see Appendix 5 for appraised studies).

Figure 2.1 below shows results of the search strategy and elimination processes. Much has been documented about the importance of caring and compassion toward patients, yet little is known about how to give and maintain compassionate care (Graber & Mitcham, 2004).

Figure 2.1: Results of the search strategy and elimination processes

Records identified through searching MEDLINE, CINAHL, BNI, AMED, n=8351

- Records identified as relevant and after duplicate removed, n=405
- Additional records identified through snowballing search strategy, n=5
- Key articles read and reviewed, n=306
- Application of exclusions such as children's nursing, exclusively on compassion fatigue or non-peer reviewed articles
- Full text articles, which met inclusions and were assigned for extraction n=35, including n=5 through snowballing search strategy
- Articles appraised with CASP (n=23, including n=18 qualitative, n=2 quantitative and n=3 mixed method)

Articles were:
- 22 from UK (13 qualitative, 1 quantitative, 2 mixed methodologies and 6 conceptual)
- 7 from USA (2 qualitative, 1 quantitative, 1 mixed and 3 conceptual)
- 3 from Netherlands (1 qualitative and 2 conceptual)
- 1 conceptual paper from Australia
- 1 qualitative from Canada and Malawi respectively

Main themes emerged:
- Compassion as a commendable trait
- Compassion and communication
- Why is compassion lacking
- Compassion versus competence
- Compassion and emotional labour
- Compassion and attention to detail
2.2 Dimensions of compassion

This section explores conceptual and methodological dimensions of compassion from the perspectives of PQNSs, CMs and NEs.

2.2.1 Conceptual framework of compassion

From the definition in section 1.2.1, it is clear that compassion is connected to the concept of suffering, and includes empathy with an appropriate act to relieve that suffering (Schantz 2007; Schultz et al., 2007). Depending on personal experiences, compassion is perceived differently and individually (Straughair, 2012a). In the literature, most conceptualisations include emotion, suffering and action. So, therefore, compassion has three main components, which includes seeing that someone is suffering, empathising with that person and aiming at alleviating the suffering (Dewar, 2011 & Van der Cingel, 2011).

Compassion as a fundamental component of care is embraced in many theoretical frameworks (Roach, 1992; Watson, 1997) (see section 1.2). In the same vein, other concepts such as empathy (Van der Cingel, 2009) as well as relationship-centred and holistic care (Dewar et al., 2011) are implicit to caring and compassionate care (see section 1.7.1). There are more related terms and concept related to compassion (see table 1.1 (von Dietze & Orb, 2000).

Compassion is also seen as a commendable trait as it can assist with emotional connection, self-awareness and emotional intelligence (Burnell, 2009, Davison & Williams, 2009., Schantz, 2007 and von Dietze & Orb, 2000) (see section 2.3). It is perceived as the ideal way to behave. Bradshaw (2009) argues that compassion is one of the main traits that gave the nursing profession its philosophy. She further says that compassion is “a virtue to be cultivated as an aspect of individual character” (p.466).

Therefore, the main dimensions of compassion derived from conceptual papers are that compassion is personal and is multifaceted. It is about identifying with others, having emotional connection and interpersonal skills, empathy to identify suffering and an appropriate action to alleviate that suffering.
2.2.2 Methodological framework of compassion

Out of the 23 primary research articles appraised with CASP, 18 used qualitative, 2 quantitative and 3 mixed methodologies. Of the 18 qualitative studies, interviews were predominantly used (focus group, telephone, unstructured and semi-structured), three studies used reflective accounts and two used story telling methods to collect data. A few studies used multi methods, mainly focus group and semi-structured interviews, but also reflective accounts and interviews for data collection. Smith et al. (2010) used multi methods (observation, interviews and reflective accounts) in their study. Therefore, methodologies to explore compassion have been mostly qualitative and have concentrated on a variety of healthcare settings, incorporating care of the older people (Dewar & Nolan, 2013, Smith et al., 2010 & Van der Cingel, 2011), acute (Dewar & Mackay, 2010), palliative care, acute mental health care (Crawford et al., 2013) and end of life care of people with dementia (Crowther et al., 2013).

For the quantitative studies, questionnaires were primarily used to collect data (Kret, 2011 only used questionnaires). For the mixed methodology studies, surveys, questionnaires and semi-structured interviews were used to collect data. Bray et al. (2014) used survey and semi-structured interviews, whereas Christiansen et al. (2015) used questionnaires and semi-structured interviews. Relying solely on questionnaires can have weaknesses for the data collection (Denzin & Lincoln, 2011). Different respondents may not capture the same meaning of questions posed in the questionnaire. On the other hand, it might be difficult to ascertain the truthfulness of the responses. For instance, it will be uncharacteristic of respondents to state that they are uncompassionate. Armstrong et al. (2000) used questionnaires to inquire into compassion and moral virtues in psychiatric nurses. They commented that it was difficult to tell how truthful the participants were with their answers.

Characteristically, in qualitative research studies, interviews are semi-structured or unstructured, giving participants the chance to express themselves at length around the topic of discussion and allowing the interviewer to respond to the ideas and statements coming from participants rather than limiting their options, using
questions that may be irrelevant to the individual (King, 2004). For instance, Bramley & Mattiti (2014) and Crawford et al. (2013) used semi-structured interviews, whereas Crowther et al., (2013) and Curtis et al. (2012) used unstructured interview method (see sections 3.4.2 and 3.4.2a). Telephone interviews can be useful in some instances. Whilst telephone interviews can provide a wide geographical access, save time and cost (travelling and venue), it can possibly assist in exploring sensitive issues that participants might be reluctant to discuss in a face-to-face encounter, they can also reduce the rapport required for in-depth narratives (Streubert Speziale & Carpenter, 2011).

Focus group interviews used by Horsburgh & Ross (2013) and Kneafsey et al., (2015) are economical, flexible and can generate rich data (MacDougall & Baum, 1997). When participants are encouraged to discuss in focus group interviews, the group dynamics can produce innovative ideas on a topic which can lead to in-depth discussion. However, some participants might find it difficult to discuss personal and sensitive issues in a group, which in turn can influence the output data (Silverman, 2013) (see section 3.4.2a).

Three researchers used observation as one of their methods to collect data (Dewar, 2011., Dewar & Nolan, 2013 and Smith et al., 2010). Some of the challenges that observing participants can pose are that it can be time-consuming and bring a level of bias. For instance, whilst spending considerable amount of time with participants, the researcher may begin to sympathise with them and their views (Denzin & Lincoln, 2011). It is important to consider the Hawthorne effect, which is when participants perform differently, usually better when they know they are being observed can also be a challenge (Jacobson et al., 2009). On the other hand, while spending time with participants, the researcher can also have an inside perspective of the "culture" of that environment. For instance, the challenges of providing a safe and compassionate environment, the impact of leadership, skill mix and staff attitudes that can have on the delivery of care can be observed. These observations can generate rich data which can give a real picture of how the participants act, but can also influence the data (Denzin & Lincoln, 2011).
In many studies, for instance, Crowther et al. (2013) & Graber & Mitcham, (2004), participants were self-selected. This can potentially introduce bias because it is unlikely that participants would describe themselves as being uncompassionate.

Carried out in the UK, Bramley & Matiti (2014) used a purposive sample of n=10 patients in a large teaching hospital. Despite that fact that there are no defined rules for sampling in qualitative research studies (Miles & Huberman, 2013), the sample that Bramley & Matiti (2014) used seemed small for a large teaching hospital. At the same time, all participants were white, despite the UK being culturally diverse. This can be classed as selection bias, which is where the researcher makes the decision of who to include in their study, which can lead to findings being questionable (Ellis, 2013). Therefore, transferability of the findings would be difficult. Crowther et al., (2013) used self-selection of participants, which presented bias and at the same time, most carers were female.

Conducted in a small area with small samples, many studies, namely Bramley & Matiti (2014), Christiansen et al. (2015), Curtis et al. (2012), Kneafsey et al. (2015), Msiska et al. (2014), Perry (2009) might not be generalised nationally to the UK, let alone internationally. Polit and Beck (2010, p.2) view generalisation as “an act of reasoning that involves drawing broad conclusions from instances – that is, making an inference about the unobserved based on the observed.” Payne and Williams (2005, p. 296) suggest that “to generalise is to claim that what is the case in one place or time, will be so elsewhere or in another time”. They seem to suggest that generalisation is a logical forecasting process. Bryman (2012) contends, stating that generalisation is about making conclusions of a population from a sample, but also from one era to another.

Miles and Huberman (1994) state that the conceptual framework “explains, either graphically or in narrative form, the main things to be studied—the key factors, concepts, or variables—and the presumed relationships among them” (p. 18). It is argued that conceptual frameworks hold ontological, epistemological, and methodological dimensions (section 3.1 & 3.2). Whist the ontological dimension is associated with knowledge of the “way things are,” and “the nature of reality,” the epistemological dimension is associated to “how things really work” in reality...
(Guba & Lincoln, 1994, p. 108). The methodological dimensions refer to the method of constructing the conceptual framework, whilst making sense of ‘real world’. The conceptual framework used in this thesis is appropriate for health care. The Donabedian’s “structure-process-outcome” framework has been predominantly used to measure quality of care (Donabedian, 1988). This three-segment method lends itself to measure quality assessment, using structure (equipment, skill mix and organisational structure), the process (the small and big acts of compassion, holding the patient’s hand and listening or providing care with competence), which influences outcome (wellbeing of the patient, safe discharge). This model is used to mainly measure quality, which is subjective in nature and difficult to define as people’s perspective of quality may be dependent on their prior experiences and culture (Donabedian, 1988). This is similar to compassion (see figure 2.2). Other reasons why Donabedian’s model is used is that it enables researchers and policymakers to conceptualise the fundamental processes, which may assist in identifying compassionate care to consider quality of care. It can be argued that compassion is an important element in the delivery of quality care.

All the dimensions explored above are incorporated in the framework of constructivism and is the theoretical position that this study has used (further described in sections 3.1 and 3.2).
Figure 2.2: Comparing conceptual frameworks of quality (Donabedian) and compassion

Donabedian’s conceptual framework for quality

Structure (resources, staff and equipment)

Process (communication, empathy, care)

Outcome (effect of the care given)

A possible conceptual framework for compassion

Identifying that someone is suffering (emotional connection, self-awareness)
The suffering could be physical or emotional

Empathy (emotional connection and interpersonal skills, therapeutic communication)

Action to alleviate the suffering
To date a number of research articles, qualitative, quantitative and mixed method, have explored some of the main components of compassion as well as compassion in many settings, such as the care of older people (Holroyd et al., 2009; Karlsson et al., 2004) or dementia care (Crowther et al., 2013), acute care settings (Hayes & Tyler-Ball, 2007 and Matiti & Trorey, 2008), acute mental health care setting (Crawford et al., 2013), education/university (Adam & Taylor, 2013; Birx et al., 2008 and Curtis at al., 2012) and compassion fatigue (Abendroth & Flannery, 2006; Hooper et al., 2010 & Young et al., 2011).

However, no research within the stated time frame (January 2000-November 2015) (see section 2.1.3) has addressed compassion from the perspectives of the NEs, CMs and PQNSs. Several themes were identified whilst analysing the literature. The studies were coded systematically into main themes (see appendix 6 for characteristics, including some strengths and limitations of the research studies reviewed). Drawing on conceptual and methodological frameworks, six main themes emerged from the literature review. These include: Compassion as a commendable trait; Compassion and communication; Why is compassion lacking; Compassion versus competence; Compassion and emotional labour and Compassion and attention to detail. Grove et al. (2015) argue that themes are derived from the data, which is a direct result of the participants’ contributions. An analysis of these themes with significant messages from the selected literature are discussed in the following segment.

2.3 Compassion as a commendable trait

A fundamental element of every nurse’s role is to deliver care with compassion (Dewar, 2011). Compassion as a commendable trait and has been unequivocally advocated by multiple authors (Armstrong et al., 2000; Badger and Royse, 2012; Bradshaw, 2009 & 2011b; Bray et al., 2014; Burnell, 2009; Crowther et al., 2013; Davison & Williams; 2009; Dewar, 2011; Dewar & Nolan, 2013; Graber & Mitcham, 2004; Horsburgh & Ross, 2013; Kneafsey et al., 2015; Schantz, 2007, Smith et al., 2010., Spandler & Stickley, 2011 and von Dietze & Orb 2000). Nursing care provided with compassion not only reduces complaints (Bradshaw, 2011a), but it positively impacts on quality care (Van der Cingel,
Cole-King & Gilbert (2011 p.29) suggest that “compassionate care can enhance staff efficiency, help elicit better staff information, so inform treatment plan and lead to better recovery and increase satisfaction.” In Van der Cingel’s (2011) study, participants (patients) suggested that compassion encouraged them to recover quicker and to achieve their goals. It can therefore be debated that compassion is a fundamental component of quality nursing care.

One of the main philosophies that emerge from Bradshaw’s (2011a, p.1798) historical analysis is the “character of the nurse”. Bradshaw (2009) argues that compassion is one of the main traits that gave the nursing profession its philosophy. A pertinent characteristic of compassion extracted from some research and conceptual papers are that it is a personal experience (Bradshaw, 2009). Bradshaw (2009) says that compassion is “a virtue to be cultivated as an aspect of individual character” (p.466). Compassion is recognised as being central to mental health nursing and the nurse-client relationship (Armstrong et al., 2000). It is also purported that compassion enhances the element of trust and relationships with clients through emotion, by entering into their world, recognising the suffering they go through in an attempt to relieve it (Dewar, 2011).

2.3.1 Compassion and emotional connection

It is said that compassion requires emotional connection and interpersonal skills (Badger & Royse, 2012., Dewar, 2011., Dewar & Nolan, 2013., Graber & Mitcham, 2004., Kneafsey et al., 2015 & Schantz, 2007). The findings of Dewar (2011) study support the idea that whilst care is being provided, practitioners need to be emotionally connected and be thoughtful of others views. Kneafsey et al. (2015) suggest that compassion is an innate emotion requiring quality time in developing a positive interpersonal relationship. They further say that care given without personal commitment is perceived as uncompassionate.

Compassion is about feeling the patients’ pain (Schantz, 2007). Schantz (2007) states that compassion is an essential component of being human and that human race feel offended when blamed for lacking compassion as it suggests that they are “non-human beings” (p.3).
It can be argued that whilst providing compassionate care, nurses might be exposed in taking emotional risks (Sanghavi, 2006). Related to emotional risks is emotional burden, is the compounded effects of emotional labour (Graber & Mitcham 2004), (see sections 1.5.4 and 2.7). Conversely, it has been suggested that emotional labour has positive influences when delivering care with compassion because this gives health care workers a sense of job satisfaction (Graber & Mitcham 2004 & Youngson 2008). At the same time, there are strategies that institutions and professionals use to respond to emotional demands of work. Some studies have acknowledged strategies such as playing the game (Hunter, 2005). Other institutions attempt to safeguard their nurses, but in turn can be unresponsive to patients. For instance, introducing tasks orientated care can limit patient contact time, hence reducing emotional demand.

2.3.2 Individualised care

Bray et al. (2014) explored the perceptions of health professionals and pre-registration students using sequential explanatory mixed methods. Data were collected using surveys and qualitative semi-structured interviews from qualified health professionals (n = 155) and pre-registration students (n = 197). According to the study, health professionals encapsulated people working in the health and social care disciplines. The provision of individualised care with warmth and empathy were concluded as the most prominent characteristics of compassionate care. “Active listening, attentiveness and understanding a patient's individual needs” were branded as paramount in delivering compassionate care (Bray et al., 2014, p. 487). The individual skills, such as awareness (being attentive to what is happening or carefully noticing distress on patient’s face), emotional response (being warm and caring) and being respectful can contribute to enhancing compassionate care (Cole-King & Gilbert, 2011).
2.4 Compassion and communication

Communication is one of the 6 Cs (DH, 2012a). ‘Real dialogue’, which is more than communication is an important element of compassion (Firth-Cozens & Cornwell, 2009, p.3). It involves honesty, showing genuine interest in the patient’s concerns, and possibly courage to tell the patient the truth. Communication difficulties have been identified as a key factor affecting patient outcomes (NPSA, 2007). Lack of communication has also been reported as one of the main reasons for patients’ complaints (SPSO, 2010). The inability to communicate between the many organisations to share information of concerns has been labelled as problematic (Francis, 2013). Within this main theme, three important sub-themes also emerged: Developing relationships with patients; Communication and emotional intelligence and Communication and empathy. Communication (listening, reporting and documentation) is the foundation of good nursing care. In order to cultivate compassionate care, communicating effectively is vital (Badger & Royse, 2012., Bramley & Matiti, 2014., Crawford et al., 2013., Crowther et al., 2013., Curtis, 2014., Dewar, 2011., Graber & Mitcham, 2004., Johnston & Smith, 2006., Jonas-Simpson et al., 2006., Matiti & Trorey, 2008., Pearey & Draper, 2008; Rankin, 2013., Sanghavi, 2006., Smith et al., 2010 & Van der Cingel, 2011).

Listening, which is the main part of communication, is acknowledged as an indispensable ingredient of nursing practice and the very basis of all significant interpersonal relationships, be it nurse/patient or nurse/nurse (Jonas-Simpson et al., 2006). Being listened to has been associated with feelings of being valued and connected, cared for with compassion and involvement with others (Bray et al., 2014 & Jonas-Simpson et al., 2006). In this study, Bray et al. (2014) provided health professionals and PQNS an understanding of how compassionate care could be demonstrated and participants were required to categorise the ones they felt were most significant. The actions that were the highest rated to promote compassionate care were to “actively listen to patients”, (p. 482). Graber and Mitcham (2004) discussed in their study that having a meaningful nurse/patient relationship demands a positive attitude and effective
communication. The participants (clinicians) (N=24) were nurses, physicians, therapists, dentists and child specialists who provided treatment or support for patients. The main group comprised hospital nurses (n=10). One of the main questions posed to the clinicians was dedicated to the clinicians’/patients’ interpersonal relationship. Amongst the clinicians, many nurses said that little things made a big difference. For instance, showing respect with a brief introduction, offering them assistance with their care and getting to know a patient can even help with the treatment. Adjusting and adapting to the way that nurses communicate in diverse situations with different patient groups is important. Some studies suggest that nurses tend to communicate less with confused patients (such as patients with dementia or stroke) than with comportsmentis ones (Jones, 1992). Patients with dementia are faced with the prospects of decreasing communication abilities. However, if nurses do not have the skills to communicate with compassion with them, the overall quality of care will be compromised (Richer et al., 1995). It is also challenging to communicate with patients with sensory loss, such as vision or hearing loss. Good communication skills support the processes in assessment, care planning and care delivery (Arnold & Boggs, 2015).

2.4.1 Developing relationships with patients

Two of Graber & Mitcham’s main themes were “meaningful patient relationships and detachment versus intimacy”, (Graber & Mitcham, 2004, p.89-90). Applicable mainly to long term care, Graber and Mitcham (2004) stated that some clinicians had close relationships with their patients. However, other clinicians said that at times some professional distance was required. Graber and Mitcham (2004, p.90) proposed “a preliminary model of affective clinician/patient interactions”, comprising of four levels, “Impersonal/practical, Personal/social, Personal/feeling and Transcendent”. They suggested that at the first level, the communication between the patient and the clinician were mainly about the care or treatment issues, or possibly deviated toward superficial subjects, for instance, a conversation about the weather.
The second level was divided into two parts. At the lower stage of this level, clinicians engaged with patients to satisfy their individual social needs (such as acceptance and appreciation from patients). At the advanced stage, clinicians satisfied social needs and obtained affection from patients. At the personal/feeling level, Graber and Mitcham (2004) proposed that clinicians should be altruistic and the focus should mainly be on the patients rather than on self. These clinicians had a strong sense of duty and were emotionally involved with the patients. Lastly, at the transcendent level, clinicians had a deep sense of compassion for their patients. They noted that clinicians had a feeling of great closeness with the patient. It can be argued that clinicians practicing at this level can be at risk of crossing professional boundaries (NMC, 2010b). At the same time, most clinicians develop relationships with patients at the first three levels. Graber and Mitcham’s (2004) study had some limitations. For instance, their study was biased as all clinicians who volunteered to be interviewed were highly caring and compassionate. Overall, showing empathy, warmth, listening to patients’ stories, while they expressed their level of pain as well as providing comfort required positive attitude on behalf of the nurses (Graber & Mitcham, 2004).

Dewar and Nolan (2013) describe the development of a model of compassionate relationship centred care. Their study explored the types of relational knowledge that underpins compassion amongst the involved participants. The study included older people (n=10), staff (n=35) and relatives (n=12). It used appreciative inquiry and a range of methods including participant observation, interviews, storytelling and group discussions to engage the participants. Key attributes of compassionate care were identified, including; recognising vulnerability and suffering; relating to the needs of others; preserving integrity and acknowledging the person behind the illness. The study suggested that compassion chiefly involves an awareness of another’s feelings, an appreciation of how they are affected by their experiences and interacting with them in a meaningful way.
Sanghavi (2006) explored what makes for a compassionate patient-caregiver relationship through narrative findings. Questionnaires were sent to patients in 54 hospitals and the transcripts yielded three major categories: communication, common ground, and respect for individuality. Patients felt that compassionate care was influenced by how clear medical facts were transmitted to them and whether they were listened to. Patients commented on non-verbal communication, such as maintaining eye contact and paying careful attention to remembering their names.

When it came to common ground, patients said that showing empathy to them was important. Treating the patient as an individual suggested that compassionate care required respecting the patients and allowing them to contribute in the care that they would receive. Sanghavi’s (2006) study was carried out in the United States. Whilst this study was predominantly focussed on the medical profession, it sends a strong message that compassion should always be reinforced. Wherever there is lack of compassion, continuous support, regular guidance and reinforcement should be provided by clinicians.

2.4.2 Communication and emotional intelligence (EI)

In section 1.2.2, it is suggested that compassion is difficult to measure. In section 1.6.1 it is proposed that there is a relationship between Emotional Intelligence (EI) and compassion. EI incorporates “empathy, self-awareness, motivation, self-control and adeptness in relationships” as acknowledged characteristics fundamental in nursing practice (Cadman & Brewer, 2001 p.322). Using a longitudinal survey, Rankin (2013) explored the possible relationship between EI and practice and academic performances to promote compassionate care. A self-report questionnaire to establish a total score and four sub scores for emotional intelligence were requested to complete by first year PQNS and midwifery students (N = 307). 178 participants returned their questionnaires. These scores were then matched to individual student’s performance. The result yielded a significant relationship between EI and outcomes practice and academic performances as well as retention. It suggested that there might be a connection between the intrapersonal element of emotional intelligence, such as
self-awareness and compassionate care (Rankin, 2013). One of the weaknesses of the study was that it was undertaken in one institution that used a particular approach to the curriculum and to the assessment strategy. Generalisation might be difficult to other institutions.

2.4.3 Communication and empathy

Making someone feel comfortable by treating them the way that one would want to be treated was seen as an important element in showing compassion (Badger & Royse, 2012, Bray et al., 2014, Horsburgh & Ross, 2013 & Matiti & Trorey, 2008). “Acting with warmth and empathy was selected as the most important attribute of compassion for both qualified and unqualified health professionals,” (Bray et al., 2014, p. 482). Using a qualitative exploratory descriptive approach with a purposive sample of 10 patients (n=10) and in-depth semi-structured interviews, Bramley and Matiti (2014) explored “how does it really feel to be in my shoes?” Whilst this research study explores mainly empathy, it also has communication as one of the themes. Fernando and Consedine (2014, p.388) suggest that “empathy is necessary to be compassionate, but one can be empathetic without being compassionate.” For instance, this suggests that one can have a good understanding of how it feels to be in someone else’s shoes without actively wanting to help. Three overarching themes emerged from Bramley and Matiti’s study: (1) being more compassionate: communication and the essence of nursing; (2) what is compassion: knowing me and giving me your time and (3) understanding the impact of compassion: how it feels in my shoes.

The theme “being more compassionate: the essence of nursing and communication” related to be one of the main ingredients that could help nurses be more compassionate. All participants felt that communication was a huge part of compassion and had the power to influence compassionate care given. Whilst patients in their study appreciated that nurses were busy; they were happy to adapt to smaller gestures of compassion (a nod or a smile) that might not involve time for relationships to be established. It was suggested that this was adequate to start an important nurse/patient relationship.
The theme “what is compassion: knowing me and giving me your time” represented the patients’ views of a compassionate nurse. The participants said that a compassionate nurse is one who has a caring attitude. The connection between compassion and caring was very strong, many participants did not demarcate between the two. Definitions of compassion are discussed in section 1.2.1. The theme “understanding the impact of compassion: how would I feel in their shoes?” implied being empathetic. The impact of individual nurse’s empathetic behaviour was heartfelt by the patients receiving care as well as observing the care of others. It is claimed that empathy is important in the delivery of compassionate care (Curtis, 2014; Dewar & Nolan, 2013 & Van der Cingel, 2014).

Many research studies propose that the more empathy the better (Fernando and Consedine, 2014). Dietze and Orb (2000, p. 168) stated that “an empathic relationship is one where a nurse is professionally detached from a patient”, which implies that empathy is feeling for someone else, but it does not necessitate an action. Van der Cingel (2014) suggested “empathy” can have its downside. She argued that treating someone the way that one wishes to be treated can have unwanted consequences. For instance, if a nurse wishes to spend time alone in moments of sorrow, as they need the time to reflect, they cannot assume this is what their patient’s wants too. This “golden rule” for giving compassionate care should therefore be ‘always assess the needs of someone in need and act upon those needs’ (Van der Cingel, 2014, p. 2) (see section 4.3.2).

2.5 Why compassion may be lacking

This section explores some of the main reasons why compassion is seen to be lacking. This ranges from the organisational culture, poor leadership to the changing role of the nurse. Christiansen et al. (2015, p.835) explored the barriers and enablers of delivering compassionate care. They argued that small acts, such as brushing a patient’s teeth as well as good attitude, such as “being approachable and non-judgemental” were some of the enablers. They debated that inadequate time spent with patients and pressures of work were some of the
major difficulties to delivering compassionate care (see sections 4.5.2 and 4.5.3).

2.5.1 Managerialist approach to care

There is a shared concern that NHS culture has shifted to being target driven (Bradshaw, 2009, Corbin, 2008, Deutsch & Sherwood, 2008, Maben et al., 2007, Spandler & Stickley, 2011, Sturgeon, 2010 & Youngson, 2008). It has also been acknowledged that time is budgeted per patient as contemporary health services seek to adopt a fast culture, whereby health care practitioners should constantly watch and work against the clock (Deacon & Fairhurst, 2008). Other threats are organisations aiming at cutting front-line staff, poor organisational culture and poor leadership, creating an atmosphere of low morale (Chirkov et al., 2010 & Seddon, 2008) (see sections 4.5.2 and 4.5.3). It is suggested that compassion is being eroded due to poor skill mix, targets, overcrowded wards, the high nurses’ workload and paper work, red tape, which takes time and energy (Pearey & Draper, 2008) a view substantiated by Firth-Cozens (2003) and Georges (2011).

Due to poor skill mix and increased workload, nurses can suffer from compassion fatigue (see sections 1.5.4 & 5.3.2), which is the inability to appreciate and tolerate patients’ and colleagues’ emotions. This can result in emotional detachment and burnout (Youngson, 2008). Instead of the blaming organisations, the responsibility for lessening compassion is on the shoulders of individual nurses (Cummings & Bennett, 2012). PQNSs appear to shift the blame to the other nurse, the relatives or difficult circumstances for a compromised level of compassion (Adam & Taylor, 2013).

Coined by the American sociologist Ritzer (1996), the term *McDonalisation* not only portrays the rigid culture being forced on the NHS in the UK, but relates to the proposal to measure compassion (Bradshaw, 2009 & Sturgeon, 2010). *McDonalisation* depicts associations with four dimensions of efficiency, calculability, predictability and control (Ritzer, 1996). The final aspect of
McDonaldisation is control over employees (nurses of the NHS in this case) who are unpredictable (Ritzer, 1996). Although Ritzer’s model cannot dehumanise nursing care, breaking care into repetitive and measurable tasks and targets can compromise patient-centred and holistic care (Bradshaw, 2009) (see section 4.6.1). As a result of the above ideal, Bradshaw (2009) argues that this can lead to the start of a national compassion index to measure appearance and outcome. ‘If adopted as proposed by both government and RCN, nurses will be expected to demonstrate the appearance of compassionate care as a facade. It asks nurses only to practice techniques such as the art of smiling, or the saying of warm words, in order that measures can be ticked and audited and data thereby gathered’, (Bradshaw, 2009, p. 467). This goes against the very ethos of compassion, that is, “a deep awareness of the suffering” (Chochinov 2007, p.184) or as Bradshaw (2009) suggests it, as a necessary component of authentic nursing (section 5.2.4). The provision of compassion can be impaired on three main levels, on the individual (stressed and inappropriate skills), team (stress on the team and low morale) or hospital as a whole (lack of resources) (Crawford & Brown, 2011; Gilbert, 2009 & Firth-Cozens & Cornwell, 2009).

Crawford et al., (2013) & Curtis et al., (2012) consider that compassionate care is being compromised by a target driven culture, such as cutting costs and meeting deadlines) in the NHS. Crawford et al. (2013) explored the production line language versus that of compassion in an acute mental health care setting. They suggest that the target driven healthcare creates a culture of threat and low morale and frustration amongst employees, hindering the provision of compassionate care. A mixed method combined with corpus analysis, which is the study of language as expressed in samples, were used. They found little evidence of “compassionate language” in the corpus. Words expressing compassion, understanding and feel featured very low in the list.

2.5.2 The changing role of the nurse

The provision of quality and compassionate care does not only depend on the nurse’s character, such as being caring and courageous and having good
communication skills, but also on other organisational and environmental factors. In the process of ‘professional socialisation and doctrinal conversion’, there has been a shift from nursing being a vocation to a profession, (Bradshaw, 2009, p.467). At the same time, there is a shift in the balance of skills (Sturgeon, 2010). Qualified nurses are expected to undertake advanced skills previously completed by junior doctors, such as cannulation, implying that more fundamental nursing care work is passed down to other healthcare workers. This can leave the patients to perceive qualified nurses as less compassionate (Sturgeon, 2010) (see section 1.6.4). It can therefore be argued that, compassion (as moral virtue and characteristic) conflicts with a style of professionalism, which tends to be more about technical and quantifiable behaviours (Bradshaw, 2009). As postulated above, the expression professionalism seems to act as a wall to compassion and compassionate care (McCaffrey & McConnel, 2015).

2.5.3 Professional socialisation

PQNSs experience two versions of professional socialisation, one at their university and one in practice (Melia, 1987). Using a grounded theory study and in-depth interviews, Curtis et al. (2012) explored the way nursing students socialise in practice. In-depth interviews with a multi-variation sample of PQNSs Adult field (n=19) were used. A sample of (n=5) of NE was also used to explore their perceptions of student nurse socialisation experiences. Their interview consisted of open-ended questions. These PQNSs felt that there was a conflict between what nursing offered in reality (meeting targets) and the professional ideal of taking the time to demonstrate compassionate care. PQNSs felt that they did not have adequate time to spend with patients. They suggest that targets imposed on patient care required the need to practise in a more task-centred than person-centred way, dehumanising activities to make them more efficient. They further argued that the reality of nursing was different to the professional ideal of compassionate practice they perceived prior to joining the profession. NEs on the other hand, express that they had the predicament
between indoctrinating the practice of compassionate care and realistically preparing PQNSs for socialisation into the contemporary NHS.

2.6 Competence versus compassion

Irrespective of the field of nursing (Child, Adult or Mental Health), all nurses should have demonstrated standards for competence of nursing. These are set out in four main areas “professional values, communication and interpersonal skills, nursing practice and decision making and leadership, management and team”, (NMC, 2010b, p.4). The above encapsulates the fact that competent nurses must be compassionate and person-centred care, must have excellent communication and interpersonal skills, be autonomous and work well in a team. Cummings and Bennett (2012) support the idea that competence and compassionate care should go hand in hand. In their study, Bray et al. (2014) argue that compassion on its own would not cure anybody.

2.6.1 Compassion as a competence

Bradshaw (2011a, p.1798) analysed the development of nursing education and identifies the three main emergent themes: “the character of the nurse, competence in knowledge and skill and ward leadership” (see section 4.1.5). The first theme, as Bradshaw (2009) states, depends on the nurturing of the value of compassion in the nurse, whilst looking after patients with the most fundamental and basic of human needs (Johnson, 2008b). Educating and preparing the nurse for competence is the basis of the second theme, which mainly involves acquiring of skills and knowledge pertinent to nursing and gaining practice experiences. Bradshaw bases leadership, the third theme, on the role of the ward sister, who makes sure that patients are cared for whilst building and maintaining a good team of nurses with the right knowledge and skills.

Together with Bradshaw (2011a), Bray et al. (2014), Badger & Royse (2012), Roach (1992) and Straughair (2012b) note the importance of competence in the provision of compassionate care. In an attempt to explore compassion and its
implications for contemporary nursing, Straughair (2012a) reviewed current political and professional drivers for compassion. The importance of compassion with competence was recognised. The Department of Health (DH) states that ‘truly compassionate care is skilled, competent, value based care that respects individual dignity. Its delivery requires the highest levels of skills and professionalism’ (DH, 2010b, p.3). Participants in Bray et al. (2014) study acknowledged the significance of compassion, but they valued the need for practitioners to be knowledgeable, clinically competent and, even more importantly, safe.

2.6.2 The provision of compassionate care

Davison and Williams (2009b) define the influence that compassion makes on clinical practice and explore factors that influence compassionate care in clinical practice respectively. They describe factors such as time, equipment, knowledge, skills and experience that can influence the provision of compassionate care (see sections 4.5.2 & 4.5.3). They also argue that the nurse can be technically competent, but not compassionate. Cummings and Bennett (2012) state that compassionate care with competence is an important nursing characteristic.

In an attempt to maintain technical skills, the nursing profession has progressively moved forward to adopt an evidence-based approach to practice; some of its compassionate care tenets have been lost in this process (Crawford & Brown, 2011). The confusion in the above statement is that on the one hand there is pressure for the NHS to be efficient and on the other there is the desire for health care professionals to provide more individualised and patient-centred care. Whilst it seems that both tactics are important to meet the challenges in the NHS, the question remains of how to attain this and thereafter maintain the right balance.
2.7 Compassion and emotional labour

It is argued that compassionate care is about emotions, which are feelings that are experienced by people (Thoits, 1989). Especially in the health care sectors which are associated with emotional risks, compassion often requires dealing with emotions (Msiska et al., 2014). A term coined by Hochschild (1983), ‘emotional labour’ is where the initiation or suppression of emotion is essential for the carer (nurse, in this case) to make sure that the person being cared for (patient) feels reassured and safe. It is an intrinsic management of thoughts, feelings and emotions that nurses cannot express to patients (Huynh et al., 2008). There are situations when one must regulate their emotions to make them more socially acceptable. So, Ashforth and Humphrey (1993) state that emotional labour is an attempt to demonstrate emotions appropriate to the situation. As emotional labour necessitates flexibility and tuning appropriately, the nurse must be experienced. Emotional labour is fundamental and frequently unacknowledged as part of the caring professions. Dealing with difficult situations, disabilities, chronic illnesses and death and dying or providing interpersonal and emotional support requires emotional labour (Gray, 2009 & Msiska et al., 2014). Many of these types of suffering cannot be cured by healthcare professionals. Due to the nature of their jobs, nurses, are in particular positions to come across this kind of suffering. Hochschild (1983) states that such emotional investment ultimately leads to emotional exhaustion caused by being tired of the emotional demands of one’s job. Emotional exhaustion is characteristic of burnout and is displayed by both physical and psychological fatigue (Maslach, 1982). Bradshaw (2011) suggests that in the nurse/patient relationship where there is emotional investment, compassion relates only to the benefit of the patient. Dewar (2011) claimed that caring does not emotionally burden the practitioners or make them fatigued (see section 4.2.5) instead gives them job satisfaction and enjoyment. It has also been argued that emotional work is associated with positive outcomes, mainly when the connections are profound (Graber & Mitcham 2004 & Youngson 2008).
2.7.1 Identifying suffering

There are some inherent difficulties and complexities involved in the emotional labour of compassionate care. In a discussion paper von Dietze & Orb (2000) focus on the concept of compassion. They state that compassion involves deliberate participation in another person’s suffering, not merely identification of the suffering but identification with it. Schantz (2007) carried out a concept analysis, argued that compassion not only urges people to recognise that someone is in pain, but to also act to alleviate any suffering.

In drawing on the self, requires the individual to relate to the suffering of others. In doing so, they need to enter into that suffering. Nouwen et al. (1982, p. 4 cited in von Dietze & Orb 2000, p. 169) state: “compassion asks us to go where it hurts, to enter into places of pain, to share brokenness, fear, confusion and anguish. Compassion challenges us to cry out with those in misery, to mourn with those who are lonely, to weep with those in tears. Compassion requires us to be weak with the weak, vulnerable with the vulnerable, and powerless with the powerless. Compassion means full immersion into the condition of being human”.

Van der Cingel (2009) studied the relationship between compassion and suffering and how one identifies severe suffering. She also discussed motives for compassion; whether it is an act of altruism or egoism. She suggested that as a healthcare professional, the nurse has a position towards the patients who are suffering. Based on the role of the nurse, she added that the nurse is socially sanctioned to do good and enhance the health and well-being of others. She further concluded that nurses have the opportunity to offer a voice to pain and suffering. Whilst exploring the nature of compassion, the paper also reviewed classical philosophers and contemporary scientists’ viewpoints. For instance, she suggested that for someone to feel compassion, they need to have “identification and imagination” as primary conditions (p.127). She further stated that to empathise is a form of identification. To imagine that the painful episode “is happening to you rather than to the one suffering” is very important (p.127).
The quotes seem to identify a form of personal attachment, which according to Blum (1980) can assist in recognising when compassion is needed.

2.7.2 Compassion and professional care

In her conceptual study, Van der Cingel (2009) explored questions related to nursing care. What if someone who is suffering wants to hide their feelings from their loved ones, then that personal attachment can get in the way. That said, nurses who can “detach” themselves from the patient might benefit. The best way forward is, a nurse who can switch between getting close to ascertain what is important and detach to prevent imposing their own perspective on the patient or even getting too involved to the point of getting fatigued (Carse, 2005). As already mentioned in section 1.5.5, Van der Cingel (2009) suggested that too much compassion can end up in self-sacrifice, which can lead to nurses facing compassion fatigue (see section 4.2.5).

Using a hermeneutic phenomenological approach Msiska et al. (2014) explored the practice learning experience of PQNSs in Malawi, with the intention of appreciating the nature of their experience. Many these PQNSs delivered care for patients with human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). A sample of 30 participants, third and fourth year PQNSs were purposively selected to participate in the study.

One of the main findings that emerged was the growth of compassionate care amongst PQNSs towards HIV positive patients. The study suggested an obvious fear of contracting HIV infection amongst PQNSs at the start of their course. As a result of that fear, PQNSs intentionally avoided caring for HIV positive patients, resulting in a “sense of legitimate emotional detachment”, (p.1246). One of their fears was based on needle stick injuries. As PQNSs progressed in their courses, acquiring knowledge and understanding on infection control, their professional attitudes changed and they came to realise that HIV and AIDS patients needed compassionate care. Initially their fear initiated emotional detachment, however, knowledge and experiential learning led to emotional engagement. Experiential learning is defined as the process where knowledge is acquired through practice.
experience (Kolb, 1984). Msiska et al. (2014, p.1250) argued the fact that emotional detachment might not necessarily have been due to ‘compassion deficit’, but merely lack of professional preparation, preconceptions and experience to look after the HIV positive patients. As there is no cure for HIV and AIDS, PQNSs also took the detached stance as a means of self-protection.

As data was only collected from one nursing school in Malawi, it would be difficult to generalise the findings. However, it can be suggested that lack of knowledge, experience and possibly preconceptions can cause fear, hence emotional detachment. However, the complexity of this is not fully recognised due to the relationship between professional care, emotional labour and the delivery of compassionate care. Experiential learning such as providing fundamental care to a patient can improve level of knowledge and can change those preconceptions into emotional engagement and possibly serve as a mean to link professional care, emotional engagement and compassion.

2.8 Compassion and attention to details

Several studies suggest that attention to small details make a big difference to the provision of compassionate care (Graber & Mitcham, 2004., Perry, 2009 & Van der Cingel, 2011). In a study conducted in the United States, using a phenomenological approach, Graber & Mitcham (2004) conducted in-depth interviews to explore the insider perspective of the lived experience of 24 clinicians from two hospitals. Clinicians described many actions or approaches to expressing caring and compassion to patients. They suggested that to make the clinician-patient relationship meaningful, attention to small, but important things such as smile were very important in the provision of compassionate care (see section 4.5.2). It was also suggested that the sample of the 24 clinicians identified were all highly caring and compassionate in their interactions with patients. For this reason, this research study could be biased as it did not look at all other Health Care Workers (HCWs) who might have been very uncompassionate. The study could have identified personal variables or predictors of compassionate behaviour. It can also be argued that as it was a self-selected sample, not many clinicians who are uncompassionate would have
come forward. Whilst self-selected sample can save time, it can also lead to the sample not being representative of the population being studied or over stressing some particular findings of the study (Ellis, 2013).

2.8.1 Paying attention to the little things

In a phenomenological study, using 7 nurses as the sample Perry (2009) carried out unstructured interviews and participant observations. This study described some everyday actions that nurses used to show compassion to older patients requiring long term care. The two main themes from this study were “attention to little things” and “keeping the promise to never abandon”. “Attention to little things” referred to assisting the patient with fundamental care, such as feeding, washing and dressing, attention to detail and giving quality time (see sections 4.2.2 & 4.5.2). The findings of Christiansen et al. (2015, p. 835) who use the examples of “talking, holding hand and just being there”, concurred with Perry (2009). Keeping the promise to never abandon referred to staying with the patient, mainly in the most traumatic instances and promising to stand by them. This study was conducted in Canada focusing on 7 nurses. Whilst the purposive sample seems small, most qualitative methodologists acquiescently acknowledge the lack of ideals for sample size. It is however agreed amongst qualitative methodologists that many factors, such as quality of interview, number of interviews per participants, experience of the researcher and the process of sampling can affect the number of interviews required to achieve saturation (Miles & Huberman, 2013).

2.8.2 Attentiveness

Whilst exploring the significance of compassion for older people with a chronic disease (long term care), Van der Cingel (2011) used a qualitative analysis of in-depth interviews with nurses (n=30) and patients (n=31) in three different care-settings. In order to understand the benefits of compassion for nursing practice within that context, Van der Cingel (2011) suggested seven dimensions expressed in frequency sequence. They were attentiveness (showing interest in whatever, small or big issue is important for the other person); Listening
(inspiring the other person to narrate the story); Confronting (to express the suffering and the associated emotions); Involvement (the nurse recognises the patients' emotion and shows genuineness); Helping (that can be with fundamental care); Presence (to be physical present) and Understanding (to appreciate the patients’ concerns) (see sections 4.2.1 & 4.5.2). Conducted in the Netherlands, this study is pertinent as it explores the care of the older people, from the patients’ and nurses’ perspectives.

2.9 Chapter summary

In summary, compassion is an old concept and is a dimension of quality care as well as an essential trait of genuine nursing (Bradshaw, 2009). It is one of the very essences of professional nursing today. Compassion in nursing remains a debated and contemporary topic for the wrong reasons. Over 300 articles were read and reviewed, thirty-five relevant articles were used for this literature review and many themes were acknowledged. After the studies were methodically coded, six main themes have been drawn from studies that explored perceptions of compassion from the three stakeholders, PQNSs, CMs and NEs in the care of the older people.

There is confusion in the literature about what compassion involves for nursing. Patients complain that lack of compassion is on the increase. This review demonstrates that compassion is a valued and commendable characteristic and good communication skills enhance the delivery of compassionate care. Also, emerging from this review is the managerialist approach to care, whereby the emphasis is on targets, which may undermine compassionate care.

Whilst compassion is a moral virtue for nurses and it is valued as ‘nursing’s most precious asset’ (Schantz 2007, p. 48), compassion without competence can even be dangerous (Roach, 1997). It is evident from the studies that competent nurses who can demonstrate compassionate care to their patient provide a recipe for safe and good quality care. It appears as nursing is moving more towards evidence based practice, the philosophy of compassionate care and the ideal of selflessness as an important quality is being compromised (Straughair,
At the same time, the role of the nurse is changing. As nurses carry out some of the junior doctors’ skills (section 2.4.2), more fundamental nursing care work is passed down to other healthcare workers, distancing nurses from direct patient contact. It can be argued that the uncompassionate nurses and other health care professionals remain a major challenge in the health care settings. These points of view were helpful in analysing the main themes that emerged from the literature (see figure 2.1).

Chapters one and two have emphasised the need for a focus of compassion in the care of older people by PQNSs, CMs and NEs. Using a pragmatic approach, Kneafsey et al.’s (2015) research was the closest articulation of a practice-based approach that carries resonance with the present inquiry. This sample comprised academic staff, health care students, clinicians and service users, who participated in nine focus groups. Whilst Kneafsey et al.’s work included academic staff in their sample, it is however unclear whether the health care students encapsulated all health and social care students or just nursing ones. At the same time, this study involved qualified clinical mentors mentoring PQNSs, whereas Kneafsey et al.’s included clinicians labelled as health care professionals. A gap appears in the literature as the perspectives of compassion from three stakeholders (PQNSs, CMs, and NEs), which have never been addressed. The main objectives for the study are given below.

Whilst it is obvious that compassionate care is at the heart of NHS policies, there are still debates as to how this care is translated in practice. The literature also confirms how the term compassion is complex and multifaceted, especially when used in the health care arena. Empathy as a form of identification is an important ingredient for someone to feel compassion (Van der Cingel, 2014). In order to prevent compassion fatigue, nurses should switch between getting close with patients and detach when appropriate (Carse, 2005). Whilst fear can act as a barrier to providing care with compassion, paying attention to details as well as to the little things can enhance compassion. This literature review has recognised the inadequacy of data about the PQNs perspective on compassionate care. This study will address this gap. Chapter 3 explores the
generic qualitative methodology, methods of generation of data and the analysis utilised in this research study.
Chapter 3: Methodology

This chapter will give an overview of how the study was set up and introduce the generic qualitative approach. An overview of the paradigms used will be discussed. Details are then given about the ethical implications particular to this study. The methods used for data generation and analyses are explored.

A pilot study to identify any deficiencies undertaken. Issues which were picked up in the pilot study were to avoid the use of leading questions, to take appropriate pauses, hence giving the participants a fair chance to answer the questions and to be able to ask to elaborate or explain some of the statements made. The leading question that was changed was “what are the good qualities of a nurse?”. This had an in-built assumption that all nurses are “good”. That question was changed following the pilot to “What qualities do you consider essential for an effective nurse to possess?”. After a thorough evaluation, minor amendments to the interview questions were made (section 3.7). An ice breaking exercise (see section 3.4.3), making the participants comfortable, was used at the beginning of all interviews. It is worth noting that all interviews took place without any interference with patient care.

3.1 Research paradigms

It is fundamentally important to elucidate the ontological, epistemological and axiological frameworks to enable readers to evaluate the significance of the methodological framework when carrying out research studies (Mantzoukas, 2004). Ontology is the philosophy of the world view, the science or theory of being (Heron & Reason, 1997). The important ontological question is: “is there a ‘real’ world ‘out there’ that is independent of our knowledge of it?” (Marsh & Furlong, 2002, p. 17). Two main differences can be noted, that there is a real world independent from our knowledge or there is no real world but one which is socially and conversationally made and therefore reliant on a particular time or culture (Marsh & Furlong, 2002). The primary stance that this study is based on is Crotty’s (1998) suppositions of constructivism. These are:
• Meanings are constructed by people as they participate with the world they are construing. PQNSs, CMs and NEs (the stakeholders) interact with patients, each other and relatives.

• It is important to get engrossed with the world and understand it based on its historical and social perspectives. The three stakeholders, PQNSs, CMs and NEs are born in their own world with its own meaning; they have and live in their own communities with their individual cultures, values and norms, all of which can shape their backgrounds and in turn, their experiences about care and compassion in the care setting. At the same time, individual beliefs are influenced by social processes which produce knowledge.

• The fundamental generation of the meaning of care and compassion is always social, arising through interaction with the stakeholders, the patients and their relatives. Whilst the process of qualitative research is almost always inductive, the meaning of compassion and how it is delivered within the clinical setting will be generated by the data received from the stakeholders.

Ontology is the ‘study of being’ and ontologists learn what people mean when something exists (Crotty, 1998, p. 10). Therefore, the researcher’s position in regards to the views of how things really are and work is pertinent. It is suggested that every paradigm is founded upon its specific ontological as well as epistemological inferences (Crotty, 1998). The reflection of the understanding and perception of the world as related to compassion is very much within the generic qualitative paradigm. This means that everyone has an equal viewpoint, that one view is not greater to another. The social process, culture and behaviour and interaction with people in context produce knowledge about compassion and the impact on the way that one thinks about it and its application to situations.

3.2 Epistemological perspective

Epistemology is the philosophy of knowledge and justification (Audi, 2000). Epistemological assumptions can be made based upon the generation,
acquisition and communication of knowledge (Buchanan & Bryman, 2011). It is conceivable to obtain knowledge about the world independently without any interventions or observation and this is always biased as it is contaminated by social norms of reality, which relates back to ontology. Whilst ontology and epistemology deal with truth, axiology is about values and ethics (Mingers, 2003), what is the crucial point of doing this research. Acquiring knowledge about the perceptions of compassion from the PQNSs, CMs and NEs and then sharing it with the providers of care and nursing education is also pivotal.

The positivist epistemology is based on objectivism, where methods to generate knowledge are independent of the world that is being researched (Crotty, 1998). Therefore, the epistemology of positivism may not completely assist in the understanding of the complications of health care practices, since much of the practices cannot be explained in a linear way or one which is based on cause and effect (Creswell, 2009). Mason (2002) suggests that fundamental to the interpretive approach to how knowledge is produced is how one interprets the world, whilst interacting with others to set social norms. To come to terms with the way reality is, Schwandt (2003) postulates that social constructivists believe in participatory approaches and that the notion that one view is not superior to another. The way that a person thinks is motivated by social interactions and developments, which yields knowledge. Instead of focussing on the truth and unbiased thoughts, social constructivists emphasise on the ways that the world is socially constructed (Schwandt, 2003).

The ontological position of interpretivism is relativism, which takes the view that “reality is subjective and differs from person to person” (Guba & Lincoln, 1994, p. 110). Relational constructivists believe that relational practice happens when people enter dialogue and attempt to make sense of what is taking place and as everyone has their own reality; there are many realities. “Language does not passively label objects but actively shapes and moulds reality” (Frowe, 2001, p. 185). Therefore, reality continues to be built through language and features of an autonomous world when they come together. For example, politics, management and culture of the NHS as well as the clinical areas, which are
different realities, can influence the perception of compassion. Relational constructivists suggest that the researcher is regarded as an expert amongst others and is integral of the process (Guba & Lincoln, 1994) (see section 3.2.1).

Based on the real world, the interpretive epistemology is one of subjectivism. Crotty (1998) suggests that the world is constructed and experienced through interactions. Interpretivism, in other words means, “the world needs to be interpreted to be understood” (Moule & Goodman, 2013, p. 173). In this research, an interpretivist approach was used to describe and understand compassion from the perspectives of the three stakeholders.

Thus, the epistemological position taken in this study is that knowledge is not pre-existing but is evolving. Knowledge about compassion, gained through cultures, experiences and care settings, interactions with each other, the patients and their relatives will have a bearing on the stakeholders’ perceptions about care and compassion. Consequently, a methodology that enables the exploration of the concepts of compassion amongst PQNSs, CMs and NEs as three stakeholders in the use and application of compassion is used.

Some of the reasons why an interpretive epistemology is appropriate are that there are numerous ways of comprehending and knowing the world, which depends on the circumstance and context. In many ways, the perspectives of the researcher and the participants can be close, suggesting that “the nature of the meaning is relative; contextual and the process of knowledge/ understanding is social, inductive, hermeneutical and qualitative” (Sexton, 1997, p. 8). A level of emotional involvement and possibly bias tend to be implicit in the interpretivist approach. Whilst this may be beneficial to better understand the participants by empathising with them and understanding their views and perceptions of compassion (embracing multiple realities), it may also blur the true picture of what is happening. As interpretivism is allied with the challenge of reliability and representativeness, results are personal, in depth and hence difficult to be generalised (Guba & Lincoln, 1994). Another challenge that is intrinsic with the interpretivism approach is with data analysis. The researcher attempts to
understand and interpret the phenomena in terms of what the participants say (Creswell, 2009).

Critics of the interpretivist perspective as a form of qualitative inquiry have decreased over the years, yet the principal argument against its viewpoints are that, taken to extreme, there is an intrinsic relativism and failure to proceed and/or develop resulting from the belief that all general ideas are constructed (Butler-Kisber, 2010). Whilst a strong emphasis was laid on the significance of spoken language rather than other forms of language, which could be non-verbal communication, and actions (Hosking, 1999), the latter was also considered when interviewing participants. Field notes were always taken after each interview in the research journal (see example in section 3.8.2e).

Researchers should make sure that there is congruence between an interpretive and constructivist approach and chose a methodology and methods of data collection that match with the appropriate epistemological perspective taken. That is, the chosen methodology and methods should be sufficiently described to distinguish between them. “Qualitative researchers direct their attention to human realities rather than to the concrete realities of objects” (Boyd, 2001, p.76). The conceptual framework developed for this study is reflected on the Donabedian Framework (1988) (see section 2.2.2 and Figure 2.2).

3.2.1 The relationship between the researcher and participants

In qualitative research studies, there are always many perspectives to consider when there is an attempt to have a full understanding of a circumstance. Basically, different people will have different perceptions of compassion and compassionate care. An important epistemological issue, which is of note is the relationship between the researcher and the participants and how this influences the link between “facts” and “values” (Ritchie, et al., 2013, p.8). In one model, the phenomena being explored are seen to be unaltered by the conduct of the researcher, leaving him/her objective in the approach and the concept/s being explored can be viewed as value free. Some researchers subscribe to the above concept; however, others suggest that the relationship between the researcher
and the participants cannot be ignored. Nunkoosing (2005) argues that there is always an element of power during interactions in interviews. This is further discussed in section 3.4.3. In summary, some of the main points arising in relational constructionism that can be applied to this research study are seeing the researcher as part of the study (see sections 1.7.1 & 3.4.1) acknowledging the complexity and the murkiness of the term compassion (see section 1.2.1) and its multiple realities and acknowledging the impact of politics (see sections 1.4.1, 1.5.2, 1.6 & 2.5.2), management and culture of the NHS as well as the clinical areas that can influence the perception of compassion (Hosking, 2002) (see section 2.5.1).

3.3 Choosing a methodology

All types of research studies attempt to appreciate and comprehend the world (Dzurec & Abraham, 1993). However, quantitative and qualitative methodologies have distinctive features (Creswell, 2003) (see Table 3.1). Quantitative methodologies incorporate uniform processes and statistical procedures and are usually related with a positivist paradigm. Using large scale techniques, facts based on empirical observations; one of the main goals of the quantitative methodology is to identify generalisable concepts based on statistical significance between dependent and independent variables (Ackroyd, 2004). As this research study explores the perceptions of compassion from PQNSs, CMs and NEs, a quantitative methodology will not be suitable.

Qualitative research is a form of social enquiry in “which the people who are being studied understand and interpret their social world and the meaning they attach to phenomena” (Bryman, 2012, p.714). In order to achieve this, data are explored (usually in the form of words or actions of research participants and pictures) (Moule and Goodman, 2013). It tends to focus on perceptions and experiences and may be used to look at issues such as patients’, nurses’ or relatives’ perceptions (Marshall & Rossman, 1999). It is difficult to quantify and measure small acts of kindness and compassionate care (section 1.2.2). However, the significance of such care can be measured in the form of exploring
PQNS’s, CMs’ and NEs’ perceptions, their satisfaction of the way that communication takes place amongst them and the way that they are supported.

Table 3.1: Differences between quantitative and qualitative research strategies (Creswell, 2003)

<table>
<thead>
<tr>
<th>Research Aspect</th>
<th>Quantitative</th>
<th>Qualitative</th>
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<tbody>
<tr>
<td>Common purpose</td>
<td>Test Hypotheses or Specific research questions</td>
<td>Discover ideas</td>
</tr>
<tr>
<td>Approach</td>
<td>Measure and test</td>
<td>Observe and interpret</td>
</tr>
<tr>
<td>Data collection approach</td>
<td>Structured response</td>
<td>Unstructured</td>
</tr>
<tr>
<td>Research independence</td>
<td>Researcher uninvolved</td>
<td>Researcher involved</td>
</tr>
<tr>
<td>Samples</td>
<td>Results objective</td>
<td>Results subjective</td>
</tr>
<tr>
<td></td>
<td>Large sample to produce</td>
<td>Small sample – often in natural settings</td>
</tr>
<tr>
<td></td>
<td>generisable results</td>
<td></td>
</tr>
<tr>
<td>Most often used</td>
<td>Descriptive and causal research designs</td>
<td>Exploratory research designs</td>
</tr>
</tbody>
</table>

Qualitative research is utilised to answer research questions that necessitate clarification or comprehension of social phenomena and their contexts (Ritchie & Lewis, 2003). Since the research question for this study is ‘to explore the concepts of compassion in the care of older people amongst key stakeholders in nursing education’, it is a suitable method to attain clarification and understanding of pre-qualifying nursing students, clinical mentors and nurse educators’ perceptions. The literature shows that a variety of qualitative data collection methods have been used to explore the perceptions of the stakeholders. However, in this study, semi-structured digitally-taped interviews of stakeholders, recorded diary entries and observational notes made by the researcher data were collected.

Qualitative methodologies are based on unique, non-numerical descriptions and interpretation within an interpretivist paradigm. It is concerned with the way in which the world is socially constructed and understood (Blaikie, 2007). Several philosophical perspectives, including symbolic interactionism, phenomenology,
ethnomethodology and hermeneutics are integrated in this paradigm. Inductive in nature and using a purposeful sample, this research study used semi-structured interviews to consider the perceptions of compassion of the three stakeholders. This study provided rich quality data, especially following debriefing sessions between researcher and supervisor and peer scrutiny where findings were presented to peers.

This study fulfils the qualitative paradigm as it is based on questions, such as stakeholders’ perceptions of compassion, the way in which they construe compassion and which can be affected by their cultures and the context (health care settings and higher education) (Patton, 2002). Since this study aims to explore the concepts of compassion from the perspectives of three stakeholders, knowledge was constructed via social interaction (semi-structured interviews) and meanings were interpreted using thematic analysis, the qualitative paradigm seemed the most suitable. Other questions that this study aims to uncover are:

- What are the perceptions of PQNSs of compassion in the care of older people?
- What are the perceptions of CMs of compassion in the care of older people?
- What are the perceptions of NEs of compassion in the care of older people?
- What are the similarities and differences in these perceptions?
- Why is compassion lacking in the care of the older people?
- What circumstances promote or compromise compassion care in clinical practice?
- How can compassion be taught in HEIs?

This is because this research is about uncovering prevalent trends in thought and opinion about compassionate care and acquiring an appreciation of fundamental reasons and motivations why nurses behave the way they do (Silverman, 2013).
Even though generic qualitative research does not have a regulatory set of theoretical conventions, it displays some or all the characteristics of other methodologies such as that of ethnography, the case study method, grounded theory and the techniques of action research (Caelli et al., 2003). In addition, a phenomenological study examines the lived experiences of the participants (Silverman, 2013). As this study explores the perceptions of compassion, it does not examine the lived experiences of the participants and as such a phenomenological approach is not appropriate. This study does not focus on social-cultural issues and is therefore not appropriate for ethnography (Percy et al., 2015). This research topic does not lend itself to the development of a theory, and is therefore not suitable for grounded theory. Several qualitative studies in education and nursing are not predominantly about culture, endeavour to bring a change in educational practice or attempt to develop a theory. This implies that some studies might not completely suit an ethnographic, phenomenological, action research or grounded theory. It can therefore be argued that when these methodologies are unsuitable, a generic qualitative method can be appropriate.

3.4 Generic qualitative research

Generic qualitative research methodology is referred as a naturalistic, interpretive method attempting to explore phenomena from the inside, and taking participants’ viewpoints as the starting point (Flick, 2006). Note that all qualitative approaches are naturalistic, but not all are interpretive (Ritchie et al., 2013). Generic qualitative methodology aims to use detailed, rich and complex data to provide an in-depth meaning of the world (Ritchie et al., 2013). Known by different terms, such as “non-categorical qualitative research” (Thorne et al., 1997) “fundamental qualitative method”, (Sandelowski, 2000), the generic qualitative approach “seeks to understand a phenomenon, a process, or the perspectives and worldviews of the people involved” (Merriam, 1988. P.11). Caelli et al. (2003); Mays and Pope (2000) & Merriam (1998) argue that researchers using a generic approach should clarify their theoretical position
unequivocally—for instance, by stating the motivation behind undertaking the study. This is further discussed in section 3.4.1.

Remarkably, the generic qualitative method is often utilised in the fields of education, medicine, nursing and marketing and is beginning to be used more widely (Caelli et al., 2003). Some of the reasons for using the generic qualitative approach are perhaps, the constraints of time and resources and its flexibility and not having to subscribe to any particular established qualitative methodology (Merriam, 1998). This often appeals to ‘professional’ researchers who work on a fixed budget, but can be seen by academics as lacking in rigour. In the case of this study, the main reason was that it simply fits its endeavour, attempting to understand the perspectives of the three stakeholders.

To define qualitative research is rather complex as it draws on a range of differing philosophies and paradigms and uses a variety of very different methods (Ritchie et al., 2013). Generic qualitative research does not have any philosophy or paradigm that is uniquely its own and it does not have a distinctive set of methods (Denzin and Lincoln, 2011). In an attempt to describe generic qualitative research as an example, Denzin and Lincoln (2011) postulate it as an interpretative approach, which makes use of field notes, interviews, conversations and recordings in a natural setting to make sense of the world. Therefore, in developing the researcher’s own generic qualitative research methodological approach the essential requirements further developed from Caelli, et al. (2003) are included: noting the researchers’ position, distinguishing methods used to collect data, making explicit the approach to rigour, and identifying the researchers’ analytic lens.

3.4.1 The researcher’s position: Reflexivity

As qualitative research is a subjective practice, the researcher brings to the data collection, the analysis and the report writing elements of their own understanding (Van Manen, 1998). A researcher comes to a project with prejudice, beliefs, prior knowledge and values (Van Manen, 1998) (see section 1.7). It is even suggested that it is in the “researcher’s best interest to clarify, his
or her thoughts, ideas, suppositions and presuppositions", (Streubert Speziale & Carpenter, 2011, p. 26).

It is suggested that the main ingredient for reflexivity is awareness (Gilgun, 2010). For most of my professional career I have worked in the caring profession as a nurse. I was aware that I was undertaking this study with my personal views about compassion and the significance I had placed on delivering compassionate care when working as a nurse. I however needed to be attuned of the implications of this on my views and judgements. Writing down one’s beliefs prior to the research study, gives the researcher a frame of reference. A research journal was kept and was constantly updated. To maintain objectivity, those thoughts and feelings were kept separate from what was shared with the participants. This emphasises the importance of researchers designating both the stance from which they articulate about the research and the approach and the methods chosen to explore the topic (Cheek, 1995., Lather, 1986 & Rudge, 1996). I feel that I could draw on a range of pertinent knowledge and experience to enlighten this research study. It also enabled me to deal more skilfully with the interviews and glean more from the data.

Stemming from my personal and professional experiences, I can suggest that my beliefs and values that can influence the study are:

- The needs of the patient in the care giving relationship are paramount. However, I also consider self-compassion and the needs of the members of team.
- High collaborative working in the provision of patient quality care is paramount.
- To consider the holistic (mainly their psychological or even personal needs) of students when providing education.
- There should be adequate, high quality and consistent delivery of education.
- At all times, health care professionals, PQNSs and NEs should strive to achieve effective communication and good listening skills with each other to provide quality care.
I also believe in applying and practicing the basic principles of both professional and personal ethics, such as; never do harm, do good, ensure fairness, promote autonomy, be open and maintain confidentiality. These are some important ingredients to make a compassionate practitioner.

As Pope and Mays (2000) emphasise the significance of the researcher’s skill to be considered of his/her role as far as the interviewee is concerned, I reflected on my position as a senior lecturer. I came to the realisation that my position as a senior lecturer and researcher could affect the interviews (see section 1.7). As I had my views about PQNSs, taking time out to reflect on my role was important. I was certain that they might feel sceptical about me at first, thinking that I was sent by the management team to investigate some hidden agenda. I prepared notes on how this might impact on my outlooks of what PQNSs might share as well as what they might think of me. This facilitated the process of reflection about possible bias that might have subtly influenced the interpretation by recognising my values, background and beliefs. The element of power, discussed in section 3.4.3 was also considered.

Throughout the data collection process, care was taken not to affect the participants’ responses (especially PQNSs and CMs). My intention was to remain as impartial as possible whilst collecting, interpreting and presenting the data, given my knowledge of the literature regarding compassion in nursing. I also attempted bracket off my knowledge of previous experiences to lessen any interference from the data.

3.4.2 Distinguishing methods used in data collection

One of the reasons for the prevalent popularity and widespread use of interviews in social research studies is that they can be used in various ways and in an epistemological stance (Buchanan & Bryman, 2011). In extremely structured interviews, the format is identical and the purpose is to curtail any prejudice that the interviewer may have (Buchanan & Bryman, 2011). The more structured the interviews are, the easier they are to analyse thereafter. The interview questions can form the foundation of an outline constructed a priori, even before the
process of data analysis begins, possibly making the coding process fairly uniform (Buchanan & Bryman, 2011). It is also suggested that in unstructured interviews, participants take an active role in building the nature of the interview, whilst appropriately directing it (see section 2.2.2).

Typically, in qualitative research studies, interviews are semi-structured or unstructured, giving participants the chance to express themselves at length around the topic of discussion and allowing the interviewer to respond to the ideas and statements coming from participants rather than boxing the interviewee in using questions that may be irrelevant to the individual (King, 2004) (see section 2.2). It is fundamental to appreciate that the relationship between the interviewer and the interviewee is fundamental in any form of interview (King, 2004). In this study, semi-structured interviews were used as the means of data collection mainly as they are appropriate to explore the perceptions and opinions of participants regarding multifaceted and sometimes sensitive issues such as compassionate care and enable further investigation whenever clarification of answers was needed (Buchanan & Bryman, 2011).

3.4.2a Face-to-face Semi-structured interviews

The designs of the one to one semi-structured interviews were informed by findings from the literature review. The interview guide for semi-structured interviews was based on topic areas, probing questions and prompts. Semi-structured interviews were used to allow focused, informal and a two-way conversation (Ellis, 2013). Whilst an interview guide was used, there was also the flexibility for other related probing questions to be asked and to explore some of the answers (Ellis, 2010). This method enabled the participants to tell their stories freely in their own words and for the interviewer to gather more in-depth data. It was endeavoured to capture the unique perspective about the role of compassionate care in the practice placement areas and the university, by engaging in prolonged contact (Shreiber & Stern, 2001). Questions sought to explore participants’ feelings and thoughts of compassionate care and the way it is nurtured both at the university by NEs and CMs in practice placements. They
attempted to explore nursing students’ perceptions about the development or inhibition of compassionate care.

Semi-structured interviews are appropriate for exploring perceptions and attitudes, values and beliefs (Ellis, 2013). Kvale (1983) suggests that some advantages of using semi-structured interviews are that they can generate a large amount of data and can assist when exploring sensitive subjects, such as ‘lack of compassion or poor care delivery’. Some of the disadvantages are that it is difficult to be sure whether participants are honest with their responses (Kvale, 1983). For instance, it is unlikely for a participant to suggest that they lack compassion. Finally, the large amount of data generated can be difficult to analyse.

Lambert and Loiselle (2008, p.229) suggested that care should be taken when interviews are used, “the assumption that words are accurate indicators of participants’ inner experiences may be problematic”. For instance, it could be that some of the participants chose to disclose what they think is socially acceptable as opposed to wrong or undesirable. Considering the above sample selection, participants had different pasts and cultural values. This of course depended on their education, experiences, and place of work. The cultural and social outlook of both the interviewer/s and the participants can influence as to what is articulated and what is heard. So therefore, an awareness of cultural differences and taking time to build a good rapport with the participants are vital (Streubert Speziale & Carpenter, 2011). Focus group interviews which are economical, flexible, inspiring, cumulative and able of producing rich data (MacDougall & Baum, 1997) could have been used, but whilst encouraging participation and multiple views, they were unlikely to provide contextual in-depth narratives. It was thought that providing the choice of telephone interviews to participants, especially to busy clinical mentors, who with different shift patterns might prove difficult, would have been convenient and flexible. Although all participants without exception were busy, they all opted for face-to-face interviews, giving their full attention throughout.
3.4.3 Making explicit the approach to rigour

In this study the researcher has attempted to be robust and rigorous. The researcher’s analysis of the transcribed interviews was returned to the stakeholders. In addition, rigour was achieved by using interpretations of the interview data from many perspectives.

This issue of power between stakeholders and researcher was considered. It is suggested by Nunkoosing (2005) that there is always an element of power during interactions in interviews, indeed in all human interactions. As there seemed to be an element of power between some of the participants (mainly PQNS and CMs) and the interviewer, it was vital that at the start of the interview, time was taken to conduct an ice breaking exercise, making the participants comfortable (see section 3.0). Depending on the situation, the ice-breaking exercise involved “something about the participants”, articulating the participants’ work experiences so far, the weather, if they enjoyed their jobs or training and why. This could enhance an exploratory concept of compassion. Hence, interacting with participants in a relaxed and informal manner where the opportunity to learn more about their in-depth experiences through semi-structured interviews was possible.

This informal environment provided building a good rapport with all participants so that follow-up or probing questions based on their responses to pre-constructed questions were also possible. Building a rapport with participants is generally recognised as a main element in effective qualitative interviewing (King and Harrocks, 2010).

The main purpose of the interviews was to invite and encourage participants to think and to talk about their prospects, experiences, and understandings of compassion and compassionate care at both the conscious and unconscious levels. The interview was guaranteed to uncover the way that the participants think, maybe about some of the people who provided care with compassion or not. This could be perceived as scrutinising the participants’ thoughts. Thus, the questions were simply phrased as well as hesitant responses were followed up.
Some pauses were taken to encourage elaboration on responses, which allowed the participants to think further. At the time that consent was sought, explaining that the interview carried no risk, it was important to get the involvement of participants in the study (see Appendix 7 for consent form). All participants were given information sheets (see appendices 10, 11 and 12 for CMs, NEs and PQNSs information sheet respectively).

A completed step-by-step transparent audit trail provides a synopsis of the different stages of data analysis (see Appendices 17-21). Despite the administrative support obtained through a grant, the “Research Challenge Fund” (see appendix 16), the interpretation of the data was a lengthy process, which could lead to information overload, resulting in complications in the analysis process. For instance, participants’ perceptions could have been oversimplified. However, the methodical usage of a framework approach with methodical coding and labelling made the data analysis process explicit. This process assisted in the provision of a transparent audit trail and ensured rigour in the research study in line with generic qualitative research.

3.4.4 The researcher's analytic lens

Unlike quantitative research designs, whereby the data analysis process is normally driven by a prearranged agenda, this data analysis used a natural and inductive process (Kilbride, 2007). The overall data analysis strategy was based on an interpretative approach, the framework analysis (FA), which is a qualitative method used for mainly applied policy research. Developed in the 1990s by Ritchie and Spencer, it can be said it is better adapted to research that has specific questions, a limited time frame and a pre-designed sample (e.g. CMs, PQNSs, NEs) (Ritchie & Spencer, 1994). For instance, questions obtained from objectives of the study as well as matters raised by the participants themselves and views or experiences that reappeared in the data. Whilst FA may generate theories, its main aim was to communicate and construe what was occurring in a specific setting, be that on a ward, in an office or a different room (Ritchie & Spencer, 2004).
FA was chosen because it is considered to be rigorous and it uses an analytical matrix-based technique to methodically provide a way of managing the data (Ritchie & Spencer, 2004). FA appeared suitable since it is a flexible process, which enables the researcher to either collect all the data and then analyse or carry out data analysis whilst collecting data. It was of great assistance to both thoroughly describe and interpret a huge amount of data in order to make sense of the perceptions of the participants. The purpose of indexing process was to cultivate a coding system, which facilitated fundamental themes to emerge. The FA also can be made available to other people, mainly the supervisors as well as the main researcher to verify the process of analysis and provide ongoing clarifications. It was felt that the graphic representation and synthesis of data was quite helpful as it enabled the researcher to trace back the original source (Ritchie & Spencer, 2004).

FA is also an intuitive method that enables the researcher to engage mentally and passionately with the data. This seemed to fit well with the constructivist epistemological approach, which assumes that there are numerous ways of comprehending and knowing the world. At the same time, the method acknowledges that the world, more particularly as this research explored compassionate care, subjected to a multifaceted variety of social and cultural factors. In the analysis stage the gathered data are scrutinised, recorded and sorted in accordance to main themes (Ritchie & Spencer, 1994). Whilst FA is predominantly used in health care settings (Gerrish et al., 2004) and in educational studies (Archer et al., 2005), it was considered to be suitable for the following reasons:

- “It is primarily based on the observation (from field notes which were taken during and just after the interviews) and accounts of the participants (interviews).”
- “It is a dynamic that allows the change or addition or amendment throughout the process.”
- “It is systematic in the sense that it allows a methodical treatment of the data.”
“It is comprehensive in nature” (Srivastava & Thomson, p. 77, 2009)

Themes designed the initial framework for this research study from which data were further analysed and categorised. From this method of theming process, participants’ non-verbal behaviours, their beliefs and values discussions and field notes were considered. This analysis, which encompassed the themes also acknowledged sub-themes. Following this, a process of secondary analysis was carried out to make the whole framework a more manageable size and to group themes where there were overlaps. Note that part of the primary and the secondary analysis was shared with the supervisor.

3.5 Ethical considerations

The four ethical principles to be considered are respecting of autonomy, maintaining beneficence, non-maleficence and justice are paramount (Dimond, 2008). Many ethical issues were considered before the data were collected for this research study. Whilst this research study posed no threats to the safety of any of the participants, the purpose for the ethical approval was to help to protect their rights and dignity (Smith, 1999).

This study was guided by the code of practice charted within the Research Governance Framework for Health and Social Care (RFGHSC) (DH, 2004). The code of practice encapsulates the procedure to look into ethical dilemmas. Attention was given to informed consent (See Appendix 7 for consent form) to make sure that participants took part in the study voluntarily. The three groups of stakeholders were given slightly different information sheets, which gave a summary of the aim and the purpose of the study and why they were selected to take part (See Appendix 10 for information sheet for students, Appendix 11 for information sheet for Clinical mentors, Appendix 12 for information sheet for nurse educators). The main reason to give different information sheet was in case of unsafe practice being revealed. PQNSs were recommended to follow guidelines from the students’ handbook, CMs were advised to use Trust policies and NEs were asked to contact their heads of departments.
Before the commencement of this research study, ethical approvals from the Faculty of Science of Portsmouth University and the Pre-Qualifying Nursing Department of Buckinghamshire New University (BNU) were granted (Appendix 8: ethical approval and UPR16 Form declaring the ethical conduct of the research from Portsmouth University and Appendix 9: ethical approval from BNU). Gaining ethical approval for this study was undeniably not “plain sailing” (Silverman, 2013, p. 30), especially when the requirements for both universities were the same. It was quite daunting and time consuming. Recruiting clinical mentors as one of the stakeholders for this study was slightly different as far as authorisation from the Research and Development (R&D) units of four hospital Trusts were concerned. The four Hospital Trusts were Hillingdon NHS, Ealing NHS, West Mental Health NHS and West-Middlesex NHS Hospital Trusts. The recruitment process for clinical mentors is explained further on in this chapter (see Table 3.3: Interviews’ numbers as per participants, Appendix 13: Dates for ethical approval from universities and Appendix 14: Interview schedule per cohort).

The study also complied with informed consent procedures, which involved both written and verbal consent with an education and information exchange that took place between the researcher and the participants (Dimond, 2008). The researcher ensured the safety and well-being of participants, and it was essential that an ethical code of conduct was mutually agreed at the beginning of the study (Meyer, 2006). The above had its challenges and participants have found it difficult to understand the nature of the research. It was advisable to therefore negotiate and re-negotiate consent throughout (Winter & Munn-Giddings, 2001). None of the natural settings were disturbed. PQNSs and NEs were interviewed on the university campus. CMs were interviewed on the hospital premises where they worked, but away from the patients. There was no patient contact and there was no risk to any of the participants.

At the very start of the interview, the process for ensuring confidentiality and as far as possible, anonymity was discussed with all participants. All names were removed from each of the transcribed interviews and, instead coded. For
instance, nurse educators were coded as NE1, NE2 and so on rather than name, clinical mentors as CM1 and CM2, and pre-qualifying nursing students as NS1 and NS2. Once the data were downloaded on to the password-protected laptop, it was erased from the digital recorder. It was also important to bear in mind not to discuss any issues arising from an individual interview with others in ways that might reveal an individual’s identity. As much as possible data were verified with participants throughout the interview and the study so they could determine this for themselves.

Data protection and confidentiality were maintained throughout the study and fulfilled by maintaining anonymity of participants. It was made clear to the participants that after successful transcription, interpretation of the interview and completion of the doctorate course the data would be stored as per university Research Data Management policy (Portsmouth University, 2015).

3.6 Research design: researching compassion in elderly care

The research design for this study included the selection of stakeholders, which involved interviews following many stages.

3.6.1 Sample selection and size

Nurse educators, pre-qualifying student nurses and clinical mentors were invited to take part in the study based on their experiences and knowledge of compassion and compassionate care. The sampling method is best described therefore as purposive (Creswell, 2003). Purposive sampling “means selecting groups or categories to study on the basis of their relevance to your research questions”, (Mason, 2002, p.124). Purposive samples (selected inclusion for the purpose of the study) were used to ensure that homogenous groups of nursing students had the relevant first-hand experience according to the groups identified (Streubert Speziale & Carpenter, 2011). There are no defined rules for sampling in qualitative research studies (Miles & Huberman, 2013), however suitable participants were then selected to reflect multiple variations (gender,
age, experience and cultural backgrounds). Purposive sampling’s inclusion and exclusion criteria for PQNSs, CMs and NEs are elaborated in Table 3.2.

Table 3.2: Inclusion and exclusion criteria for PQNSs, CMs and NEs

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Exclusions criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQNS</td>
<td></td>
</tr>
<tr>
<td>First cohort: PQNS who are in the process of completing the first six months of the course.</td>
<td>PQNS who previously worked as a health care assistant prior to joining the course. Having already been exposed to the clinical practice placements, they may have preconceived ideas.</td>
</tr>
<tr>
<td>Second cohort: PQNS who had successfully completed the first year of the programme and have progressed into the second year.</td>
<td>PQNS from the children’s nursing field. The likelihood that they would provide care to older patients is minimal.</td>
</tr>
<tr>
<td>Third cohort: PQNS who had successfully completed the first two years of the 3-year programme and have progressed into the third year.</td>
<td>Non-qualified CMs.</td>
</tr>
<tr>
<td>CMs</td>
<td></td>
</tr>
<tr>
<td>Only CMs with a recognised teaching qualification such as “Mentorship in Practice”. CMs with at least a year experience of mentoring PQNS. Only CMs working with the older patients.</td>
<td>NE with less than one-year experience. NE who does not have the teaching qualification.</td>
</tr>
<tr>
<td>NEs</td>
<td></td>
</tr>
<tr>
<td>NEs involved in the delivery of teaching sessions for pre-qualifying nursing students (only Adult and Mental Health fields).</td>
<td></td>
</tr>
</tbody>
</table>

3.6.1a Pre-Qualifying Nursing Students

The population per cohort is 250 (excluding forty children’s nursing students who might not be exposed to nursing older people), to achieve approximately 210 eligible students. Multiple variations sampling, which is a strategy for purposive sampling aimed at capturing and describing the core themes that cut across a great deal of participants, was used (Patton, 1990). PQNS from two fields (adult and mental health), who had been exposed to theory and practice experiences, and reflected multiple variations (gender, age and cultural backgrounds with both male and female, different age groups and from different cultural backgrounds (White, Black and Asian) were identified where available.
It was anticipated that for semi-structured interviews, 6-8 participants from each cohort of students would lead to data saturation, which is when the repetition of data is obtained or no new stories heard (Streubert Speziale & Carpenter, 2011). These were independent cohorts of pre-qualifying nursing students Years (1, 2 and 3) who, for each cohort, would have shared the same experience or gone through the same process of learning. For each student cohort, except year 1 (only 7), 8 participants were interviewed. Details of numbers are given in Table 3.3.

3.6.1b Nurse Educators

Nurse educators are one of the nursing students’ role models who can help to maintain their confidence (McKinley, 2004). The main reason for getting the views of the nurse educators was because, together with mentors, they are the main ones who teach and nurture the nursing students whilst attempting to provide “a holistic course” (Delaney, 2009, p.32).

There are over forty nurse educators involved in the delivery of teaching sessions for all pre-qualifying and post-graduate nursing courses. All nurse educators (twenty-five) involved in the delivery of teaching sessions for pre-qualifying students were invited in a meeting room. Nurse educators (twenty) with at least a year experience involved in the delivery of teaching sessions to the two nursing fields (adult and mental health) were identified.

Suitable participants were then selected to reflect multiple variations (gender, age, experience and cultural backgrounds). As semi-structured interviews were being used, 6-8 participants led to data saturation (Streubert Speziale & Carpenter, 2011). Details of numbers are given in Table 3.3. The total number of nurse educators involved in the project was 8.

3.6.1c Clinical Mentors

There are approximately 400 clinical mentors in the four trusts (about hundred per NHS Trust, which are Hillingdon, Ealing, West London Mental Health and
West Middlesex Hospital NHS Trusts). Mentors from two fields (adult and mental health were invited).

Suitable participants were then selected to reflect multiple variations (gender, age, experience and cultural backgrounds). Details of numbers are given in Table 3.3. The total number of clinical mentors involved in the project was 8.

Table 3.3: Interviews’ numbers as per participants

<table>
<thead>
<tr>
<th>Participants</th>
<th>White (W)</th>
<th>Ethnic minority (EM) groups</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (M)</td>
<td>Female (F)</td>
<td></td>
</tr>
<tr>
<td>First year pre-qualifying students</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Second year pre-qualifying students</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Third year pre-qualifying students</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Clinical mentors</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Nurse Educators</td>
<td>0</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>23</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>39</td>
</tr>
</tbody>
</table>

3.6.2 Recruitment of participants

The researcher asked all three stakeholders to take part in the research using email. Emails were sent to many NHS Trusts. The stakeholders were invited to take part in interviews one-to-one or over the phone.

3.6.2a Pre-Qualifying Nursing Students

The email clearly stipulated the research title, its aims, exclusions, such as “students who were health care assistants prior the commencement of their
course would be an exclusion”, explaining the purposive sample, confidentiality and anonymity throughout and beyond the study. This email triggered an interest and a few students (second and third year) started responding to my request. Whilst a fair number of students were being recruited, especially those from the second and the third years, it was still difficult to recruit the first-year group. On reflection, it is believed as the researcher was teaching on the second and third year modules made this process slightly easier. Two further emails were sent to recruit some first-year students, but no one responded. The researcher eventually went to speak to all first-year students to get their attention. Throughout this process pressure points such as exams and assignment dates submissions were taken into consideration before organising interviews.

3.6.2b Nurse Educators

An email was sent to all potential participants making the request to take part in the study. All forty nurse educators were invited for the interviews. Having thanked them for their interest, there was also clarification that some potential volunteers would not be selected to fulfil the purposive sample criteria. However, they were also informed that if they were not selected, they could receive a copy of the final report.

3.6.2c Clinical Mentors

An email was initially sent to the NHS Research & Development (R&D) of the four Trusts concerned. The email elaborated on the research project and its intention. The study protocol, the participants’ information sheets, the REC approval letter from Portsmouth and Bucks New Universities, consent forms as well as copies of ethical approval from Portsmouth and Bucks New Universities were sent. Also, attached in the email was the researcher’s curriculum vita.

It is worthwhile pointing out that the experience of gaining access to the four Trusts was very different. Two of them allowed straight-forward access, but the other two requested further documents following the completion of Integrated Research Application System (IRAS). They were the NHS R&D form and the
study Site Specific Information (SSI) form. Out of the four Trusts chosen, three were acute general hospitals and one was an acute mental health hospital. Since emails were sent to one of the four trusts and hardly any correspondence was received, it was decided that only the remaining two general and the mental health Trusts would be used. It is however worth bearing in mind that the participants (CMs) of that hospital Trust had similar experiences to the participants of the other two acute general ones, which is working with the older people. Equally, data saturation was reached.

3.6.3 Data collection

The main data collection started in October 2013 and proceeded over a four and half month period when all participants were interviewed (PQNSs, CMs and NEs). Whilst all interviews were digitally recorded, field notes (analysed in conjunction with the interviews) were taken during each and every interview to substantiate observations and discussions.

Data saturation was reached at the point in which continuous data collection, but no new ideas emerged (Ellis, 2013). This meant that there was no need to continue with additional data collection.

3.7 Pilot study

A pilot study, which can reveal deficiencies in the design of proposed semi-structured interviews, was conducted and minor issues were then addressed prior to data collection (Streubert Speziale & Carpenter, 2011). As mentioned before (see section 3.0), a small steering group comprising one clinical mentor, one student representative and a nurse educator involved in the teaching of post-qualifying nurses were used. This helped in acquisition of confidence and fluency with the interviewing technique. All interviews (face-to-face) were guided by a flexible interview schedule (Appendix 14) that was developed around the identified research objectives (1-3).

Section one focused on exploring pre-qualifying nursing students’ perception of compassionate care. This section also aimed at covering an adequate
description of the impact that nurse educators at the university and the day-to-day care delivery by mentors could have on the nursing students’ perceptions of compassionate care. Open-ended questions were posed such as:

“What qualities do you consider essential for an effective nurse to possess?”

“How will you promote empathy and dignity?”

“When you hear the word “compassion,” what do you think of?”

“What does a compassionate practitioner mean to you?”

Section two focused on determining factors that might prevent or enhance compassionate care (behaviour) in the delivery of patient care. Open-ended questions such as were posed:

“How do you see the purpose of nursing and care of patients?”

“How does your commitment to compassionate care affect how you treat your patients?” (N/A to the 1st cohort before practice placement)

“Can you describe any factors that may have prevented or contributed towards compassionate care (behaviour) in the delivery of patient care?” (N/A to 1st cohort before practice placement)

Finally, the main points of the interviews were summed up and participants were thanked for their contributions towards the research project (Rubin & Rubin, 1995).

In addition, it was ensured that:

• The researcher had experience to conduct all the interviews.
• The researcher established a rapport and engaged as well as encouraged participants to use their own words to describe their unique perspective of their experiences.
In addition, probing questions were used to obtain further data on issues of particular interest to the participant being interviewed.

Prior to the commencement of the pilot study interviews, the researcher checked that participants received prior written information. The interview procedure was briefly explained including the purpose of the interview and overview of the interview topic areas that was covered. Reassurance was given that there were no right or wrong answers but that the participant should feel free to answer as they wanted. It was also emphasised that the participant would be free to stop the recorder at any time.

The interviews took between 20 minutes to 45 minutes depending on what participants wanted to share during that time. After consent to take part in the study was fully discussed and when participants were happy to proceed, written consent was obtained before the interview began. As a precaution, and for those participants who did not want to be recorded during the interview, the researcher had pen and paper to take detailed notes. One copy of the consent form was given to the participants to keep. The digitally recorded interviews were transcribed verbatim to remind the researcher of ideas and concepts during the initial phase of the analysis.

Hence, data analysis and data collection took place simultaneously to inform each other (Creswell, 2003).

3.7.1 Participant input and data collection technique

A maximum of three interviews were conducted in one day. At the same time, at least an hour was left between interviews to take field notes and allow reflection and complete field notes. Note that all interviews were digitally taped and were face-to-face as noted earlier.

Information presented to all participants was given both in verbal and written forms. Different information sheets, but the same consent form, were used and all participants were made aware of the purpose of the Professional Doctorate in Nursing. All participants gave written and verbal consent at the start of the
interview. In order to get a complete picture of what was being said, not only was the interview digitally recorded, but the other factors such as facial gestures were noted just after the interviews. Field notes can emerge from observations (Chiseri-Strater & Stone Sunstein, 1997). They included notes of the date, time and place of observation, some specific facts about what happened at the site of the observation. Additionally, sensory impressions sights, sounds, and other gestures were noted. All the above complimented the meanings of the findings (see Table 3.9 for an example). Reading those field notes brought back the whole interviewing experiences with every participant. In turn this assisted in the writing of the findings

3.7.2 Participants’ validation

During the course of each interview, the validity of data collection was checked and confirmed by reiterating some of the issues raised. To confirm the accuracy of information, the transcripts were sent to participants for feedback. This gave them the opportunity to read and review their own transcripts and allowed them to make any additional comments to ensure the accuracy of their statements. Once data from all participants were considered, and a final written account produced making sure that it resonated with their comments made in the interviews, interviewees were asked to return any comments or feedback on their transcripts within two weeks.

Taking data back to participants for validation is open to some criticisms. For instance, they might get ‘cold feet’, might even suppress material or contested explanations, which they might perceive as uncomfortable (Robson, 2011). All participants in this study were compliant. To acquire maximum engagement and participation with the participants, active listening strategies were used. This involved attending to how they presented during interviews and their responsiveness to questions. Note that participants were inclusive of male and female students from all three years of the BSc programme, a wide range of ages, and were from diverse ethnic and religious backgrounds (Table 3.3: Interviews’ numbers as per participants).
3.7.3 Researcher’s validation

Random samples of initial transcripts were sent to the academic supervisor to independently check validation of development. The emerging themes were discussed and agreement reached.

3.8 Stages of data analysis

All interviews were fully transcribed and their analysis was undertaken with the help of NVivo version 10. The process of thematic analysis using the Framework approach, which provided both a systematic and rigorous data analysis, was used. A thematic framework was used to sort out and organise data (according to key themes and emergent concepts) to provide a series of main themes subdivided by related subtopics (Ritchie & Spencer, 1994). This was realised by drawing on *a priori* issues and questions obtained from objectives of the study as well as matters raised by the participants themselves and views or experiences that reappear in the data (Ritchie & Spencer, 1994).

The main characteristics of the framework approach when analysing qualitative data comprise of five phases, which are presented in Table 3.4.
Table 3.4: Five Stages of Data Analysis adapted from Pope & Mays 2000 (p.116)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Familiarisation</td>
<td>The researcher immersed himself in the raw data by listening to tapes, reading transcripts and studying reflective notes. Initial notes were made following the interview regarding the topics discussed (to act as a record and reminder of emerging ideas). Individual transcripts from interviews were read through (the researcher immersed in the data to help integrity and validity of process). Thematic summaries of the content of the interviews were noted and a list key ideas and recurrent themes were created.</td>
</tr>
<tr>
<td>2. Identifying a thematic framework</td>
<td>The researcher identified all themes. The emerging themes from the data were selected and linked, such as issues raised by the respondents and experiences and views that recurred in the data, with the overall aims and objectives of the study. A detailed index of data which labelled the data into manageable sections were retrieved and explored.</td>
</tr>
<tr>
<td>3. Indexing/Refining the data</td>
<td>A categorisation of the data as themes were sorted and labelled. A hierarchy of themes and sub themes from the text was identified. Cross sectional codes in which a system of categories was applied. This enabled comparisons and connections. An audit trail to note the process of the refinements was used.</td>
</tr>
<tr>
<td>4. Charting/Retaining data in context</td>
<td>Each main theme was displayed in a chart allocating a row to each respondent and a column denoting a separate subtopic. This rearranged the data using a matrix format and retained the links to the original data.</td>
</tr>
<tr>
<td>5. Mapping and interpretation</td>
<td>Data from each case were synthesised into the framework. Associations between themes were used to explain findings. Links to literature and actual quotes aided an actual reflection and interpretation of data collected. Reflexivity was used to explore researcher’s views.</td>
</tr>
</tbody>
</table>
3.8.1 Illustrative Example of the use of the FA

In this study, semi-structured interviews were utilised to collect data from 39 participants (N=39), (n=8 NE), (n= 8 CM), (n= 8 second and third year PQNSs respectively) and (n= 7) first year PQNSs. Using the FA, a joint approach to analysis, allowing the development of themes inductively from perceptions, views and experiences of research participants, and deductively from existing literature was taken.

3.8.2 Transcription

Since the content, instead of the organisation of participants’ answers for analysis mattered the most, extended silences, breaks and nonverbal communication (such as laughter and grimaces) were illustrated within the text. All transcripts were checked for mistakes by listening back to the digital recorder and simultaneously constructing the transcripts. Every transcript was thereafter substantiated with field notes made throughout and instantly after the interview, mainly where opinions were given after the recorder was turned off. There was one situation when a PQNS phoned a couple of hours after the interview to clarify one of her responses. A different person using funding awarded by the “Research Challenge Fund” carried out transcription and this took the form of three stages.

3.8.2a Stage 1: Familiarisation with the interviews

Each transcript was read twice and the digital recorder was listened back to become familiar with the whole data set. The recordings were listened to just after the interviews took place, allowing the re-experiencing of the moments of the interviews. These field notes, hours of digitally recorded interviews and their transcripts were assembled. As transcriptions of data were undertaken by another person, the tapes were listened to and appropriate transcripts read simultaneously to confirm the content of the transcripts. This familiarisation method was crucial, not only to confirm the data and to find patterns/themes being developed, but also reading and making notes in this way was easier to
work around hundreds of pages of transcript. Therefore, the tapes were re-run and listened to group central concepts and themes within the data; simultaneously posing questions and associating statements within the data (Rubin & Rubin, 1995).

The primary aim of the study, which was to explore the concepts of compassion in the care of older people amongst key stakeholders in nursing education: pre-qualifying nursing students, nurse educators and mentors, was revisited. Re-examining the sample population enabled the researcher to have a broader comprehension of the richness of the data in relation to all participants, their circumstances and features. This was fundamental to guarantee integrity and validity of the process.

Re-listening and ultimately reading the transcripts facilitated the process of identifying recurring themes (Table 3.5). Memos were utilised to take note of emergent themes, appreciate the questions that linked the data and note what to further investigate. Labels to code notes were useful when reading transcripts later and preparing the data for analysis (Strauss & Corbin, 1998).

Labelling, sorting and synthesising facilitated the entire process of familiarisation with the available data (Ritchie et al., 2003). Isolated, but exceptionally robust or conflicting views about compassionate care were also noted. Familiarisation through understanding and taking notes made the process of sifting manageable through the hundreds of pages of transcript later in the analysis.

3.8.2b Stage 2: Identifying a thematic framework

The main purpose of this stage was to identify repeated themes and ideas, and relating these to a conceptual framework. The perceptions of the framework approach were depicted from topics introduced from a priori understanding of the study’s aim and a review of the literature. Ultimate reading of the transcripts facilitated additional development of concepts and themes and these were coded in the text.
Key themes such as ‘working practices’ and ‘role model’ were indexed and coded, labelled to the data in the transcripts; for instance, code 2.1 was tagged to any interview reflecting the sub theme ‘communication skills’ and included subcategories such as ‘In the practice areas and at the university’. Tables 3.5 and 3.6 show a preliminary example of the sequential log linking to the kinds of themes developed. This process was replicated for all seven themes, leaving an audit trail.

Every single transcript was scrutinised facilitating the process of comparing and contrasting the text responses. Having satisfied that all data had been considered and there were no new emerging themes, text strings were acknowledged, summarising their meaning (Van Manen, 1998). Interesting sections of text were highlighted, labelled and coded by the researcher. This alternated from only a few words, to sections of sentences or whole paragraphs. Notes were then detailed using the right-hand margin, for instance queries to remember as the analysis progressed. Below are two excerpts of coding. Two of the CM participants spoke; one of how staff attitude influenced the compassionate care that was provided and the other of what compromises compassionate care. The first CM mentioned empathy, having good rapport with the patient and providing holistic care. This was labelled as ‘traits of a compassionate practitioner’. The second mentioned distractions, red tapes, poor skill mix and too much paper work. This was labelled as ‘practices that can compromise compassionate care’. The focus of the underlining data stressed on interesting parts of the data that was felt worth of note.
<table>
<thead>
<tr>
<th>Ind ex</th>
<th>Categories</th>
<th>Sub-categories</th>
<th>Clustering</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Mentoring</td>
<td>supporter, guide, advisor, supervisor and assessor</td>
<td>Positively impact PQNS and the rest of the team and on patient care.</td>
<td>Caring, firm and friendly</td>
</tr>
<tr>
<td></td>
<td>NEs as role models</td>
<td>Personal tutor, link lecturer, mentoring, competence and knowledgeable</td>
<td>Leadership skills and lack of time. Knowledge and understanding. Link lecturer to visit students regularly (once weekly)</td>
<td>Teacher, advisor, role model, mentor, supporter, good mentors (CMs, PQNS, NEs). Liaise with main health care professionals</td>
</tr>
<tr>
<td>1.2</td>
<td>CMs as role models</td>
<td>Mentoring Knowledge and understanding</td>
<td>Staff shortages, poor skill mix and lack of time Leadership skills</td>
<td>To provide, maintain and enhance a good learning environment. To lead by example and to be good mentors (CMs, PQNS, NEs).</td>
</tr>
<tr>
<td>1.3</td>
<td>PQNS as role models</td>
<td>Attitude and behaviour Being motivated Show enthusiasm and willingness to learn</td>
<td>Observational skills</td>
<td>To be ready to learn, to maintain professional values, for example turn up on time for different allocated shifts, maintain a good level of communication.</td>
</tr>
<tr>
<td>2.1</td>
<td>Communication skills</td>
<td>In the practice areas and at the university</td>
<td>Reflection on university's and hospital experiences</td>
<td>The influence of the curriculum, education, information, explanations, teaching, training both from NEs and CMs (CMs, PQNS, NEs)</td>
</tr>
<tr>
<td>2.2</td>
<td>Collaborative working</td>
<td>Team working and communication</td>
<td>Hospitals’ and university culture</td>
<td>Instances of working together with link lecturers CMs, PQNS and the other ward staff. Examples of doctors, physiotherapists, CMs, PQNS and other health care professionals working together. Regular meetings and mentor updates (CMs, PQNS, NEs).</td>
</tr>
</tbody>
</table>
### Table 3.6: Coding of ‘traits of a compassionate practitioner’ and ‘Practices that can compromise compassionate care’

<table>
<thead>
<tr>
<th>Coding</th>
<th>Clinical mentor 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traits of compassionate practitioner</td>
<td>If I had described somebody as being a compassionate nurse, being a compassionate person, I think it is somebody that would be able to empathise with me and be able to see things from my perspective, even if they don't agree with it. But that they would be able to see it and perhaps have some appreciation of what I would be going through or what I would be experiencing, or why I would be making the decisions that I make. Do you understand that? So that you know if I decide to not take a medication and I have my reasons for not taking it or if I had decided I wanted to go home regardless of it being high risks or something like that, that they would be able to appreciate why it was so adamant to me. It might have been because of many reasons for me, but that they would be able to appreciate it, I think that being able to put another person – to be able to get across to them that you can appreciate where they are coming from, even if it is they are going to lose their leg and have to use crutches or be in a wheelchair - fair enough you don't know what it feels like, unless you have lost it, but that you have some sort of an idea.</td>
</tr>
<tr>
<td>Patient's advocate</td>
<td>Patient's advocate</td>
</tr>
<tr>
<td>Notes</td>
<td>Empathy</td>
</tr>
<tr>
<td>Practices that can compromise compassionate care</td>
<td>There is a lot of distractions that will prevent you from doing that compassionate care for instance in the middle of serving meals, a new admission comes in – so you don't know what to do, so I like to see that patient, and I go and receive that patient – that is a factor. Sometimes so many patients that the staffing is so limited so the skill mix is poor, we have four staff nurses taking care of 30 patients you get about 2 nurses staff nurses, 2 HCA, so shortage of staff is also, I know that. I think that will prevent and sometimes relative will come in. You are very busy trying – I know that we have to alleviate the pain of their relatives, but they are sometimes a hindrance with the work that you are doing. When you are treating them in a way they disturb us and want to ask questions, so we have to stop what you are doing – and somewhere someone else needs you badly. Too much paperwork takes your time, your bedside nursing, you cannot interact with your patient – you can't give bedside care, the real care is compromised and this is really sad.</td>
</tr>
<tr>
<td>Interruptions in the delivery of good nursing care</td>
<td>Inadequate staff members</td>
</tr>
<tr>
<td>Distractions</td>
<td>Red tapes</td>
</tr>
</tbody>
</table>
3.8.2c Stage 3: Indexing

Themes and ideas that emerged from the data were labelled. This was drafted by carefully studying each transcript, listing and arranging the themes into clusters in a hierarchical fashion, thus giving a structure to the data collected (Ritchie & Lewis, 2003). Once the index was created and underlined, relevant notes were appended to the theme or sub theme. For instance, ‘staff attitude’, as a higher order category was one of the main themes to emerge from the interviews. Under this higher order category, the subcategory was assigned a descriptive code; for example, ‘traits of compassionate practitioner’ became the sub themes (Table 3.6). All the themes were defined using similar principle and the preliminary data were coded.

After some data was collected (three interviews from three different cohorts) were reviewed by my supervisor, labels were assigned and the meaningfulness of the data discussed. After reading the transcripts twice, and further discussion with the supervisor, a few codes was decided on, each with a brief description. This lead to the preliminary analytical framework. The decision was made that some codes were conceptually linked and consequently should be grouped together. For instance, ‘role model, mentoring, CMs, NEs, link lecturers, personal tutors and PQNSs as role models and attributes of the role models.’ Note that PQNSs do not always recognise role modelling as part of their attributes. The method of filtering, applying, and refining the analytical framework was completed until no new codes emerged. The ultimate framework comprised of twenty-three codes, grouped into seven categories, each briefly describing and explaining their meaning and examples of what concepts or elements might be encapsulated under that code. The example below shows all seven categories, all of which are interlinked from the final analytical framework with essential codes and some explanations.
Table 3.7: Coding

<table>
<thead>
<tr>
<th>Category</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Role model</td>
<td>Mentoring</td>
<td>The benefits of supportive mentors in fostering the development of educational and clinical skills of PQNS.</td>
</tr>
<tr>
<td>NEs as role models</td>
<td></td>
<td>Teacher, advisor, role model, supporter, good mentors (CMs, PQNS, NEs).</td>
</tr>
<tr>
<td>Link lecturers as role models</td>
<td></td>
<td>Teacher, adviser mainly PQNS and CMs, but other health professionals on practice matters (mentors’ updates), advocation, good mentors (CMs, PQNS, NEs).</td>
</tr>
<tr>
<td>Personal tutors as role models</td>
<td></td>
<td>To take a holistic view of the PQNS’ learning experience and achievement.</td>
</tr>
<tr>
<td>CMs as role models</td>
<td></td>
<td>To provide, maintain and enhance a good learning environment. To lead by example and be good mentors (CMs, PQNS and NEs).</td>
</tr>
<tr>
<td>Attributes of role models</td>
<td></td>
<td>To be competent and knowledgeable. Have socialised behaviour such as being passionate and approachable, personal commitment, investment of time.</td>
</tr>
<tr>
<td>PQNS as role models</td>
<td></td>
<td>To be ready to learn, to maintain professional values, for example turn up on time for different allocated shifts, maintain a good level of communication.</td>
</tr>
<tr>
<td>2. Working practices</td>
<td>Communication</td>
<td>The importance of all forms of communication, but mainly listening skills and non-verbal communication with the older patients.</td>
</tr>
<tr>
<td>Spending quality time</td>
<td></td>
<td>Spending time with the patients, giving them undivided attention.</td>
</tr>
<tr>
<td>Collaborative working</td>
<td></td>
<td>Instances of working together with link lecturers CMs, PQNS and the other ward staff. Examples of doctors, physiotherapists, CMs, PQNS and other health care professionals working together. Regular meetings and mentor updates (CMs, PQNS, NEs).</td>
</tr>
<tr>
<td>Curriculum</td>
<td></td>
<td>To explore whether the curriculum was meeting its main aim. The influence of the curriculum, education, information, explanations, teaching, training both from NEs and CMs (CMs, PQNS, NEs).</td>
</tr>
<tr>
<td>Compassion fatigue</td>
<td></td>
<td>Compassion fatigue is similar to burnt out: Working relentlessly without breaks, going home late after shifts. Feeling physically, emotionally and socially tired, which can lead to a decline or resentment to care for patients. CMs or NEs suffering from compassion fatigue can lose the ability to enjoy life both personally or professionally.</td>
</tr>
<tr>
<td>3. Care philosophy</td>
<td>Rapport with patient</td>
<td>Being patients’ advocates get them involved and listen to them (CMs, PQNS, NEs).</td>
</tr>
<tr>
<td>Empathy and dignity</td>
<td></td>
<td>Having the right skill mix to be able to provide quality care and care with compassion (CMs, PQNS, and NEs), whereby the privacy, confidentiality and dignity of patients are maintained.</td>
</tr>
<tr>
<td>4. Clinical leadership</td>
<td>Promoting a compassionate culture</td>
<td>Creating and nurturing a caring and compassionate culture that originate from the leader and maintain by all members of staff.</td>
</tr>
<tr>
<td>Right skill mix</td>
<td></td>
<td>Adequate and proper staff skill mix</td>
</tr>
</tbody>
</table>
5. **Staff attitude**

<table>
<thead>
<tr>
<th>Traits of a compassionate practitioner</th>
<th>One who can empathise, respect patients and maintain dignity (CMs, PQNS, NEs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What can enhance compassionate care?</td>
<td>Evidence based practice, caring attitude</td>
</tr>
<tr>
<td>What can compromise compassionate care?</td>
<td>Poor practices, poor staff attitude</td>
</tr>
</tbody>
</table>

6. **Quality care**

<table>
<thead>
<tr>
<th>Patient focus (holistic care)</th>
<th>The provision of holistic care, a culture that enhances compassionate care (CMs, PQNS, NEs).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student focus</td>
<td>Students’ background and culture are important, but support and education will assist with the provision of a safe and pleasant patient journey.</td>
</tr>
</tbody>
</table>

7. **Nature and nurture**

<table>
<thead>
<tr>
<th>Whether compassion is an inborn or a learnt trait?</th>
<th>Compassion is not only an inborn trait; it can be and should be nurtured.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion is difficult to teach</td>
<td>In HEIs (classrooms) compassion can be very difficult to teach</td>
</tr>
</tbody>
</table>

The final analytical framework to each transcript was applied using the package QSR NVivo version 10. This meant importing all transcripts into NVivo ready for indexing. This in turn also allowed access to the supervisor who could confirm the main themes arising from the data. Basically, and systematically every transcript was carefully read and re-read, emphasising on each significant part of the text and appending a suitable code from the final analytical framework. Below is an extract from the transcript for ‘clinical leadership’ where the part of the text was highlighted as pertinent to the theme ‘promoting a compassionate culture’ in which the participant discussed how to gain respect from students and other health care professionals.

An example is seen in participant 26 (CM 6)

Researcher: Why does enabling compassionate care matter – not only to patients, but to students and your staff as well?

Participant 26 (CM 6): *I think, particularly as a leader, if I am leading that way from the top – if I can do it, they can do it, but if we have identified that they haven't got that in them then that it the ones that we would be concerned about, but it is very important because if we are showing that to our patients, I actually do it to my staff as well, I am*
very passionate about caring for them, for developing them, I will still challenge them because when things aren’t right it is going to make a difference to my patients, so therefore I do challenge it, because actually I hope through that they will respect me because actually I am trying to challenge something that isn’t right, and I always ask the nurses and the team to treat their patients the way they would treat their mum, and if I know, if I challenge them with that, because I have reflected back on my own life, and it is only when I have had my own losses that it made a big difference to me, and that was when I was 15 years into nursing, but it can make a big difference and I have said, do you think the way that you spoke to that person was caring and compassionate, and actually if you just get them to reflect back, and how would you like it if it was your mum in that bed. I think that really makes a difference.

3.8.2d Stage 4: Charting data into the framework matrix

After all the data, had been coded using the analytical framework, it was summarised using verbatim words. As exemplified below, the matrix consisted of one row per participant and one column per code. A different sheet was used for every category. Using verbatim words and inserting them into the cell in the matrix, data from the transcripts for every participant and code were abstracted. NVivo was very helpful in this phase, mainly because it enabled rapid and easy recovery of recorded data for specific codes within every transcript. There was an attempt to maintain a balance between over-condensing the data which could have diluted the richness of the data. On the other hand, under-condensing the data could have been overwhelming and confusing, probably blurring what the themes were referring to (Ritchie & Lewis, 2003). The example below in Table 3.8 is an extract from the ‘role model’ matrix. Underlining indicates verbatim text.
<table>
<thead>
<tr>
<th>Nurse educator role</th>
<th>Role of link lecturer</th>
<th>Role of CMs</th>
<th>Role of PQNS</th>
<th>Role of the personal tutor</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think first and foremost through being a role model. And I think that is really powerful.</td>
<td>I think link lecturers are essential in that respect because when you are out in practice with students it is fresh, it’s there, it’s just happened, and that is a really good point, a really good opportunity at which to get students to talk through what they have just seen or have been part of. So I think at that point you have got an excellent opportunity to allow them to reflect and then perhaps having had that immediacy to then go away and do some more deeper reflection and to perhaps to link that more with some of the theoretical issues around compassion.</td>
<td>I’d like to see much more compassion being role modelled out in practice. We have very compassionate mentors but we always have feedback from students about those who aren’t, and that applies to not just to the patient but to the students. Some of our mentors lack compassion towards their students, and those generally, and this is purely anecdotal, but those mentors who are not terribly well engaged in supporting students are generally not terribly well engaged in compassionate care.</td>
<td>It’s easier to teach student that has a good attitude towards learning, listening, towards the provision of compassionate care – those who are grounded</td>
<td>Your personal tutor really looking after you, your link lecturer knowing where you and knowing what your problems might be. And about us having that communicative on between all the staff about a student if they are in trouble and how we can support them and how we can direct them and having regular conversations with students about how they are getting on, and I think that doing that, being quite proactive in that tells our students that we understand what they want and what they need at an individual level – which is compassionate.</td>
</tr>
</tbody>
</table>
3.8.2e Stage 5: Mapping and interpretation

The last stage concerned mapping the variety and nature of the concepts and recognising links amongst perceptions to explain the findings (Pope & Mays, 2000). This encapsulated the aims of the research and the themes that emerged from the data. Diagrams and tables were used to look into the relationships between the concepts was considered to be helpful (Green, 2004).

Different themes emerged from the data set by rereading the matrix in an attempt to link within and between participant and categories. This was mainly influenced by the original research objectives, but also new ideas emerged inductively from the data. Emerged ideas were explored and fleshed out. Below is an example of a memo that was written about the category ‘staff attitude’, looking at the ‘traits of a compassionate practitioner’, ‘practices that can enhance compassionate care’ and ‘practices that can compromise compassionate care’. The memo was structured using sub-headings, precise codes that it was related to, an insight of the raw data, debate of any unexpected cases, and additional ideas for comparison and consideration. This field note in Table 3.9 was written straight after interviewing a clinical mentor (CM) in the ward office. Patterns within the data were identified using bullet points, bold and italic fonts and underlining. This memo is incorporated into the final theme “staff attitude”.

Table 3.9: Exemplar of field notes: ‘staff attitude’

<table>
<thead>
<tr>
<th>Date: 4\textsuperscript{th} December 2013</th>
<th>Time: 12h15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of observation: office of ward manager in a busy surgical ward in a hospital in London</td>
<td></td>
</tr>
<tr>
<td>Sensory impressions: this was a narrow and long as well as packed office with not only files and books, but with computers, a white board and some dressings. We were interrupted twice by other staff members asking for advice and querying about a patient. The office did not smell of the ward, which smelt of a combination of faeces, urine, vomit, antiseptics and disinfectants. The ward was extremely noisy, from the sound of patients calling for the nurse, the call bell, a group of people, namely nurses and the pharmacist talking. The office door was however soundproof, which help for the interview to take place.</td>
<td></td>
</tr>
<tr>
<td>Personal about recording field notes: as the researcher, I felt quite engrossed in the conversation. I felt that I was talking to someone with whom I can associate with, as the way that she described of dealing with patients was very similar to the way that I have always dealt with patients and will always do. I even felt emotional when the CM told me the extent she went to get a smile of the patient’s and his wife’s faces.</td>
<td></td>
</tr>
<tr>
<td>Specific words, phrases, summaries of conversations, and “insider” language Questions about people, or behaviours, for future investigation</td>
<td></td>
</tr>
<tr>
<td><strong>Ideology versus practicality</strong>: compassionate care is seen as an essential component of nursing care but difficult to achieve. Monetary and practical constraints (e.g. good staff skill mix and time) test the philosophical ideology underpinning this fundamental care concept.</td>
<td></td>
</tr>
<tr>
<td><strong>Codes</strong></td>
<td></td>
</tr>
<tr>
<td>Staff attitude: should be caring, providing holistic care with dignity, confidentiality and respect; use a patient-centred approach.</td>
<td></td>
</tr>
<tr>
<td>Summary of data</td>
<td></td>
</tr>
<tr>
<td><strong>Ideology and holistic care</strong></td>
<td></td>
</tr>
<tr>
<td>Participants view compassionate care as essential, whereby not only the physical and psychological care of the patient is considered, but also the social, spiritual and the care of the family and/or carer. They said that treating the patient with care and dignity is vital, but it is also important to know what is behind the illness, knowing and dealing with the person and the family as a whole is also essential.</td>
<td></td>
</tr>
</tbody>
</table>
An excerpt from the interview is given and key phrases/partial sentences are highlighted as they reflected ideas related to compassion:

I had an example the other day, a couple had been married 50 years, celebrating their golden wedding anniversary and the patient, the man, I won’t say his name, but he had requested from the hospital radio to have this certain music on and his wife had requested it because they were celebrating that day, and unfortunately with a change of shift and then the patient had to be moved to another bed because we had a highly confused patient that was at risk, so we had to put him that bed. The patient was telling the nurses that I just want to listen to this song which was Nimrod and that was the song that they had wanted to celebrate with and unfortunately, he missed the tune being played on the radio. So the next afternoon I met with them and the patient’s wife was very upset, so I actually sat down with both of them and apologised to them obviously, and they explained to me about their golden wedding anniversary, I don’t think the patient had actually explained it adequately to the nurse when they moved at that time – it was 8.00 in the evening so there was a lot going on and it was busy – so he felt that he wasn’t being listened to – he said I just wanted to listen to this radio – they could have put it on – anyway that particular afternoon I sat down and listened to both of them and obviously I apologised and actually I went and got the radio organiser and the man put it on then and there for them. And they actually really appreciated the fact that a) I apologised but it was also unfortunate, because it had been pre-arranged and an emergency happened. But the fact that I actually spent that afternoon listening to them, they so appreciated it and the wife was in tears. But I could see how special that was to them and I think actually just alright we got it wrong the first time, that emergency happened, but we were able then to listen, and I bought in a couple of the nurses and I said do you know this is really special – 50 years is fantastic isn’t it. And we need to listen to what our patients are saying and they wanted to sit and listen together. So, that was lovely.

Participants commented that compassionate care is essential, but with inadequate fundamental resources, this can be difficult to provide and can lead to poor quality care. For example, seen in the excerpt given below:
I think the **busyness of the ward, if you are short of staff and lack of time can prohibit this to happen**. But actually, in the long run, if you take that extra time you are going to have a better outcome experience with the patient, like even my lady this morning. I think you if are well staffed and you have got a good team, stable team; that can enhance it. I am lucky here, maybe that is the leadership model, I don't know. Actually, if you look at areas where leaders are not quite so passionate or dedicated, then actually is that the areas that have the problem in retaining staff and providing that compassionate care. I think if you have got a stable team and the team are actually learning from you, a role model, then you are going to have a better outcome with the patients.

3.8.3 Identification of findings

The emerged themes were the most superordinate ones also related to the aims and objectives of the study. Themes across the five cohorts were similar. Consequently, they were collectively used for the purpose of investigating the themes further. Those quotes or words were utilised that best represented the theme. Brief explanations of all the themes are outlined in Table 3.10 and a diagrammatical representation is given in Figure 3.1.

**Table 3.10: Brief explanations of Themes**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Brief explanations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role model</td>
<td>Inspiring and caring, giving constructive feedback to students. Nurturing students and encouraging. Creating and maintaining a standard that the student will learn from you. Having excellent communication and listening skills.</td>
</tr>
<tr>
<td>Working practices</td>
<td>Instances of working together with link lecturers CMs, PQNSs and the other ward staff. Examples of doctors, physiotherapists, CMs, PQNSs and other health care professionals working together. Knowing and recognising when patients are in pain for instance.</td>
</tr>
<tr>
<td>Care philosophy</td>
<td>The provision of holistic care, a culture that enhances compassionate care. Being patients’ advocates.</td>
</tr>
<tr>
<td>Clinical leadership</td>
<td>Creating and nurturing a caring and compassionate culture that originates from the leader and maintained by all members of staff.</td>
</tr>
<tr>
<td>Staff attitude</td>
<td>One who can empathise, respect patients and maintain dignity.</td>
</tr>
<tr>
<td>Quality care</td>
<td>The provision of a safe and pleasant patient journey</td>
</tr>
<tr>
<td>Nature and nurture</td>
<td>The assumption that compassion is either an inborn and can be learnt.</td>
</tr>
</tbody>
</table>
Figure 3.1: Diagrammatical representation of the themes

- **Care philosophy**
  - Patient rapport
  - Empathy and dignity

- **Role model**
  - Mentoring
  - NEs as role models
  - Link lecturers as role models
  - Personal tutors as role models
  - CMs as role models
  - Attributes of role models
  - PQNS as role models

- **Working practices**
  - Communication skills
  - Spending quality time
  - Collaborative working
  - Curriculum
  - Compassion fatigue

- **Nature and Nurture**
  - Whether compassion is an inborn or a learnt trait?
  - Compassion is difficult to teach

- **Staff attitude**
  - Traits of a compassionate practitioner
  - What can enhance compassionate care?
  - What can compromise compassionate care?

- **Clinical leadership**
  - Promoting a compassionate culture
  - Right skill mix

- **Quality care**
  - Patient focus (Holistic care)
  - Student focus (Nurturing compassionate care)
3.9 Chapter summary

In this chapter the methodology used for this study has been described and justified. The ontological, epistemological and axiological frameworks have been discussed. The primary stance that this study was based on was Crotty’s (1998) suppositions of constructivism. The epistemological position taken was since knowledge is subjective, evolving to reflect multiple realities.

It was decided that ethnography, grounded theory, phenomenology and action research methodologies were not entirely appropriate to base this research exploring compassion, compassionate care in the care of older people from the perspectives of three stakeholders. A generic qualitative research framework was developed, incorporating some of the strategies of the above four key methodological approaches. In the exploration of an appropriate methodology, a pilot study, how access was gained to participants, as well as the ethical issues that relate to the use of interviews were detailed. Having explored the inclusion and exclusion criteria, purposive sample was used to identify and recruit 39 participants, (NEs=8, CMs=8 and PQNs=23). Participants were selected to reflect multiple variations. 6-8 participants from each cohort of students lead to data saturation (Streubert Speziale & Carpenter, 2011). Participants were predominantly accessed by using emails. Semi-structured digitally-taped interviews, recorded diary entries and field notes were used to collect data.

Several ethical considerations were considered to ensure that no threats to the safety of any of the participants and the researcher were compromised (Smith, 1999). Every participant gave both written and verbal consents which were obtained prior to every interview. Confidentiality was maintained by downloading data onto a password-protected laptop, whilst anonymity by using codes to identify every participant.

In order to ensure rigour, transcribed interviews were returned to the stakeholders for feedback and to check for accuracy. A sample of initial transcripts were checked and validated by the academic supervisor. An ice breaking exercise was used to make the participants feel relaxed. Data analysis
took several forms, leading to a rigorous analysis and interpretative comments to
demonstrate the varied and diverse uses of compassion and compassionate
care. All interviews were fully transcribed and Framework Analysis was utilised
because of its rigorous, flexible and analytical matrix-based technique to
systematically manage the data (Ritchie & Spencer, 2004). NVivo version 10
was used in assisting the analysis of data. The process of identifying themes
was facilitated by memos, re-listening and ultimately re-reading the transcripts.
Seven themes and twenty-three sub-themes were identified and coded. The
next chapter looks in more detail at the themes that emerged from the data.
Chapter 4: Findings

This chapter describes all the main themes identified in the preceding chapter. Generic qualitative data analysis revealed seven themes (see figure 3.1). Main themes can be defined as elements of the participants’ accounts describing certain perceptions and/or experiences that is seen by the researcher as relevant to the research question (Braun & Clarke, 2006). The main themes and sub-themes are now fully described below. Note that the order of these themes discussed is in accordance with the importance with which they were described by the participants. As previously discussed verbatim quotes have been selected on the basis that these best illustrate the main theme, or sub-theme being described. Each verbatim quote is written in italics followed by codes. The findings are further analysed and fully discussed with links to contemporary literature in Chapter 5.

4.1 Theme one: role model

All participants (N=39) were asked, “How can compassionate care be nurtured amongst our students?” and all independently replied that compassionate care is best taught through role modelling. Hence, role modelling was viewed as the dominant theme. All CMs and NEs agreed (n=16) that they see themselves as role models, while only 6 PQNSs thought the same. Six participants (n=6), three NEs, one CM and two 1st year PQNSs implied that role modelling can be unclear, even subtle, as it has no standards when compared with more traditional approaches to teaching, such as teaching in a classroom.

“Role models are inspiring and confident” (NE, 1, PQNS, 4, & 5, 1st Year).

All three stakeholders PQNSs, CMs and NEs suggested that leading by example is the essence of role-modelling and it is the process by which they can assist the PQNSs in attaining and maintaining skills and knowledge.

Role modelling is probably the best way to show compassion in nursing (Clinical Mentor, 5, CM5).
Whilst all PQNSs (n=23) suggested that CMs act as role models, only three PQNSs (n=3), one from year one and two from year two, said role modelling is also obvious amongst NEs, two said that every health care worker should be a role model.

*From university, right into practice working with the mentors, I really see where these lecturers were nurses who give you and share their experiences of the care they deliver to the patients out there. They will give you examples whilst teaching (PQNS, 1, 2nd Year).*

Within the role model theme, three initial subcategories emerged which were later further sub-divided from three into seven as follows: (1) Mentoring, (2) NEs as role models, (3) Link lecturers as role models, (4) Personal tutors as role models, (5) CMs as role models, (6) Attributes of the role models, (7) PQNSs as role models.

4.1.1 Mentoring

This sub-theme refers to the role of mentoring as part of being a role model. The two main role models for the PQNSs are the NEs and the CMs. A couple of themes of good mentorship that emerged following a systematic review conducted by Jokelainen et al. (2011) were facilitating students’ learning whilst creating a supportive learning environment and consolidation students’ professionalism – including “empowering development of professional attributes and identity and enhancing attainment of professional competence” (Chandan & Watts, 2012, p.3).

It was perceived by two CMs that PQNSs find it difficult to see themselves as future CMs. There is an argument that all nurses should become mentors (RCN, 2007). On the other hand, the two CMs noted that they need to appreciate that they were once PQNSs and can use their positions to help them. This will enable both parties to form the relationship founded on shared respect (Horsburgh et al., 2001). A few students commented on the invaluable contributions that mentors have in the clinical areas.
You couldn’t be without a mentor; you would be like a lost bunny (PQNS, 4, 2nd Year).

Whilst PQNSs expected a few qualities of their CMs, such as having good interpersonal skills, being approachable and leading the team with enthusiasm (humanistic role models), they also preferred those with dedication and integrity: those who are inspiring.

The good ones are those who go the extra mile. They can even come on their day off to complete the students’ competency (PQNS, 5, 2nd Year).

Six participants (n=6), four PQNSs and two CMs said that some of the dedicated mentors sometimes come before the start of their shifts or stay behind to see to students or even come on their days off to see students, predominantly to complete their paper work.

Sometimes I need to meet a student outside on my own day off – in my own time - just to make sure we are up to date on the paperwork (clinical Mentor, 7, CM7)

On the other hand, a few PQNSs commented that poor mentors lack knowledge, cannot teach and can throw them into improvised circumstances. For instance, leave them with a patient and reappear a long while after.

Other mentors will say right we are working here, you go off and do that, and then you won’t see them for half a shift (PQNS, 4, 2nd Year).

The above is echoed by NEs (n=4) after PQNSs fed back to them. The comment below was expressed by only one participant, a NE.

We have very compassionate mentors but we always have feedback from students about those who aren’t, and that applies to not just to the patient but to the students. Some of our mentors lack compassion towards their students, and those generally, and this is purely anecdotal, but those mentors
who are not terribly well engaged in supporting students are generally not terribly well engaged in compassionate care (NE, 6).

It was suggested and resonated by all PQNSs that the practice areas and their learning environments are as good as the mentors. This implied that good mentors made the practice experiences more enjoyable and beneficial. Some of the features of a conducive learning environment are where there is a good link that works well with the affiliated HEI. For instance, protected and dedicated time is allocated for mentoring, whereby the whole multi-disciplinary team gets involved in the delivery of teaching sessions and the assessment processes. Acceptable and suitable educational resources, such as books and internet access as well as nursing journals and an educational board are available where educational matters and updates are posted (Jarvis & Gibson, 1997). Creating a social environment which fosters compassion for PQNS and each other can translate in promoting compassionate care to patients.

It can be argued that there is no structural framework in many of these clinical areas to facilitate effective mentoring. However, ‘good’ mentoring in some areas is purely due to the selfless attitudes of some CMs (see section 1.4) who sacrifice their own time to assist students. However, ‘bad’ mentoring, can be described by those CMs who fail to show any interest in supporting their students (see above comments from NE, 6).

It's important to allow time for PQNSs – but again because it is so busy and what have you, you learn by doing – it is this sort of rush, rush, but I think it is how we teach them that can make the difference (Clinical Mentor, 6, CM6).

One CM suggested that poor practice seems easier to emulate,

PQNSs pick up very quickly; poor practice even quicker (Clinical Mentor, 4, CM4).

When a CM deals with an elderly patient who might be confused because of dementia, showing an understanding, holding their hand whilst communicating effectively is an example of good practice. This in turn can enthuse the PQNSs to
do the same. Delivering care with compassion, being respectful, simple and clear when communicating as well as giving the patient a chance to express them can make a big difference to role modelling.

4.1.2 Nurse Educators (NEs) as role models

All NEs conveyed a high degree of happiness with their work. At the HEI where the research was carried out, NEs fulfilled many roles, from teaching in the classroom to being personal tutors to facilitating clinical skill sessions. All PQNSs (n=23) stipulated that role modelling is more easily demonstrated in clinical areas, by CMs. In contrast, sixteen NEs (n=8) and CMs (n=8) suggested that role modelling is equally important within both higher education (HE) and in clinical areas, but can be slightly more difficult to demonstrate in HEIs. Some NEs stated that demonstrating compassionate care to every group of twenty students in a skills laboratory or seminar could be challenging.

Students in the skills labs/seminars – to be honest, I don’t think in the skills labs we really have the chance to witness that – working with manikins and each other - because 20 students to 1 lecturer it just doesn’t happen (NE, 5).

Two NEs (n=2) however stated that though not easy, compassion could be demonstrated in the seminars or practical sessions at the university. Reflecting on true and genuine case scenarios, some of which could have been experienced by NEs or those written by professional organisations such as the RCN is a technique that can be utilised to achieve this.

I think sometimes the scenarios can be used, I think sometimes we need to use more everyday scenarios, because most of us are dealing with patients in everyday activities, so I think sometimes it is very easy to pick scenarios maybe if you are thinking about care and compassion at the opposing ends of the scale, so we might have a scenario that we use where we ask the student to unpick where people are behaving in a totally uncompassionate way. And again, by using reflection how could we do this differently, how could we – and I think also it’s about using different scenarios, it’s about taking it from a
management context for example, taking an incident maybe when there was a relative complaining whatever, thinking about how was that managed, how could we have managed it differently, but specifically looking at compassionate care but being realistic too (NE, 6).

One first year student felt that NEs can demonstrate compassion in the delivery of clinical skills sessions. She felt that the NE did her formative assessment in a non-judgemental way. The NE empathised with her whilst actively wanting to help.

*Oh, my god yes. In my first practical session, which was to do with vital signs and measuring, the lady/nurse (I think she was a nurse) who did my evaluation; I felt that she was very compassionate, very understanding and very reassuring. My praise sandwich was very like – very flat bread – you know – but I didn’t feel that I was being judged in any way, I didn’t feel that – I felt like I was being told I can do this – you know what I mean – I was helped and she was very understanding (PQNS, 2, 1st year).*

4.1.3 Personal tutors as role models

One of the other important roles that NEs should fulfil in relation to showing compassion to PQNSs is “personal tutoring”. HEIs in the UK facilitate a personal tutoring programme for PQNSs, as required by the NMC (2004), which assists their learning in academic and practice settings for the duration of their programme (Braine & Parnell, 2011). According to the HEI policy where this research study was conducted, all PQNSs are expected to have a personal tutor, whose primary role is to take a holistic view of the student’s learning experience and achievement, being the first point of contact and a source to refer PQNSs to specialist support, like the students’ union (BNU, 2014).

Compassion is provided in the personal tutor role through adequate support to enable students to develop into independent and creative learners and to foster an aspirational educational culture and producing successful graduates. Whilst most PQNSs in this study viewed this role as being of great value, especially in a crisis, others were unaware of it, perhaps because they did not have to use this service.
Some said that personal tutors helped them to learn “without being pushy”, mainly when they were going through some form of crisis.

Yes, I think if you have any problems or things like that, they are compassionate and they empathise with you and they find a solution for you, that is what I have found from them (PQNS, 7, 1st Year).

Yes, there is a support network from the University that are being provided for people that are having difficulties on the course and having problems, there is the compassion there. For example, one of my classmate’s ex-partner, the father of her child died and then she was really struggling and the University, the personal tutor was really supportive of her with that and made sure that she had extra time to do work (PQNS, 5, 3rd Year).

According to the guidelines of the university where this research was conducted, all students are assigned a personal tutor who remains in this role until they complete the course.

Just last week, a student came into me last Friday and said that they had seen practice which amounted to verbal and physical abuse and so I demonstrated compassion toward the student in the way that I dealt with her, cleared my diary, gave her time and reassured her and then how I actually dealt with the scenario in terms of the processes that I then followed, so there is that way we show compassion (NE2).

A few PQNSs did not seem to think highly of this role as they perceived the personal tutor mainly for students with personal problems.

I would say no – in the university I don’t think that we are being listened to – we are being dictated to- there is a lot of power within the university (PQNS, 3, 1st Year).

When the above statement was explored, the first year PQNS further stated that she was sometimes made to feel like a child because she was being dictated to as opposed to being spoken to. She gave the example that if somebody came late,
they were just put to shame in front of the group of students, without being given the opportunity to justify the lateness. The NE failed to understand, empathise and demonstrate compassion to the PQNS.

4.1.4 Link lecturers as role models

Four hours weekly are allocated for link lecturers’ visits for the HEI in question, although this is not a nationally recognised practice. There is an expectation for the link lecturers to support the learning environment, mainly the PQNSs, CMs and other staff by the weekly visits. This can include talking to PQNSs, whilst helping with identifying learning opportunities, helping them with the practice documentation, delivering teaching sessions on skills as well as updating the mentors. However, the geographical separation of the university and clinical areas, which can be scattered, may make this process rather difficult to achieve. Consequently, travelling to clinical areas has increased, making a conflicting demand on time. It is however worth pointing out that link lecturers are meant to visit clinical areas every week and, even though this happens, it can be difficult at times to meet with every student every week, mainly because of shift patterns.

The link tutoring, I think is really that valuable – I think it is valuable to have but it’s not as good a role as it could be because you don’t see a tutor often enough. I have had one who was really good; she would be there every time. (PQNS, 4, 2nd Year).

Whilst the link lecturer role has many challenges, such as travelling time, they tend to provide support to CMs with the supervision and assessment of PQNSs. The role is rather pertinent when supporting mentors with failing students. Meetings and action plans will need to be instigated and completed promptly and on time. Seeing both the CMs and the PQNSs together can be an excellent opportunity to clear misunderstandings and allow time for reflection, whilst creating a good rapport with both parties.

I think link lecturers are essential in that respect because when you are out in practice with students it is fresh, it’s there, it’s just happened, and that is a
really good point, a really good opportunity at which to get students to talk through what they have just seen or have been part of. So, I think at that point you have got an excellent opportunity to allow them to reflect and then perhaps having had that immediacy to then go away and do some more deeper reflection and perhaps to link that more with some of the theoretical issues around compassion (NE6).

All NEs and most CMs as well as PQNSs valued the link lecturer role, stating how the joint working between the NEs and CMs enriched and benefitted PQNSs’ clinical experiences. CMs stated that mentorship updates, which consisted of providing the most up to date information about the curriculum and practice as well as other teaching sessions were regularly facilitated by link lecturers. The weekly visits make the link lecturer accessible to answer any question concerning the competency handbook, which basically is a record of the students’ skills.

My last placement was a nightmare to the point where I couldn’t tolerate it for much long. The link lecturer was very good, she took us away for an hour and she taught us stuff and everything else (PQNS, 4, 3rd Year).

However, some PQNSs complained that they did not see their link lecturer weekly, others rarely throughout their entire placements.

I have been on another placement when I have seen the link lecturer for 10 minutes for the whole placement. So, if it is done right, it works very well (PQN, 4, 2nd Year).

The inconsistency in the level of accessibility of link lecturers is problematic as some students will have more support than others. This can lead to link lecturers missing the opportunity to see students, assess and de-escalate situations, such as those relating to lack of student’s support. For instance, the link lecturer can intervene if PQNSs are not given the opportunity to work with their CMs or are not provided with learning opportunities to enhance their nursing skills.
4.1.5 Attributes of role models

Many CMs suggested that after obtaining patient consent, teaching most of the clinical skills such as dressing a wound, attending to the fundamental nursing skills such as washing a patient are beneficial through role modelling. Other skills such as report handovers, ward rounds, patient admissions can also be undertaken. These skills need to be supervised and carried out in a compassionate way by competent mentors. Whilst there is a difference between direct and minimal supervision, it is recommended that PQNSs are always supervised when giving direct care in clinical practice (NMC, 2010b). Direct supervision is more appropriate to newly recruited PQNSs, who have never been exposed to nursing or that type of clinical area or “…where this is within the requirements for safeguarding and protecting the public…” (NMC, 2010b, p.20). Minimal supervision is more relevant for more experienced PQNSs, who can work more independently, for example, by managing the care of a well-defined group of patients. However, CMs should be easily contactable, especially to provide the level of support needed to ensure public protection. PQNSs must prove that they can operate under direct supervision before they can practice under indirect or minimal supervision.

To be a mentor in care of the elderly ward, although it is basic you get more time with the student, but if you are a mentor in A&E you don’t have much time – so really, it’s a big impact to the student because mostly students are left on their own without guidance, without supervision because you don’t have the time … to supervise them. The mentor needs to make time for the student as well (Clinical Mentor, 9, CM9).

When the above statement was further explored, the CM said that whilst the care of older people can be physically demanding and ‘heavy’, her ward seemed less busy than an A&E unit. However, it was identified that in the care of older people wards seldom benefit from a favourable skill mix (RCN 2010a) (see sections 1.3, 1.4.1 and 4.4.2). At the same time, wards that care for the older people normally find it more difficult to recruit and retain staff nurses (Ball and Pike, 2009) (see
These can have added pressures on other staff members as well as PQNS. Routine and fundamental nursing tasks can take longer to complete.

All participants (N=39) were asked “what does a compassionate practitioner mean to you”? Six of the NEs (n=6), four of the CMs (n=4) and six of the PQNSs (n=6) said that they expected a compassionate practitioner to be someone who demonstrated both clinical and teaching competence and had the ability to impart information and knowledge to others.

*An emotional and psychological aspect and that then entwines with being a competent practitioner (NE, 3).*

It can be suggested that practising with a good level of competence will assist NEs and CMs to adequately fulfil their roles. Building therapeutic relationships through safe, effective communication with stakeholders, including PQNSs and other health care professionals seems vital (see sections 2.2.1 and 2.3). The ability to work both autonomously and in teams whilst providing and promoting safe, person-centred, evidence-based practice seems commendable. To have an in-depth understanding of the speciality of nursing that they work in or teach and can impart that knowledge is almost intrinsic. Whilst some CMs said that they would not call themselves experts, they however stated that they had a wealth of experience in some fields of nursing that they could offer PQNSs a range of pertinent skills that would enhance the quality of their training.

*I wouldn’t call myself an expert on it either, but when you work with it for many years, I have worked for over 20 years with older people in mental health settings, I think I should have some experience and something to offer (NE, 5).*

Many PQNSs stated that they enjoyed working with practitioners who were knowledgeable, irrespective of whether they were NEs or CMs and they perceived that intelligent practitioners with up-to-date knowledge and skills provided compassionate and individualised care (see section 2.5.1). This view was also shared by NEs and CMs.
To be confident, caring, and knowledgeable and competent (PQNS, 7, 3rd year).

Two other NEs (n=2) stated that compassion is a type of socialised behaviour, that is people can display a kind behaviour, but how that kindness is developed, is through socialisation and through observation. The socialisation skills can be developed by being part of the team in which one can see, observe and analyse the CMs demonstrate clinical skills in practice. However, if the NEs want to be role models for compassionate behaviour they should establish the PQNS/NEs relationship by making use of stories, scenarios and anecdotes and then communicating with PQNSs can be challenging at times. All PQNSs (n=23) perceived that compassionate behaviours were more apparent in CMs than in NEs. NEs (n=3) on the other hand agreed that compassionate behaviours were easier to be displayed by CMs.

It’s role modelling, and I think it is not necessarily what we just do here in the University, a lot of it is about what is going on in practice as well (NE, 1).

Two CMs (n=2) and two NE (n=2) even suggested that having the passion and drive to look after patients and teach PQNSs were the reasons they were in their respective professions.

I think it is the passion that is within me that drives me because I have had personal experiences of it happening to someone in my family. And so that drives me even further to make sure that it does happen on my ward. I like to teach (CM, 6)

All CMs (n=8) implied that nurses should know their patients well enough to be able to effectively look after those who were old, sometimes confused or unable to verbally communicate.

Well it’s quite simple because a patient needs your help, for instance if a patient is in pain – well verbally, communication comes in so many ways – some patients are unconscious, but as a nurse you should know if they are in
pain by observing their movement or facial expression. As a nurse, you should know if that patient is in pain (Clinical Mentor 4, CM4).

4.1.6 PQNSs as role models

CMs stated committed and interested students would also influence the CM/PQNS relationship. PQNSs should appreciate that they have the principal role in making the most of their learning experiences during clinical placements, by taking responsibility of their own education through interaction, being good team players (RCN, 2009). CMs (n=8) expected students to be prepared prior to commencing their practice placements. CMs anticipated PQNSs to read up about the speciality of the wards, contact the ward staff, possibly through an informal visit or at least a phone call prior to commencing the practice placement. CMs suggested that having some ideas as to what to expect of the ward and its speciality, helped in identifying learning opportunities. The above was echoed by all NEs (n=8).

I say carry on with your work, but I am here for you to help you and support you, but you have to take some responsibility by yourself. I am not going to be holding your hands and following you. I explain to you that these are my expectations. Follow that, but if you are stuck with that procedure then by all means come back to me, I am quite happy to do that (CM, 4).

Four participants (n=4), two NEs and two CMs mentioned that it would be ideal if every staff member embraces role modelling as one of their responsibilities. One CM went further by suggesting that some PQNs should role model to their fellow PQNS. For example, in the case of PQNSs, second year PQNSs can mentor first and third year PQNSs can mentor second. This vitally important trait can be cultured from the beginning of the course and maintained throughout.

In summary, it was argued that role models with good interpersonal skills, demonstrating care with compassion can rejuvenate staff, whilst creating a culture of engagement and understanding and improve others’ ability to be compassionate (Chellel et al., 2013 & RCN, 2007). Role modelling is perceived to be vitally important and powerful in facilitating learning with compassion. This is in line with
literature that addresses the importance of role modelling in the provision of compassionate care (Armstrong, 2008., Chow & Suen, 2001., Davies, 1993., Gray & Smith, 2000., Jokelainen et al., 2011., McGurk, 2008., Price & Price, 2009 & Wright & Carrese, 2002). Using the interpretive epistemology (see section 3.2), the CMs and the NEs might not understand the constraints (such as childcare issues and travel commitments) that PQNSs have. At the same time, the PQNSs might not have explained their ‘issues’ (see section 4.1.3). However, one can argue that due to a target driven culture (Bradshaw, 2009) and managerialist approach to care (see section 2.5.1), CMs as well as NEs might not have the time to listen to the PQNSs concerns. Demonstrating compassion to one another would involve working together to identify the problems, show empathy and act to alleviate PQNSs’ concerns (figure 2.2).

In order to explore compassion and implications for contemporary nursing, the Point of Care programme at The King’s Fund (Firth-Cozens & Cornwell, 2009) and Straighair (2012a) have identified role modelling as an important way of demonstrating compassionate care to PQNs and other staff members. Research evidence substantiates that qualities such as compassion, integrity and competence in role models are pertinent to the patients (Paice et al., 2002). This means that patients will have the benefit of skilled and professional staff who display good attitude to care. This resonates with findings from the systematic review carried out by Passi et al. (2013), emphasising the prominence of role modelling as an important process for the professional development of learners. They highlight that role modelling with competence happens when delivery of skills (clinical and teaching) are articulated in a personalised and humanistic fashion, encapsulating traits such as empathy and compassion (see section 2.5).

4.2 Theme two: work practices

This section refers to how some of the work practices are significant in facilitating, maintaining and enhancing compassionate care both in the clinical and educational settings. Within this main theme, five subthemes emerged: (1) Nursing communication skills, (2) Spending quality time with patients, (3) Collaborative working (4) Curriculum and (5) Compassion fatigue. These aspects of work
practice were considered to ultimately impact on compassionate care of the
patients being cared for and can be further broken down into a number of sub-
themes.

4.2.1 Nursing communication skills

All participants (N=39) were asked “when you hear the word “compassion,” what
do you think of?” and there was agreement that someone who communicates well
with everyone, from the patients to any member of the multi-professional team.
Real dialogue (Frank, 2004) or real communication (Cummings, 2012), was seen
as a vital part of compassionate care, indicating that there was a level of
understanding and connectedness amongst team members (see section 2.4).
Nineteen participants, six NEs (n=6), eight CMs (n=8) and five PQNSs (n=5)
stated that information giving to patients could be a good start to the patient/nurse
relationship. They said that actively listening, considering any gestures, especially
if patients fail to communicate properly and then offering them the chance to voice
their feelings and concerns were important to that relationship.

A lot of time as practitioners, we tend to think that we know best. If I could put
it crudely, the patient should take in what we give them, because we think we
know best, we talk down to people, we don’t inform them of what is
happening, people wait unnecessarily, and it’s one of the worst things about
being a patient if you don’t tell them what is happening. And if you are looking
after somebody, you are not communicating, you are not telling them anything
– people will not respect you – they will say I do not want to know this person.
Just sitting down with somebody – even if you telling them that you have not
been able to do this yet, but as soon as I can I will do it, keep people in touch
(NE, 4).

4.2.2 Spending quality time

In nursing, time is care and time is money (Huber & Oermann, 2000). Whilst
insufficient nursing time leads to poor quality care, providing an excess can
contribute to the high cost of care (Aiken, 2008). Arguably, the “right” amount of
nursing time for individual patients can be difficult to ascertain. Some of the participants also commented on the importance of providing undivided attention to the older patients, mainly if they are confused or unable to speak. They argued that compassionate care can be offered by spending quality time with patients.

*I know non-verbal communication is really, really important. I wouldn’t expect them (nurses) to be talking to me and yet I would be very aware that they weren’t actually listening to me. So, it’s all about having very good listening skills. And I would expect to have their undivided attention – I am not necessarily expecting someone to be very touchy-feely towards me in the sense of showing compassion (NE, 5).*

4.2.3 Collaborative working

Collaborative working is central to delivering quality care (Leathard, 2003). Five PQNSs commented on how they gained a better understanding of compassionate care whilst working in a team. They saw the way that the healthcare team functioned; how the mentor communicated with the patients, their families, colleagues and students was beneficial to everybody. They saw how different health care professionals worked together with the aim of providing the best possible care to the patient. It is worth noting that compassionate care provision does not fall under the jurisdictions of nurses. Whilst patients receive care from the team of health care professions, PQNSs also learn from that team.

*The way the surgeon, the oncology doctor, the neurologist along with the practice nurse dealt with the patient was very compassionate. The patient was diagnosed with a grade 4 tumour and thus would not live for long. The team took time to explain, giving information to the patient about her condition and how they would help. As the patient seemed overwhelmed with too much to take, the practice nurse explained that she was the back up for what they missed at that point in time (PQNS, 2, 2nd year).*
4.2.4 Curriculum

The Francis Report (2013) gave accounts of the most distressing personal stories from patients and patients’ families in response to the despicable level of care they received at the Mid-Staffordshire Foundation Trust. Patients were failed of the most fundamental care, from nutrition to being left in their own excrement. Patients were denied of respect, privacy and dignity and they were left in dirty conditions. All participants (N=39) were asked, “How do you see the teaching of compassionate care changing following the problems at Mid-Staffordshire revealed in the Francis report?” Only nine participants, three NEs (n=3), two CMs (n=2) and four PQNSs (n=4) suggested that care of the older people focusing on dementia care should be incorporated in the curriculum. One of the NEs even suggested the way that the curriculum was formulated, seemed to leave little room to incorporate care of the older people, where the focus could be on the aging process and the diseases that are inherently predominant amongst this group.

*If you look at the elderly care and where it fits the curriculum – there does not seem to be any room for the elderly, is this sending the wrong message? (NE, 4)*

One first year student went further by saying that prior to commencing the nursing course, students should work for a year in the care of older people, where they can learn how to provide fundamental care. She rationalised by saying that, this is ‘real nursing’ and if these students would still like to pursue nursing as a career afterwards, there would be a greater likelihood that they would stay in the nursing profession for long. This is in line with recommendation 187 of the Francis Report (Francis, 2013) (see section 1.6).

*See, I am in two minds because there was talk by the government of making student nurses do one year HCA work or one year of doing some sort of care work before they became nurses. I think that is quite a good idea. Because after a year of working with different types of people, you will know if you can, if you are up to the standard of moving on. You have children coming out of school with ‘O’ levels, but do they actually know what they need to be doing?*
They should be spending a year, doing care work or something, to get their experience before they come on this course and say yeah I can do it. I went to college with a couple of girls and they were just like left school and they would say we are going to be nurses, and I used to think yeah okay! You are going to be in for a good shock. And they would ask me, oh, do you have to wash them, give them personal care and take them to the toilet? And I am like, don’t worry girl, go for it. I don’t think they have got the life experience, and I think that is a problem. So, I think they do need to have one-year experience and see how they go from there (PQNS, 1, year 1).

One second year PQNS said that without any experience in healthcare prior to the course, students lack the confidence to speak with patients, meet with the mentor and even wash a patient. As a student who never worked in healthcare prior to beginning her course, she described herself as “a wreck” for the first couple of days of her placement in her first year. A third year PQNS said that what mattered the most prior to starting on the course was having basic nursing skills or having some experience of caring for older people.

*I think every student nurse should have a least a year of HCA work before they are even considered on the course (PQNS, 4, 3rd year).*

The rest of the participants stated that the curriculum was meeting its aims. They suggested that it was what they were being taught at the university prepared them for what they might see in practice. They said that compassion is difficult to teach as patients “aren’t, don’t go by the book or wards don’t go by the book at all.” Two PQNSs (n=2) articulated that the university equipped them with the right knowledge.

*I think the University equip us with the knowledge we need to do and what we should be like, but I think in practice it’s not always the case (PQNS, 3, year 3).*

Three of the NEs (n=3) suggested that the curriculum overprescribes on acute care and does not give enough credence to care of the older people. As such one
of them then stipulated that patterns of behaviour are simply around tasks, on how
to prioritise care and less about holistic care. Whilst appreciating the nature of the
department, he explored an example from an accident and emergency department
(A&E), where the focus was mainly on saving life.

So, it can be sometimes people for example may go into an A&E department –
that is an area that I have some experience with – and you don’t see
compassion – what you see is prioritisation, treatment options being done
quietly and effectively and the client is then moved on, so its boom, boom,
boom. However, if you were to go to a palliative care unit, you might actually
see evidence of compassion there quite obvious (NE, 8).

Three NEs (n=3) suggested that the curriculum will have to change to
accommodate the NMC (2010) requirements which states that nurses must have
adequate skills to meet the needs of older people and people with dementia. They
said that whilst compassion is mentioned in most modules, no specific learning
outcome addresses this concept.

Well I think the curriculum – it will have to change – I think in the sense of
thinking it is difficult to separate the two, elderly and compassion – when they
go hand in hand as the saying is said (NE, 5).

All twenty-three PQNSs (n=23) were asked “how has the curriculum equipped you
so far to appreciate and implement compassionate care?” Four third year PQNSs
(n=4) stated that they only remember being taught about compassionate care in
their first year. Two second year PQNSs could not appreciate how the curriculum,
which they described as being “too academic” assisted them to adequately provide
the compassionate care that is required by every nurse. They viewed “too
academic” as being too many theoretical/summative assessments, which are
obstructive for teaching compassion (see sections 4.3.1 & 4.7.2). They suggested
that they would prefer formative practical assessments, whereby compassion can
be demonstrated and assessed (like being assessed when taking someone’s vital
signs (see first year PQNS citation in section 4.1.2).
I think we did a little bit on the subject in our first year – I don’t remember so much in the second year (PQNS, 2, 3rd year).

I don’t think it really has equipped me at all. Because it would seem to be academics, but having no nursing, healthcare experience, I was quite worried about going into practice (PQNS, 3, 2nd year).

Four NEs (n=4) stated that compassionate care is a nebulous term which tends to be hidden in the curriculum and it was up to the NEs to tease these out in seminars and skills sessions.

I think as an educator we have to, not un-hide it, we have to open it up to our students, and for me where I bring compassion in is in maybe examples of our years in practice (NE, 5).

They added that the meanings and applications of compassionate care could be better discussed with students when discussing other elements of nursing care and work practices such as dignity, responsibility, privacy, patient centred care, and team working.

We should be bringing it in along the concepts of like dignity and things like that, into every aspect of nursing care that we talk about. And I am sure for most of us we probably do, I hope we do that. It’s not something we necessarily think about but if you look on the curriculum and you look on individual module plans, you would find it in the underlying values, but you don’t actually find it, oh this week we are going to give a lecture on care and compassion. Maybe we should do (NE, 5).

Whilst agreeing with above statements, another NE stated that she saw compassionate care as being incorporated as a thread throughout every module and the person facilitating this process would be the NE. Compassionate care should be enshrined in one of the learning outcomes, making sure that it is consistently covered.
I would rather see it weaved throughout every module, but the vehicle for that weave is the person in the classroom teaching demonstrating compassion towards the students, which they pick up really quickly, but also, we can then apply it to practice, and it is the application with compassion that I think is important. So, I wouldn’t go with saying that we need a completely different curriculum with a module on compassion, I would rather just see it throughout, our role modelling, our demonstration in compassion and caring and the relationship with academia and practice very closely weaved together so that we are constantly going backwards and forwards weaving it through (NE,2).

Four NEs (n=4) suggested that reflective practice incorporated in the curriculum assisted students in appreciating compassionate care. They could reflect and write about incidences that happened in the practice area.

I suppose a lot of what you read in reflective assignments, probably if you mark 20 you would probably I would say have 3 or 4 where you feel they have been behaving in a compassionate way (NE, 6).

4.2.5 Compassion fatigue (CF)

Similar to burn out, compassion fatigue (CF) is associated with emotional and physical tiredness that health care workers can develop over a period of time (Figley, 1995) (see section 1.5.4). CF can affect the nurse holistically. Nurses can feel physically, emotionally, spiritually and socially drained that they can start revealing signs of resentment to care for patients or colleagues (McHolm, 2006). Nurses suffering from CF can lose the ability to enjoy life both personally or professionally. Three CMs stated that due to shortage of staff and relentlessly having to mentor students, they either have to stay behind or turn up on their days off to complete students’ paper work.

Yes, we need more time – they say we have one-hour protective time, but that never happens – so sometimes I need to meet a student outside on my own day off – in my own time - just to make sure we are up to date on the paperwork – it’s just crazy and you don’t want the students to stay a bit longer
after working because they have also got their own life – you have your own life and children waiting for you (CM, 7).

When asked “how do you see the teaching of compassionate care changing following the problems at Mid-Staffordshire foundation Trust revealed in the Francis Report?”, two NEs (n=2) and two PQNSs (n=2) said that what happened in Mid-Staffordshire was not only due to a loss of compassion. They continued, stating that it was due to professionals being “burnt out”.

If you are going into a work situation day in and day out and you have little or no staff, then sooner or later, you will get to a point, and it will be a survival mechanism, where you will do what you can, it won’t be the best that you can do, it will simply be what you can do to survive. I think that Mid Staffs, like so many other hospitals that we haven’t discovered yet was a crisis of staffing over a significant period of time and that impacted on care (NE, 8)

4.3 Theme three: care philosophy

This section explores the significance of care philosophy in instilling and culturing compassionate care. This main theme developed when participants answered the following two questions “how will you promote empathy and dignity and when you hear the word “compassion,” what do you think of?” Within the care philosophy theme, two subthemes emerged, (1) Patient rapport (2) Empathy and dignity. Care philosophy as encapsulated by the participants (CMs, PQNSs and NEs) was about structure of care and values to assist patients making choices and about respecting and honouring those decisions.

Giving the patient the choice, asking them what do they want, what is your expectation from this assessment and let them speak – they don’t have to be put under pressure – you can make up your mind and come (CM, 3).

Twenty-one participants (n=21), sixteen PQNSs (n=16), three CMs (n=3) and two NEs (n=2) suggested that the care philosophy of the ward should be about empowering patients and promote independence as much as possible.
It is about working with a patient, working with their strengths and encouraging them to do things for themselves – but I think it is also important that our students need to be to know about what a patient can expect from us – what we can – what is it we are not able to do, what other people can pick up, but the patient needs to be informed (NE, 4).

You can treat a person’s illness in hospital and they can go home, it’s making sure that the care is continuing and empowering them as much as possible. For me it’s empowering them as much as possible to do it themselves because I can sit there and I can feed them, but it is better if they can feed themselves (PQNS, 5, 3rd year).

4.3.1 Patient rapport

Participants said that at times, communicating or establishing a rapport with some of the older patients was very challenging. Twenty-two participants (n=22), twelve PQNSs (n=12), seven CMs (n=7) and three NEs (n=3) suggested that one of the ways to build a good rapport is early into the relationship. Two CMs (n=2) and two PQNSs (n=2) said that patient rapport was about taking the time to know the patients and doing small things for them (see section 2.7).

I always look forward to an opportunity at the weekends when I can do a lot for my older patients, because I like talking to them, I like cutting their nails sometimes, and compassionate about cleanliness, make sure their hair is tied or washed – things like that nurses forget – that they are so up to clinical skills that they lack the personal care of the patient, which I believe is really important for them (CM, 7).

Feeling connected was deemed as of utmost importance by two CMs (n=2) and two NEs (n=2) in order to build that rapport. They argued that being emotionally present would “help you make a genuine engagement”.

It is all about having that passion and the emotional relationships with your patients really (NE, 1).
Two third year PQNSs (n=2) stated that every patient is unique and understanding their stories is very important.

There is more behind them – so every individual has their own little story – so you respect that story, everyone is unique (PQNS, 8, 3rd year).

However, paying attention to older patients whilst doing little things, like washing their hair, whilst communicating and attempting to know what is behind the illness require quality time (see section 4.2.2). This is arguably difficult to offer to patients in a target driven culture (see section 2.5.1).

4.3.2 Empathy and dignity

Empathy is the aptitude to recognise the feelings of a patient and to convey those feelings to someone else (Stein-Parbury, 2005), whereas dignity is defined as valuing and respecting patients whilst treating them as being of worth (RCN, 2008). All thirty-nine participants (N=39) were asked as to how they would promote empathy and dignity and twenty-five (n=25) stated that empathy was about understanding the patient’s views and dignity was associated with being respectful. All participants said that maintaining empathy and dignity are part and parcel of promoting compassionate care (see section 2.4.3).

Well, empathy, I would just make sure that people knew that I was always there as a shoulder, someone to talk to, someone that will sit there and listen or someone that is going to give advice if someone needs it. Dignity, treat them as someone you would want to be treated yourself. Pretty simple really, if you don’t want to be treated in one way, then don’t treat someone else like that (PQNS, 6, 2nd year).

Twenty participants (n=20) associated dignity with the physical environment, such as drawing the curtains, knocking on toilet doors prior entering to maintain privacy and confidentiality.

I will make sure that the screen is pulled around her when I am going to do any of her personal care (PQNS, 1, 2nd year).
Nineteen participants (n=19) referred to dignity as being the way that staff members communicated, for instance the tone and loudness of the voice especially when passing confidential information. They also mentioned getting the patients involved in their care, never talking over them and ways of maintaining dignity whilst communicating with unconscious patients.

For instance, if a patient is in pain – well verbally, communication comes in so many ways – some patients are unconscious, but as a nurse you should know if they are in pain by observing their movement or facial expression. As a nurse, you should know if that patient is in pain (CM, 2).

4.4 Theme Four: clinical leadership

This section examines how clinical leaders play important roles in instilling, facilitating, maintaining and enhancing compassionate care within the whole work environment. This main theme emerged when participants answered the following two questions 1) “What does a compassionate practitioner mean to you? 2) Can you describe any factors that may have prevented or contributed towards compassionate care (behaviour) in the delivery of patient care?” Within the clinical leadership theme, two subthemes emerged, encompassing (1) Compassionate culture and (2) Right skill mix. One NE said that that most nurses are compassionate, but if they are put in an extreme environment, where there is a poor staffing level and high acuity of patients, they are not listened to by management, poor leaders who do not show compassion towards staff members, then it is more challenging to demonstrate compassionate care. She also said that the clinical leader is one of the strongest indicators of how staff members would behave. This is line with Francis report (2013), discussed in section 1.4.1.

If the ward manager is compassionate and caring, I think that is one of the strongest indicators of how the staff are going to behave – that leader of that ward – at ward manager level, I am not talking about higher or middle layers of management – I think if that person is compassionate then that has a tremendous effect on the ward (NE, 2).
As in other themes, sub-themes can be identified.

4.4.1 Compassionate culture

Organisational culture can be defined as the way that things are done around a particular place (Schein, 1985). This was explained to all participants during the interview. Across the three groups participants discussed organisational culture from the macro-level (NHS perspective) and that of the micro-level (the ward culture). Only two NEs explored organisational culture from the NHS perspective. They commented on the period of change within the NHS, reconfiguration of service and staff members feeling uncertain about their future and that of the organisation. They referred to the substantial amount of pressure on the wards and the turnover of patients. They however said that they should work together to demonstrate and promote compassionate care.

_The work is enormous and there is no let-up (NE, 6)._ 

The rest of the participants mainly focussed on the ward environment and its influence on the caring culture. Four participants (n=4) suggested the care patients received was influenced by the way that the ward functioned, the way that compassionate care was delivered and by the people (mentors, senior nurses and ward managers) who provided the care. They commented on how leading by good example can make other members of staff realise of the importance of compassionate care. They said that some of the main attributes these nurses revealed were commitment towards patients and proper engagement and spending time with patients.

Yes, on my first placement, we had a very young lady who had been diagnosed with leukaemia. She had two children and obviously when you are diagnosed with something like that, it completely rocks your world over. She was more worried about her kids. I noticed that the charge nurse of that ward, above all nurses went into her room and sat down with her and let her ramble on for about a good hour, of what she was worried about, and things like that, and then he was able to sort out special times for the kids to come in and see
her and things like that – he really took on board what she had to say – but it wasn’t just for her, he did that for every patient on his ward and I found that, above all the wards that I worked on, his ward was the best one and all the patients just seemed so content on the ward just to have him in charge (PQNS, 8, 3rd year).

4.4.2 Right skill mix

According to participants, an adequate skill mix would be making sure that staffing levels (nurse-to-patient ratio), including both qualified nurses and health care assistants were appropriate to provide patient safety (see section 1.4.1). Five PQNSs (n=5) and three NEs (n=3) stipulated that an appropriate skill mix would allow compassionate care to take place.

Leadership, appropriate skill mix, appropriate environment, training and education – I just mean that when nurses feel comfortable and competent caring for the patients – I think then they are less focussed on the hard core skills and they can focus more on those softer skills of compassion because when a nurse, from my experience, is very worried – technologically worried, they focus and they can demonstrate less – it doesn’t mean they are not compassionate – it just means they may just demonstrate less compassion. So, I think leadership, appropriate environment, competence, support, staffing ratios that are appropriate to acuity of patients, and appropriate shift patterns as well. When people are exhausted, there is no doubt, they can be more frazzled and demonstrate less compassion (NE, 2).

One NE disagreed with the above assertion stating skill mix does not always impact on compassionate care, saying that the care given depends very much on the nurse.

You know you could have what you might consider to be a really poor skill mix, but if it is made up of people who are very good communicators, do see compassion as really important – it can be great. You can have a skill mix of very highly qualified nurses who don’t see compassion as important, who are
very task orientated, so it is not skill mix – no – it’s individuals, and it comes down to them (NE, 5).

Ten PQNSs (n=10) argued that most of the fundamental nursing care is delivered by newly qualified nurses, health care assistants (HCAs) and PQNSs. Whilst no one can deny that compassionate care depends on the nurse’s ability to understand the patient and act appropriately, it can also be argued that compassionate care will be compromised if there is a poor skill mix. This can act as a barrier to care delivery, limit time spent per patient, increase the workload and exhaust the nurses on duty.

4.5 Theme five: staff attitude

Staff attitude refers to the way that participants perceived that staff members reacted when seeing, communicating and caring for patients. In total three subcategories emerged which included; (1) Traits of compassionate practitioners, (2) Practices that can enhance compassionate care and (3) Practices that can compromise compassionate care. The main questions that addressed this particular theme were:

“What does a compassionate practitioner mean?”
“Can you describe any factors that may have prevented or contributed towards compassionate care (behaviour) in the delivery of patient care?”
“How do you see the teaching of compassionate care changing following the problems at Mid-Staffordshire revealed in the Francis report?”

4.5.1 Traits of compassionate practitioners

Various words and descriptors were used to qualify the practitioners who participants perceived to be compassionate. Some of which were caring, maintaining privacy and dignity, promoting confidentiality, someone who understands and empathises, someone who listens and communicates well with the sick and vulnerable and most importantly holistic care.
It means treating every patient, every individual, how I would like to be treated, so with that care and compassion being kind, understanding, have that listening ear, actually taking on board all the patients’ needs as well as what they have come into hospital with – so looking at holistic care I think (CM, 5).

Amongst the PQNSs, mostly first years’ (n=6) explored the importance of caring and having the willingness to help patients as main ingredients to providing compassionate care.

It’s someone who provides care and thinks of how that will affect the patient. Someone who is always on the side of their patients and they can empathise what the patient wants and what their needs are (PQNS, 6, 1st year).

Several participants (n=29), seventeen PQNSs (n=17), six CMs (n=6) and six NEs (n=6) said that trust was paramount when a patient/staff or staff/staff relationship is concerned. They said that it was important to build a relationship with the patients, to know the person behind the illness. They also stated that this could be achieved by relating to particular interests or hobbies. Participants said that nurses should attempt to fulfil the simplest and smallest promises that they make.

A compassionate practitioner needs to be kind, empathetic, enthusiastic, competent and supportive, to other members of staff to promote and deliver quality care to the patients. Build a relationship with patients. If patients can have trust in your care, that in turn will provide safe delivery of care (CM, 8).

Four NEs (n=4), two CMs (n=2) and three PQNSs (n=3) stated that compassionate care required a tailored and individual approach, which is patient-centred. Some of these participants suggested that it would take a good nurse to know his/her patients well in order to deliver care specific to their needs. They said that whilst getting to know patients, their routines, it helped to engage with especially those who were confused.

A compassionate practitioner is someone who is able to meet the person with respect and dignity, and I think there is some element of warmth in it as well.
Somehow a practitioner who appreciates the uniqueness of that person’s situation and can sensitively work with that person – so I think it has the elements of respect and warmth in that title (NE, 7).

4.5.2 Practices that can enhance compassionate care

In terms of nurses’ attitudes, many issues were raised by participants in response to some of the practices that can enhance compassionate care (see Table 4.1). As explored in the previous segment (section 4.1), “role model” was said to be one of the most powerful tools to enhance and nurture compassionate care. It was perceived that it was often the way that role models “did it”. They also suggested that someone who “comes in happy, comes into every bay and says hello to all the patients and have that kind of personality” enhanced compassionate care.

Not hurried, using language that they understand and you think I wouldn’t mind if he was telling my relatives things like that – then you feel, not going over the top about it (CM, 5).

Participants (n=34) stated that in a lot of cases they would appreciate if they could have more time to see to the patients, not only meet their physical but their emotional needs too.

Having that little bit of extra time just to listen to them, just to treat them with where they are at that moment, people that have got bad news given to them, people that have got a poor prognosis, it’s very variable and its quite an emotional roller-coaster but I guess that is my experience in a way, but actually it is then how you teach the junior staff or the Band 6’s, how you cope with that (CM, 6)

It was perceived by all 39 participants from all cohorts (NEs, CMs and PQNSs) that communication was central for the provision of good compassionate care for older people. It was also claimed by PQNSs that communication was vital when mentoring, making learning more conducive. One CM stated that factors such as poor vision or hearing impairment, side effects of medication that could affect
mental status and language differences between the patients and nurses can make communication even more challenging.

An elderly lady from a Pakistani family used to live in France with her husband – no children – all of a sudden she was moved to her relatives here in England - so you can see that although she doesn’t understand us – we just do sign language or sometimes we speak with one of the nephews/nieces and with proper channel of communication with the family and the patient benefits from it because there is not much education going on with the relatives (CM, 7).

It was stated by 28 participants (n=28) that the provision of holistic care would enhance compassionate care. Defined as all nursing practices that contribute towards healing the patient as a whole, the main aim of holistic care is to cater for the physical, psychological, emotional and social/cultural wellbeing (Frisch et al., 2000).

You are looking at the patient as a whole, in order to offer the best service, with that I mean respect and dignity and all those things – so I think selflessness is important when I think of compassion (PQNS, 2, 1st year).

Compassion is caring – caring about what you are doing – caring about that person and ensuring you are doing the best for that person, not just treating it as a routine task – oh I have got to wash that person, I have got to do this and this – she is a bit sad at the moment, let’s go and wash her first because then we can talk to her, see what is wrong with her, find out, cheer her up, maybe she is just worried about where her husband is, he has not come in on time – just find out what it is so the compassion is looking at a person as a whole and not just a bed number or piece of paper (PQNS, 7, 2nd year)

Two second year PQNSs suggested that simple things could give patients a boost and cheer them up. They said that for instance, smiling where appropriate, cracking a joke, sharing daily news or even listening to patients’ stories could help with the provision of compassionate care.
I will give them a magazine, even ask if they would like the paper, so if they want any, I quickly get them from the staff room, and I let them read the paper, and I ask them is there any news in the paper today that you can share with me. And they would - things like that. I have learned that spending a little time with them helps (PQNS, 1, 2nd year).

4.5.3 Practices that can compromise compassionate care

The National Patient Safety Agency (2007) identified communication difficulties as a major factor compromising quality care and a main contributor to patients’ complaints. However, understanding the patients from their perspectives and listening attentively to them was said to be another good quality of a nurse.

They need to have the skill to listen to their patient and try and interpret and understand from their perspective, their views and what they are trying to say to you (PQNS, 6, 1st year).

In terms of nurses’ attitudes, many issues were raised by participants in response to some of the practices that can compromise compassionate care (see Table 4.1). Workload, which could be due to poor skill mix, inadequate resources or too much paperwork and poor staff attitudes towards patients were some of the worst work conditions which participants claimed to affect them. One CM suggested that compassionate care could be affected by Trusts’ policies and procedures. Another CM said that due to shortage of staff members, either the care delivered could be delayed or missed. She said that there had been occasions whilst they were short of staff, when family members came in. She continued by saying that not only did family members disturb the care delivery, but they asked many questions, which could have been answered at a later stage.

Sometimes we have so many patients and staffing is limited, so the skill mix is poor, we have four nurses taking care of 30 patients you get about 2 staff nurses, 2 HCA. I think that will prevent good care and sometimes relative will come in. You are very busy trying to care for the patients – I know that we have to alleviate the pain of their relatives, but they are sometimes a
hindrance with the work that you are doing. When you are treating the
patients in a way relatives disturb us and want to ask questions, so we have
to stop what you are doing – and somewhere someone else needs you badly
– and there is not enough staff to do that kind of thing (CM, 2).

Nineteen participants, seven CMs (n=7) and twelve PQNS (n=12) said that they
have excessive amounts of paperwork to deal with. As a result, bedside nursing
care and patients’ interaction were compromised, impacting on the whole of
nursing care. This could also lead to compassionate care being reduced to tasks
and processes, even failing to properly identify the patient as stated by one NE.

The time factor – can’t say a lot, but too much paperwork. Too much
paperwork takes your time, your bedside nursing, you cannot interact with
your patient – the real care- you can’t give bedside care because you have to
concentrate on paperwork– because patients want to have one to one – we
haven’t got enough time to do that and this is really sad (CM, 2).

Another thing is paperwork – nursing is now 10% nursing care and 90%
paperwork (CM, 7)

Some participants, (CM=5) and (PQNS=8) mentioned how resource scarcity could
lead to delayed treatment. Three CMs said that meeting deadlines and targets
negatively impacted on patient care.

We have to meet deadlines, cutting down of resources and meeting their
targets like in face to face contacts. They said that you have to have 57 face
to face contacts per month – but we also have to evaluate the care we are
giving, not to the 57 face to face contacts, but we have to look at the quality,
it’s so important (CM, 3).

Two CMs (n=2) went further by saying that due to shortage of beds, there had
been instances where they had been asked to discharge patients when they felt it
was unsafe.
You are short of staff, they are pushing you to discharge a patient without much resources – these are very stressful situations (CM, 7).

One CM said that due to Trust’s rules and regulations, some personalised care could not be met. From the example below, the patient wanted to have a fried egg, but the CM refused mainly on the basis that this would break the Trust safety regulations. One second year PQNS even stated that “we are following too many protocols.”

It has become more pressurised I think – in the sense that you have all these targets to meet, and policies and rules and regulations and you think – they just want that fried egg – someone just bought them in something to eat, but you can’t heat it in the microwave – you can’t do this and you can’t do that (CM, 5).

Seven participants (n=7), six PQNSs (n=6) and one CM (n=1) said that compassionate care could be compromised if the qualified nurses felt that providing some of the fundamental nursing tasks was not part of their duties.

I think a lot of it is down to people’s attitudes. It’s down to their attitudes, I’m a qualified nurse, I don’t have to wash somebody’s bum or do anything (PQNS, 1, 1st year).

Two PQNSs (n=2) and one CM (n=1) stated that too demanding or even patient with undesirable attitudes can prevent nursing staff from delivery the compassionate care.

Sometimes there are times when patients physically or verbally abuse you, sometimes you just cry, I cannot handle this (CM, 7).

One can argue that by definition some patients who are in need of care or who are in pain, can be demanding or discourteous.
Table 4.1: Practices that can enhance and compromise compassionate care

<table>
<thead>
<tr>
<th>Practices that enhance compassionate care</th>
<th>Practices that compromise compassionate care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competent and knowledgeable practitioners</td>
<td>Practitioners lacking competence and knowledge</td>
</tr>
<tr>
<td>Right staff</td>
<td>Inappropriate/inexperience or lack of staff</td>
</tr>
<tr>
<td>Good communication skills</td>
<td>Inadequate communication skills</td>
</tr>
<tr>
<td>Good skill mix</td>
<td>Wrong skill mix</td>
</tr>
<tr>
<td>Adequate time and proper line of</td>
<td>Lack of time to spend with patients</td>
</tr>
<tr>
<td>communication with patients and staff</td>
<td></td>
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<tr>
<td>Less paper work</td>
<td></td>
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<tr>
<td>Manageable workload</td>
<td>Too much paper work</td>
</tr>
<tr>
<td>No target, just concentrate on quality</td>
<td></td>
</tr>
<tr>
<td>Adequate and proper resources</td>
<td>Heavy workload</td>
</tr>
<tr>
<td>Interprofessional working</td>
<td>Targets, red tapes and protocols</td>
</tr>
<tr>
<td>Good leadership</td>
<td>Lack of resources</td>
</tr>
<tr>
<td>Right attitude towards caring with</td>
<td>Fragmented care</td>
</tr>
<tr>
<td>compassion</td>
<td>Poor leadership</td>
</tr>
<tr>
<td>Fresh, happy and full of life professionals</td>
<td>Burnt out professionals</td>
</tr>
<tr>
<td>Holistic and patient-centred care</td>
<td></td>
</tr>
<tr>
<td>Quiet rooms to be able to talk to patients/relatives</td>
<td>Patients, staff and relatives with unrealistic expectations</td>
</tr>
<tr>
<td>Dignity, respect, privacy</td>
<td>Fragmented care</td>
</tr>
<tr>
<td>Regular updates feedback to patients and PQNS</td>
<td>Lack of respect, privacy and dignity</td>
</tr>
<tr>
<td>PQNS</td>
<td>Lack of feedback to both patients and PQNS</td>
</tr>
<tr>
<td>Good team work</td>
<td></td>
</tr>
<tr>
<td>Openness</td>
<td>Blame culture</td>
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4.6 Theme six: quality care

This section explores how quality care can be enhanced through the provision of compassionate care. Quality care can be defined as the provision of a safe and comfortable patient journey facilitated by competent and skilled nurses with compassionate care (Henderson et al., 2007). Within the quality care theme, two
sub-themes emerged, encompassing (1) Patient focus (holistic care) and (2) Nurturing compassionate care.

4.6.1 Patient Focus (holistic care)

All participants (N=39) were asked “when you hear the word “compassion,” what do you think of?” and twenty-eight (n=28) mentioned someone who can provide holistic care. A holistic approach to nursing is perceived as not only looking after a patient’s physical, but the psychological, emotional, social, spiritual and environmental needs (Berg et al., 2005). Some of the terms and words other than compassionate care used to describe holistic care by the participants were “maintaining dignity and privacy”, “being kind”, “loving”, “humane”, “fundamental care”, “spiritual care”, “empathetic”, “respect”, “genuine concern”, “individualised care”, “good communication skills” and “patient-centred care” (see appendix 21).

For me it means treating every patient, every individual, how I would like to be treated, so with that care and compassion being kindness, understanding, have that listening ear, actually taking on board all the patients’ needs as well as what they have come into hospital with – so looking at holistic care I think (CM, 6).

Patient-centred care can be defined as a holistic approach to patient care, whereby the care provided is designed and personalised according to patient’s needs (National Voices, 2013).

You can treat a person’s illness in hospital and they can go home, it’s making sure that the care is continuing and empowering them as much as possible. For me it’s empowering them as much as possible to do it themselves because I can sit here and I can feed them, but it is better if they can feed themselves (PQNS, 5, 3rd year).

Three PQNSs (n=3) and two CMs (n=2) even suggested that compassionate care is correlated with quick and safe discharge.
Ignoring somebody is not going to help them in any way what so ever. But if somebody feels more relaxed and more comfortable where they are, it helps speed their recovery as well. You know when somebody says you are well rested and you are feeling comfortable and feeling happy it helps you promote your recovery better whether it is physically or psychologically. But if you are upset and anxious about something, like when you get run down and stressed, it is going to promote the wrong balances (PQNS, 4, 2nd year).

Two NEs (n=2) and one second year PQNS (n=1) associated holistic care mainly with spiritual care, for the patients to find comfort and meaning and purpose in their lives and experiences.

It will help patients mentally and physically, because doing all the things that you have to do, providing physical needs, I wouldn’t say spiritual because sometimes you will sing with them, but have to be prepared to treat that person. You prepare them mentally for instance if they are going for surgery or something they are very scared, and so you have to put their mind at rest by telling what they want to know. And by doing so, it helps them to recover quickly and get out of the ward quickly (CM, 2).

4.6.2 Nurturing compassionate care

All CMs (n=8) and NEs (n=8) were asked “who will it be easier to mentor, first, second or third year students? Why?” There were a variety of answers, but the overall perception was that depending on attitudes, students were easy to mentor. However, they said that nurturing was easier if students had an underlying caring attitude.

I think it can be nurtured but I think amongst all students, but if they really haven’t got it in them then maybe they will never get it. There are certain people that will never get it. I think it can be nurtured to see if you can get the best out of them and actually with that encouragement you can get it but sometimes, occasionally you can’t (CM, 6).
Two CMs (n=2) and three NEs (n=3) suggested that first and third year PQNSs were easier to mentor and teach. For first year PQNSs, it was because they were more receptive, interested and for third year because they became more focused to complete the course and were looking forward to being leading by example as qualified nurses. It can therefore be argued that second year PQNSs need more support, whilst engaging them in care and compassion. The NEs also mentioned that constructively reflecting students’ practice experiences helped them to appreciate and understand the importance of compassionate care in the delivery of quality care.

In relation to compassion there is always, I think a point at the beginning of any course where they come in fresh, new, excited, enthusiastic, they want to do it right, they want to get it right, and you have got them at a point where they are really eager, so I think that the 1st year is always a good one. However, I think that once they are out in practice and they are beginning to see what compassionate care really means, then they are going to come back with examples of good care and poor care and they are going to be able to reflect on that with support from lecturers, and are going to think how am I going to change what I do to make my care compassionate. By the third year you are hoping that they are not just reflecting on their own care but when they are out there leading a group of people how can they influence them to give compassionate care (NE, 6).

4.7 Nature and nurture

This section explores how compassion can be a combination of both an innate characteristic and a learnt behaviour. Some people believe that compassion is a gift or an innate human feature (Roach, 2002), whilst others have argued that compassion in nursing care can be developed, enhanced and nurtured (Goetz et al., 2010; Kalish et al., 2011 & Kramer, 1974). It is a behaviour that people can learn from their family (upbringing and experiences), society, employment (role modelling). Living or working in an environment whereby everyone has an aptitude to understand and empathise with the other person and actively wanting to help, can play a key role in enhancing that compassion.
4.7.1 Whether compassion is an inborn or a learnt trait

All participants (N=39) were asked “whether they view compassionate care as an inborn or a learnt trait?” They all replied that it is a combination of both. One female nurse educator suggested that nurses need some caring characteristics from the outset.

_I don’t think that you can take somebody that has got no compassion in them, no caring, not want to care, and actually want to make them care – they have got to have something in there – and you can grow that – but if they have got nothing there to start with you can’t grow it. It is like saying that you have got to have the seed there so that you can nourish it with the food and the water and grow it – because if there is no seed, then it is not going to happen (NE, 1)._

Three NEs (n=3) said that nurses needed to be self-aware, manage difficult situations, such as death and be emotionally intelligent. One of the NEs said that to be able to provide compassionate care, nurses need to have self-awareness to be aware of others and how they impact on others.

_I think that it is both. I think some people have stronger traits of in their personality in relation to how they communicate, how they approach people, how assertive or submissive they are. There are some elements that are there already but anything or everything can be also taught and it can be enhanced. I really think that the self-awareness of where we are, push it forward a fair bit – I think that is a key thing. I don’t think that any of our students are rude on purpose, they might not realise they come across as too assertive, so I think there is both elements – some of it is taught and learnt through teaching through experiences but some people find it easier to take it on board than others (NE, 6)._

Emotional intelligence is the aptitude for someone to know their own feelings and of other people’s, to differentiate between those feelings and identify them appropriately to help them in the way they think and behave (Goleman, 1995).
Participants suggested that emotional intelligence was vital as it allowed the nurse to identify, comprehend and appraise the patients’ emotions with their own.

*If we are going to look for compassionate behaviours, we have to look for individuals who are self-aware but are aware of others. So, we are looking at the emotional/intelligence spectrum (NE, 8).*

4.7.2 Compassion is difficult to teach

Two NEs (n=2) were adamant in stating that compassionate care is solely based on role modelling and this skill is very difficult to teach in classrooms. On the other hand, four other NEs (n=4) stated scenarios, originating from practice and life experiences can be used to instil and develop compassionate care. Thereafter reflection, what went right, wrong and how else to improve and move forward can cement those skills. This resonated with six PQNSs (n=6).

*I think compassionate care is difficult to actually teach – I don’t think that you can actually put it into a curriculum and say this session today is going to be all about being a compassionate person – because I don’t think that you can teach that to people in that way. There is no theory behind it, I think it is all about having that passion and that emotional relationships with your patients really, and I think that the best way for it to be incorporated into a curriculum is through role modelling and exampling so therefore within sessions within your class that the examples you are giving to students, from perhaps your previous experience as a practitioner yourself or examples that have been given from text books, is that you draw out that compassion that needs to be delivered to the patients (NE, 1).*

*I think more reflective practice and for people to actually reflect on their skills have been a better way to approach care with compassion. I don’t think people took it on board (PQNS, 5, 3rd year).*

Whilst one cannot deny that compassion is easier to be demonstrated in practice by CMs as role models, one should also question as to why NEs find it difficult to teach. It is suggested that the curriculum is “too academic” and driven by acute
care, leaving little room for the integration of the care of the older people (see section 4.2.4). At the same time, the care philosophy (see section 4.3) which enables practices that enhance compassion (see section 4.5.2) depend on an environment that supports a culture of holistic care, whereby PQNSs would be listened to and empathise with. Students also suggest that some of the summative assessments should be replaced by practical formative ones (see section 4.2.4).

4.8 Chapter summary

This chapter has described the seven main themes (role modelling, working practices, care philosophy, clinical leadership, staff attitudes, quality care and nature and nurture) of the findings, based on the number of times the participants mentioned the issues. Without exception, all thirty-nine participants considered that compassionate care is best demonstrated through role modelling (the dominant theme), which was considered to be a combination of innate and learnt behaviours. Work practices, such as enhanced communication (Cummings, 2012), spending quality time and collaborative working are perceived as vital components in maintaining care with compassion.

Twenty-one participants suggested that the care philosophy of the ward should be about empowering patients. It is argued that care philosophy, such as promoting dignity, empathy and maintaining good patient rapport are important elements to culture and instil compassionate behaviours. Four participants suggested the care patients received was influenced by the way that the ward functioned, the leaders’ role. Clinical leaders can assist in maintaining a culture of compassion. In relation to staff attitudes, twenty-nine participants said that trust was fundamental in a patient/staff or staff/staff relationship. Twenty-eight participants suggested that to maintain quality care, someone who can provide holistic care is important. The findings have been discussed using examples of how of compassionate care is perceived from PQNSs, CMs and NEs perspectives.

Through in-depth analysis of the data a better understanding of issues that can enhance or inhibit compassionate care has also been presented. This research
study has described the perceptions of the three stakeholders. Whilst compassion is a contemporary subject in health and is being discussed and researched extensively using both qualitative and quantitative methodologies, no study has yet explored these three stakeholders’ views.

Following this chapter, the author defines compassion as the ‘ability to appreciate and empathise with an appropriate action to ease suffering.’ The action needs to be appropriate to the situation (see sections 2.4.3, 4.3.2 & 6.1.1). This is in line with the conceptual framework described in sections 2.2.1 and 2.2.2. However, compassion can be demonstrated in five different levels. Level 1, ‘Compassion- ‘, can be perceived as empathy without competence which can harm the patient. An example of compassion- can be demonstrated by a nurse attending to the patient who is in pain, but administers the wrong medication. This can be worthless and unsafe (Roach, 2002). Level 2, ‘Compassion’, can be viewed as empathy without competence, but with an action to ease suffering. An example of compassion at level 2 can be demonstrated by a nurse being there or holding a patient’s hand in moment of grief, spending quality time with patient (see section 4.2.2). Level 3, ‘Compassion+', can be perceived as empathy with competence and with an action to ease suffering. A practical example demonstrating compassion+, can be a nurse dressing a patient’s wound with the right dressings and establishing good patient rapport (see section 4.3.1). Level 4, ‘Compassion++’, can be viewed as appropriate empathy with competence and with an action to ease suffering. Compassion++ can be exemplified by a nurse who administers analgesia to relieve pain and dresses a patient’s wound with the right dressings. Finally, level 5, ‘Compassion+++’, can be viewed as appropriate and situational empathy with competence and with an action to ease suffering. Compassion+++ can be demonstrated by a nurse who dresses a patient’s wound at a time convenient to patient, with the right dressings and having already administered analgesia prior. The following chapter will analyse the findings in relation to specific methodological approaches.
Chapter 5 – Discussion and recommendations

This chapter proceeds to further analyse the findings, explored in chapter 4 in relation to specific methodological approaches. In this chapter a picture is painted of the analysis of that approach in relation to contemporary literature, along with an account of the strengths and limitations of this study. Precisely, this chapter focusses on how the findings substantiate, test and complement the contemporary research literature related to compassionate care. Finally, table 5.1 illustrates the similarities and differences of the perceptions of compassion in the care of older people amongst the three key stakeholders.

As previously debated in the literature review chapter (Chapter 2, mainly sections 2.3 and 2.4), findings emphasise that patients cherish the personal elements of compassionate care (Badger & Royse, 2012., Dewar, 2011., Dewar & Nolan, 2013., Graber & Mitcham, 2004., Kneafsey et al., 2015 & Schantz, 2007). Emphasis is laid on the importance of emotional connections and the value of emotional intelligence as important considerations (Rankin, 2013). Despite the agreement in the literature of the way that care is delivered is very important; not very much is documented about how this delivery is transmitted in practice (Dewar, 2011). In particular, there is insufficient evidence of the views of PQNSs on compassionate care. This research adds to the body of knowledge by looking through the lens of the PQNS, their views of compassionate care both in the clinical practice and at the university. Equally, this research compares these views to those of the CMs and the NEs.

This discussion is framed initially by a debate around care of the older people and compassionate care. Major themes emerged from this study and are presented in Chapter 4. Sections within this chapter examine the meaning of the findings in the light of the existing literature, and consider the implications and recommendations for policy, research, clinical practice and nurse education. In this chapter an interpretation of these findings is discussed.
5.1 Caring for the older people

The older people’s care setting is a complex and often difficult place for nurses who are expected to be compassionate and deliver compassionate care and develop professionally within it. The increase in numbers of ageing population necessitates knowledgeable as well as competent nurses who can deliver compassionate and holistic care that can meet the diverse and culturally sensitive needs of this patient group (Shreoder, 2015). As stipulated in Chapter 4 (see section 4.2.4), the curriculum at the university where the research was conducted does not adequately incorporate care of the older people as well as dementia care. This is because its curriculum’s main foci are acute care and care of long-term conditions.

One of the main challenges that HEIs face is how to make PQNSs more enthusiastic about the care of older people (Shreoder, 2015). This is not helped by the media, which portrays caring for the older people as basic, unappealing and stereotypes this group as “bed blockers”, (Maben et al., 2012) (see section 1.3). Thus, there is a lack of training and skills around care of the older person and those suffering from dementia. Consequently, PQNSs will feel ill-equipped to respond to the health needs of these patients. The above points echo with Tabet et al. (2005) who state that dementia education is low profile in the nursing curriculum. Priest and Holmberg (2000) argue that this lack of knowledge can spark undesirable behaviours between staff and unfulfilled patients’ needs (Hanks, 2008). This can generate frustrations amongst both staff and patients. Negative emotions created by this lack of understanding can result in stress and compassion fatigue (Youngson, 2008). Post Francis report in 2013, it was suggested that the content of pre-registration nurse education would be reviewed by the Health Education England (HEE) to accommodate the skills to work with older people (DH, 2013c).

As nurses are moving away from delivering the fundamental care, mainly due to taking up the role of “mini doctors” or seeing themselves as “overqualified”, they run the risk of denying good basic nursing care to older people who are most in need (Sturgeon, 2012). Findings from chapter 4 highlight that communication and engagement as well as spending quality time with some of the older patients are
challenging and in agreement with Kneafsey et al., (2015). Surely, these will contribute to reasons why compassionate care is lacking. This substantiates the claim made in chapter 4 (section 4.2.4) that the care of older people including a basic understanding of care of the patient with dementia should be incorporated within the pre-qualifying nursing curriculum. At the same time, it should be stipulated within the job description of qualified nurses that they should be skilled in delivering fundamental nursing care to all people. A few PQNSs suggest that coming on a nursing course without a background in healthcare, especially the fundamental skills acquired whilst caring for the older people can have drawbacks, not having a sense of ‘real nursing’ (see section 4.2.4). This is substantiated by recommendation 187 of the Francis Report (Francis, 2013), suggesting that prior to commencing the pre-qualifying nursing course; potential PQNSs should work in the care sector (see section 1.6).

This work was designed to explore compassion and compassionate care, to explore it and become better able to understand it. At the same time, illuminating the processes needed to develop and improve its use within the professional lives of stakeholders applying to, using it in and teaching about it. In the end, it may not be possible to fully comprehend compassion, but the discussion presented below attempts to meet the objectives set out in Chapter 2, but the challenge is to attempt to explain some factors that help PQNSs, CMs and NEs to understand it, gain insight into some of their perceptions of it, which can influence its development or inhibit its application to practice.

5.2 Compassion and compassionate care are more likely take place

This analysis picks out areas whereby, when these areas are present, compassion and compassionate care are more likely to be an integral part of practice.

5.2.1 Leading by example

Findings from chapter 4 (section 4.1) highlight the prominence of role modelling and all participants in the study valued the importance of their peers, CMs and NEs as a means to role model compassion and it was viewed by them as very powerful
in the delivery of compassionate care. Thus, a role model is a person who leads by example, who inspires and, in health care, the term is linked with competence, good social values and behaviour and effective communication skills (McGurk, 2008). There is robust evidence in my research study of the worth of leading by example from all the stakeholders, PQNSs, CMs and NEs. One can argue that CMs and NEs need to be led by example, by senior staff members such as nurse matrons and managers. Establishing a good rapport with PQNS whilst creating a supportive environment is vital (Joubert et al., 2006). One can argue that having adequate time to role model PQNSs through, active listening, negotiating, influencing and supporting (Dewar & Nolan, 2013) can support a culture that enhances compassionate care, unlike what seems to happen in some clinical areas whereby CMs give up their own time to assist PQNSs (see section 4.1.1, citations from PQNS, 5, 2nd Year and clinical Mentor, 7, CM7).

An individual who leads by example of compassionate behaviour enables CMs, PQNSs and NEs to show compassion to themselves and to patients (Firth-Cozens & Cornwell, 2009). To colleagues, it provides supportive behaviour and can even lower stress levels (Gilbert & Proctor, 2006), whereas embarrassment and adverse comments can induce cortisol stress responses (Dickerson & Kemeny 2004).

5.2.1a A wide range of health care professionals

Health care settings do not operate only with nurses. PQNSs work with and learn from a wide range of health care professionals, ranging from doctors to physiotherapists and occupational therapists. The strategic characteristics of multidisciplinary working are teamwork and collaboration (Hogston & Marjoram, 2007). This is concurred with by Restifo & Yoder (2004).

Jarvis and Gibson (1997) stipulated that all learning stems from experience and that working in clinical placements is consequently the most real learning experience that can be provided for PQNSs. Therefore, compassionate care through leading by example seems to occur more in the clinical areas. Fundamentally, PQNSs learn from socialising professionally, either in class or in
clinical practice (Lynn, 1995) whereby they can develop their professional identity (Holland, 1999).

5.2.1b Mentoring behaviours

The role of CMs in leading by example and supporting students to reduce anxieties as well as providing social support in practice is well documented (Chandan & Watts, 2012). Both CMs and the PQNSs argued that positive examples of mentoring behaviours between them mutually aided their relationships, while creating an environment of respect and pride. Most PQNSs suggested that the level of mentoring that they receive can directly affect their success level, whilst CMs suggested that PQNSs should be receptive to guidance. This concurs with the study by Murray and Main (2005) whereby positive role-modelling behaviours, such as mentors who display an enthusiastic, caring, non-judgemental approach and give constructive feedback, are reported.

Most of the literature on leading by example focuses on its positive element. Indeed, it is argued that social (or cultural) context shapes many of a person’s attitudes, ideas, and behaviours in ways that individual cognitive capability for learning alone cannot (Daniels, 2001). PQNSs, CMs and NEs join with others, nurses, other members of the multi-disciplinary team and patients to form learning communities. However, negative observations of leading by example are known to have a powerful impact on the professional behaviours of learners (Passi et al., 2013). Through scenarios and reflection on practice experiences, classroom strategies could be designed to make use of these negative experiences and turn them into positives. From this, valuable lessons about the way that compassionate care is given can be learnt.

It is also evidenced in this research study that not only can PQNSs have poor experiences from working with health care workers who do not lead by example, but can even start emulating those practices (section 4.1.1). More of the basic nursing care is being delivered by HCAs, newly qualified nurses and PQNSs. If it is argued that PQNSs emulate their mentors and do the same when they qualify and nurses will take on more of the junior doctors’ role, then basic care will only be
delivered by health care assistants. If this model of care perpetuates, qualified nurses run the risk of working even further away from their patients.

5.2.1c The personal tutor

From the relatively limited literature on the role of the personal tutor role in nursing, it has been noted that the relationship between PQNSs and the tutor is unclear (Richardson, 1998). For instance, in this research study, most students who seemed to have “personal problems” tended to see and access the personal tutor and valued that relationship of genuineness, trust/acceptance and empathic understanding more. At the same time, the significance of the tutor/PQNS relationship is undoubtedly different according to the PQNSs’ experiences and encounters with the tutor (Gardner & Lane, 2010). For better access, the role of the personal tutor needs to be advertised and available to all students. Key outcomes from the study by Collington et al. (2012) highlight that link lecturers support students and mentors, and sustain clinical credibility. This concurs with the findings of my research study as both PQNSs and CMs benefit from the link lecturers’ visits. Link lecturers provide support to both PQNSs and CMs, sometimes through teaching sessions and mentor updates.

Findings from this research study add to the body of knowledge suggesting that the delivery of compassionate care should be seen as the business of every single member of the multidisciplinary team, including the NE and the PQNSs. PQNSs learn from the whole team and their fellow students. Whilst PQNSs can hardly see themselves as future mentors and role models (see section 4.1.6), it is also very clear that role modelling is more easily demonstrated by CMs than NEs and PQNSs (see section 4.1.1). PQNSs, on the other hand can be role models, not to other fellow students but to other members of the team. NEs, who fulfil roles such as link lecturer and personal tutor are also pertinent and enhance the value of compassionate care if used effectively. However, NEs prefer compassionate role models who deliver care with competence. Compassionate care developed and enhanced through socialised behaviour and observations when demonstrated by CMs is beneficial to PQNSs.
5.2.1d Personal qualities

Findings from this study concur (section 4.1.5) with those of Joubert et al. (2006) and Elzubeir and Rizk (2001) in that they report on the significance of personal qualities such as dedication, honesty, politeness, enthusiasm are very prominent in leading by example. Here, PQNSs suggested that compassionate behaviours were displayed by both CMs and NEs, but they seemed more apparent in CMs (section 4.1.2).

5.2.2 Empathy: an ingredient for compassion

Within the nursing profession, there is a general agreement that empathy is pertinent to the delivery of comprehensive nursing care (Gustin & Wagner 2013., Kelley & Kelley, 2013 & Kneafsey et al., 2015). Empathy is a broad topic and it remains an abstruse concept (Hojat et al., 2009). Whilst empathy has been defined in many terms, such as being in somebody else’s shoes, seeing the world as others do, understanding of someone else’s feelings, it is also viewed as an important quality for nurses and health care professionals (Hojat, 2007). Being the foundation of patient care, empathy is the cornerstone of the patient-nurse relationships (Spiro, 2009).

It can be argued that whilst compassion and empathy are related terms, they should not be used as synonyms. Empathy has both emotional and cognitive aspects (Cole-King & Gilbert, 2011). Not only does it require the ability to identify someone’s feelings, but also to make sense of them and provide an emotional response. The example that one of the participants in this research study gave, was to recognise that a patient who could not talk, was in pain. However, to then approach him and provide analgesia is more than empathy, but compassion, not only appreciating the patient’s pain, but the active will to relieve it. It can then be debated that compassion is therefore a reaction to empathy (Kret, 2011) (section 2.3.3).

Empathy also enables nurses to comprehend and respect the significance of patients’ dignity (see section 4.3.2). Irrespective of age or level of consciousness;
participants in this research study voiced the view that patients’ dignity should always be maintained. They also suggested that empathy cannot be taught. It is discussed in Chapters 1 (section 1.7.1) and 2 (section 2.3.3) that empathy is an essential ingredient of compassionate care (Fernando & Consedine, 2014). They further argued that to be compassionate not only involves feeling for someone, but the act of relieving the suffering. This is in line with the conceptual framework, explored in section 2.2 and with the Level 2, ‘Compassion’, examined in section 4.8.

5.2.3 Compassion as a moral virtue

Many authors emphatically argue that compassion is a moral virtue (Armstrong et al., 2000., Bradshaw, 2009., Burnell, 2009., von Dietze & Orb, 2000 & Schantz 2007) (see section 2.3). As a virtue, compassion has a moral and intellectual component that is universalisable. Compassion is a virtue that the individual cultivates as part of his or her character’ (Bradshaw, 2009, p. 466). Bradshaw (2009) further claims that compassion can be nurtured through repeated exercises of compassion. The philosophy of nursing is based compassionate traits (Bradshaw, 2011a). Patients are meant to be at the centre of care, whilst nurses are destined to be kind. Bradshaw (2011a) suggests that care provided with compassion reduces complaints and can positively impact on the patient journey, implying that patients are listened to and treated well. Some of the words associated with a compassionate practitioner from the literature are “kindness, empathy, generosity, sympathy, generosity, altruism, benevolence, humanity, compassion, pity, empathy and acceptance” (Crawford et al., 2013, p.3591-3592). Table 1.1 illustrates “Attributes of a ‘compassionate mentality’. Participants in this research mainly used words such as empathy, kindness and humaneness. Maintaining dignity and privacy were also mentioned.

5.2.4 Authenticity

From many conventional counselling psychology standpoints, it is generally perceived that authenticity is a very important characteristic of well-being and contributes to healthy functioning (May, 1981). Lopez and Rice (2006) also found
correlations between authenticity and relationship satisfaction. It is proposed that a nurse who can switch between getting close to patients to ascertain what is important and distancing to prevent getting fatigued (sections 1.5.4 & 4.2.5) is the way forward (Carse, 2005). This skill can be very challenging. However, being emotionally connected is important to provide care with compassion (Badger & Royse, 2012., Bradshaw, 2009., Bray et al., 2013., Burnell, 2009., Crowther et al., 2013., Davison & Williams, 2009., Dewar, 2011., Dewar & Nolan, 2013., Graber & Mitcham, 2004., Horsburgh & Ross, 2013., Kneafsey et al., 2015., Schantz, 2007 & Van der Cingel 2011). Van der Cingel (2011, p.10) argues that “without authenticity the feeling of compassion would not be real and that’s precisely what patients feel.”

5.2.5 Ongoing personal and professional development

The findings chapter emphasised clinical leadership as being important in the enhancement and maintenance of compassionate care. Clinical leadership, as a core element in the support of compassionate care has been articulated by many writers, such as Cummings & Bennett (2012), Francis (2010, 2013), Kneafsey et al. (2015), NMC (2010b) & O’Driscoll et al. (2010) (see section 4.4). Emphasis has been laid on the importance of nurse leaders in assisting the pledge to deliver good quality compassionate care and thereafter accepting accountability (DH, 2010b). Ongoing personal and professional development should be part of the wards’ culture (Bryant, 2010). It is clear from the literature that in order to guarantee the delivery of high-quality compassionate care, effective leadership should exist at all levels (Francis, 2010 & 2013).

5.2.6 Compassion is viewed as a humanistic endeavour

Findings from this study emphasise that quality care is vital in enhancing and sustaining compassionate care. Throughout their pre-registration nurse education, and beyond, PQNSs and CMs respectively are taught about the humanistic elements of care, which involves individualised, person-centred, holistic care and it is of the utmost importance for the provision of good quality care. All PQNSs (n=23), all CMs (n=8) and NEs (n=6) commented positively on the humanistic
nature of the role of the mentor and that concurs with Joubert et al. (2006) (see section 4.1). PQNS as well as some CMs favour humanistic vis-à-vis competent role models. They mostly favoured the humanistic elements of the CMs and the NEs. PQNSs (n=4), CMs (n=6) and NEs (n=6) did mention on the importance of knowledge and competence in mentors, and this concurred with studies by Wright and Carrese (2002) and Lombarts et al. (2010).

Established in 2009, the Care Quality Commission is an independent body that registers and regulates services provided by healthcare providers in the UK. Quality care is about patient safety, good patient experiences and patient empowerment, whilst also offering choices and better information (CQC, 2010). The introduction of the 6Cs (see section 1.6.3) intended to facilitate nurses and other health professional to develop, enhance and sustain quality of care delivered to patients (NMC, 2015). In the light of this, compassionate care that is an integral part of the patient experience is vital.

Good quality care encapsulates ensuring that the patient has a good experience whereby the care is holistic and patient-centred. This means that the physical, mental and emotional needs are catered for in a continuous fashion (Maben & Griffiths, 2008). Attention to details can also lead to the improvement of quality care (Perry, 2009 & Van der Cingel, 2011). Findings from this study reiterate and participants agree that compassionate care enhances quality, holistic and patient-centred care. Participants of this research argue that treating the patient as a person, while exploring their condition on an individual level is important. Five participants suggested that if patients are looked after with compassion, this could positively impact on safe discharge (see section 4.6.1). They argued that if somebody feels relaxed and comfortable, both their physical and psychological wellbeing are enhanced, which can speed up their recovery. On the other hand, if patients are upset, anxious and are being denied of information and good care, this could lead to a prolonged hospital stay.
5.3 Compassion and the delivery of compassionate care are interrelated

This analysis picks out differing dimensions whereby compassion and compassionate care are less likely to take place.

5.3.1 Care without engagement

Compassion should not be replaced with a ‘care without engagement’ approach (Kneafsey et al., 2015, p. 1). Engagement, which relies on communication, is one of the 6Cs, the other five being care, compassion, commitment, courage and competency (Cummings, 2012). Multidisciplinary working is not a new phenomenon in health care settings. Over the years, government documents such as the NHS Knowledge and Skills Framework (DH, 2004), No Decision About Me Without Me (DH, 2012), and Valuing People (DH, 2010b) have put more emphasis of its importance in the provision of quality care.

5.3.2 Compassion fatigue (CF)

As discussed in in sections 1.5.4 and 4.2.5, linked with traumatic stress, CF is a form of burnout (Joinson, 1992). At the same time, there is adequate literature to suggest that compassion is a form of forecaster of psychological health and well-being. It has been demonstrated that compassion is linked with improved optimism, being socially affiliated and being kind to the self and others (Fredrickson et al., 2008., Hutcherson et al., 2008., Lutz et al., 2008 & Pace et al., 2010). The paradox here is whilst it has been suggested that continuously providing compassion to others can lead to CF, compassion also enhances selfless attitudes and behaviour, and attracts social connectedness that can be psychologically beneficial (Jazaieri et al., 2012). The balance however lies when a nurse is able to adjust between getting close to a patient to provide compassionate care and detach to prevent getting fatigued (Carse, 2005) (see section 5.2.3).

Health care workers “should be consistently compassionate and that compassion could not and should not be faked nor substituted with a care without engagement approach”, according to Kneafsey et al., (2015, p. 9). They further argue that whilst ‘consistent compassion’ is the ultimate goal, it is not a realistic expectation, mainly
due to work pressures (p.9). There are clear challenges linked with meeting this raised expectation expressed in table 4.1 as practices that compromise compassionate care. It is also fair to suggest that these practices should not be perceived as impossible nor should they be considered as justifications for behaviours displayed by uncompassionate nurses.

5.3.3 Culture

Evidence from the literature suggests that most PQNSs enter the profession with a sense of altruism (Lowenstein, 2008). The disturbing predicament is that whilst they get further into their course and even after qualifying, they seem to become less compassionate (Burhans & Alligood, 2010, Johnson et al. 2007; Maben et al., 2010 & Miers et al. 2007). Maben et al. (2010) further suggest that the compassionate ideologies are impaired by organisational dynamics, staff shortages and poor skill mix with an attitude of just finishing the job.

5.3.3a Organisational culture

Targets remain the main driving force behind NHS culture (Bradshaw, 2009 & 2016., Corbin, 2008., Deutsch & Sherwood, 2008., Maben et al., 2007., Sturgeon, 2010 & Youngson, 2008). The fast and prescriptive culture, whereby the health care practitioner only has a certain set time to complete a task can be counterproductive as far as compassionate care is concerned (Deacon & Fairhurst, 2008). Bradshaw (2009) argues that the setting of quantifiable targets for compassion will only have the effect of producing inadequate genuine nursing care (see section 2.5.1). Consistent with her rationalisation, compassion is at odds with a style of leadership that stresses on technical and quantifiable behaviours (McCaffrey & McConnel, 2015).

5.3.3b Culture of compassionate practice

Compassion in practice (DH, 2012) recommends the development of a culture of compassionate practice using a common vision, beliefs and actions. Requiring a whole system approach, environments, organisational structures and processes are important ingredients in the achievement and sustenance of this vision
(Bradshaw, 2009; Burnell, 2009 & Crawford & Brown, 2011). These dimensions, which should be practiced and maintained by all healthcare professionals to enculture compassionate care, were also recognised as important in my study. Table 4.1 illustrates what participants in my research study considered as practices that can enhance and compromise compassionate care.

5.4 Difficulties arising with compassion and compassionate care

This analysis identifies that when there is difficulty in distinguishing compassion from another key element of care tensions can arise, making it difficult to determine between the two.

5.4.1 Compassion with competence

In section 2.6, “competence versus compassion” is explored and competence is viewed as more important (Bradshaw, 2011a., Bray et al., 2013., Badger & Royse, 2012., Roach, 1992 & Straughair, 2012). NEs from my research study confirm what Roach (2002) articulated that compassionate care without competence can be dangerous (see section 4.8). This is consistent with the DH’s pronouncement (2010a) which states that compassionate practitioners should be skilled, competent and respect every patient’s dignity. All CMs and NEs and some PQNSs viewed it is desirable to have those who can deliver compassionate care with competence. One can argue that ‘compassion +++’, whereby appropriate and situational empathy with competence and with an action to ease suffering is the most commendable level for a nurse to be at, compassion without competence can still be appropriate in some situations such as holding someone hand and providing comfort in a moment of grief ‘compassion ‘(see section 4.8).

Whilst exploring the crucial structure of pre-registration education, systems of support for newly qualified nurses, creating and sustaining compassionate nurses with competence, the Willis Commission Report (2012) makes some recommendations. Amongst these are the importance of learning together and from different professionals and the recognition from employers, universities,
5.4.2 Communication and compassion

Findings from chapter four (section 4.2) focus on some of the important work practices that can improve and sustain compassionate care. Within the Work Practices theme, five sub-themes emerged, encompassing aspects of approaches underpinning good nursing ‘communication skills, spending quality time, collaborative working, curriculum, compassion fatigue’ and how they impact on compassionate care. All participants in the study valued these work practices.

Members of the health care team should communicate effectively with each other to ensure continuity, safety and quality of health care for all (DH, 2010a). There is strong evidence in the literature as well as in my research study that effective communication is central for the provision of good compassionate care for older people (Bramley & Matiti, 2014., Curtis, 2015 & Dewar & Nolan, 2013) (see section 2.4). Giving patients the opportunity and freedom to be involved in their care requires communication, which nurtures mutual respect and trust (Clayton, 2006). Communicating with patients who are old, fragile, confused and those having problems with thinking and articulating can be very challenging (Fadil, et al., 2009). Therefore, assessments based on observations and history taking from family members/carers is crucial (Frazier-Rios & Zembrzuski, 2007). Knowing that a patient is in need of pain relief without them verbalising, is a trait of an expert and a good nurse (Benner, 1984) is evidenced in my study. Knowing the person behind the patient (Frank, 2004), listening and the use of both verbal and non-verbal communication (Gilbert, 2004., Miller, 2004 & Van der Cingel, 2011) resonate in my research study. It is important to “actively listen to patients” and “be attentive to patients’ needs”, (Bray et al., 2014, p. 482).

The National Patient Safety Agency (2007) identified communication difficulties as a major factor compromising quality care. An important factor that impacts on patient/nurse communication is time, which is becoming more and more restricted. Knowing the patients and giving them time are viewed as important elements to
compassionate care (Bramley & Matiti, 2014). Whilst time and resources are recognised as scarce in health care settings, the findings from my study provide some evidence which can possibly alleviate tensions caused by these limitations. For instance, being frank with patients, letting them know when one will be back to see them, and providing realistic expectations can reassure them (Perry, 2009). In their study Kneafsey’s et al. (2015) asked participants which behaviours are vital to compassionate care. Most of them responded on the extent and the way they are spoken to, the attention that they receive, the level of personal engagement and thereafter have a feeling of connection. What is known now as a result of my research study that was not known before is that, whilst listening to and engaging with the patients are vital, being frank, open and knowing them are also pertinent to effective communication.

5.5 The integration of compassion in the curriculum

Teaching compassionate care should be an integral component both in theory and practice and should be on-going (Dewar & Mackay, 2010). The Willis Commission Report (2012) emphasises the role of the NEs to teach conditions in a holistic manner using case studies (Hemingway et al., 2011) to enhance the delivery of compassionate care.

The above resonates in my research study, but it also suggests that compassionate care is part of the hidden curriculum, leaving it open to the possibility of being inconsistently delivered by the NEs team.

Nurturance requires that the mentor has the ability to understand and support the mentee’s values (Schultz, 2004). However, CMs need adequate time to build that relationship, to teach and to give feedback. This research study suggests that mentors think they are not given adequate time to complete PQNSs paper work and to properly mentor them. They come early before the start of their shift, stay behind after the end of their shift or come on their days off to complete students’ assessments (see section 4.1.1). This suggests that CMs find their workload pressures increasing, leaving little time to teach and support PQNSs. This can
result in overtired and unhappy CMs and PQNSs, potentially leading to compromised patient care, sickness and compassion fatigue.

5.6 Nature and nurture

Described as ‘a continuous and inconclusive debate’, the question of whether compassion is inborn or learnt has been asked by many (Lancet 2007, p.630). In an attempt to make healthcare system more compassionate, Youngson (2008) argues that empathy is as much a skill as an inborn character trait. Whilst reflecting on his practice as an anaesthetist he acknowledges that he gradually taught himself how to get to the heart of patients’ worries in a single visit.

One of the few researchers who has argued that “compassion is a gift” and cannot be acquired is Roach (2002, p.14) (see section 1.2). Adequate evidence from the literature substantiates the claim that compassion is both innate and taught (Goetz et al., 2010). Through meditation, the mind can be compassionately trained (Buddhist perspective). Lately, however, the teaching of compassion been appraised empirically. Gilbert has written extensively and carried out various research studies on compassion and suggested programmes such as Compassion-Focused Therapy (CFT) and Compassionate Mind Training (CMT) (Gilbert, 2007, 2009, 2010). The process of applying a compassion model to psychotherapy is CFT. Used as a form of group-based therapy, CMT is designed as a compassion-based therapeutic interventions intended to assist people with high level of embarrassment and self-criticism (Gilbert & Irons, 2005). Findings from my research study argue that compassionate care can to be taught, learnt and nurtured. Participants however also added that nurses should have ‘something there and we can work on that’, that is the basic aptitude to show compassion. This needs to be first assessed at the time of recruitment and selection (sections 1.6.1 and 1.6.3) and thereafter be monitored throughout the duration of the course. Overall, most participants agreed that compassion is very difficult to teach. Table 5.1 illustrates similarities and differences in the perspectives of compassionate care from the three stakeholders.
5.7 Recommendations

Findings from my research study advocate that every staff member, (the qualified mentors, health care assistants or students) as well as NEs, should lead by example with regards to compassionate care (see sections 4.1, 4.1.1 & 5.2.1). Those who work on the ward therefore value it. It is even more powerful when those with status exhibit this skill, as PQNSs tend to emulate and identify with those people (Sinclair, 1997) (see section 4.4). NEs feel that demonstrating by setting good examples to PQNS in classrooms is more difficult than on the ward. Therefore, in seminars and skills sessions, compassion can be taught using contemporary scenarios whilst reflecting on practice experiences. This can also be facilitated with a reduced ratio of PQNSs to NEs, to offer better students’ support feedback (Dake & Taylor, 1994) (see section 4.1.2).

Also, revealed in this research study is how PQNS find the compassionate care provided by the whole team benefit them for their learning as it promotes evidence based practice (see sections 4.2.3 & 5.2.1a). As a result, patients are then offered the best care (Hogston & Marjoram, 2007). The findings from this research also add to the fact that patients should be actively considered as part of the team and they should constantly be consulted on matters concerning their care.

In an attempt to reduce compassion fatigue, a nurse should have the skill that enable them switching from getting close to patients to ascertain what is important and distancing (sections 1.5.4 & 4.2.5) (Carse, 2005). Good leaders should advocate compassion at all levels (section 4.8). Ongoing personal and professional development to promote care with compassion should be part of the wards’ culture (Bryant, 2010) (see section 5.2.5).

As far as the curriculum is concerned, it is recommended that compassionate care should be fully implemented within one of the main learning outcomes of each module, making sure that its delivery is as consistent as possible (see section 5.5). As students are allocated the same personal tutor for the duration of their course (section 4.1.3), reflection can be used to integrate compassion in allocated personal tutor sessions (in the three-year programme). It is argued that a safe and
trusting environment, whereby both the PQNSs and the personal tutors are viewed as equal partners is important. That environment can help in transforming these experiences into “a place of possibility”, rather than worrying about “pleasing the teacher” (Gillespie, 2005, p. 212). PQNSs can reflect on critical incidents based on their recent practice experiences. In collaboration, personal tutors and PQNSs can identify themes (learning needs), which can then be analysed, and skills needed to deliver compassionate care can then be identified and addressed (Adam & Taylor, 2013). Students can thereafter develop individual ‘toolkits’ of ways designed to empower them to meet those learning needs (Adam & Taylor, 2013, p. 1243).

In order to integrate compassion within the pre-qualifying nursing curriculum, Jack and Tetley (2016) suggest exploring the meaning of compassion using reflective poetry. A “caring words website” has been developed to form a poetry community, which students can access and contribute. Jack (2015) argues that reading poems with others can diminish the sense of loneliness that PQNSs often feel when exposed to challenging issues in the clinical areas, such as death or patients with extreme pain. Davis (1997) debates that exploring poetry can help building self-confidence and whilst appreciating others’ feelings can develop empathy. However, understanding, creative reading and writing poems can be challenging for some PQNSs (Jack, 2015). On the other hand, the emotional needs of some vulnerable PQNSs should be catered for after being exposed through their poems (Jack, 2015).
Table 5.1: Similarities and differences in the perspectives of compassionate care from the three stakeholders

<table>
<thead>
<tr>
<th>Similarities</th>
<th>Differences</th>
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</thead>
<tbody>
<tr>
<td>Compassionate care is best taught through role modelling.</td>
<td>Some PQNS and CMs preferred the humanistic role models.</td>
</tr>
<tr>
<td>Approachable with good interpersonal skills are the best role models.</td>
<td>NEs preferred competent role models</td>
</tr>
<tr>
<td>Role modelling is easier to be demonstrated by CMs than NEs.</td>
<td>PQNS found it difficult to see themselves as role models</td>
</tr>
<tr>
<td>Without real communication, it is difficult to demonstrate compassionate care.</td>
<td>Three NEs said that the curriculum is overprescribed on acute care.</td>
</tr>
<tr>
<td>Most participants viewed that the curriculum met its aim as far as the teaching of compassionate was concerned.</td>
<td>Care of the older people and dementia care need to be incorporated.</td>
</tr>
<tr>
<td>Compassion is difficult to teach.</td>
<td>A couple of NEs and PQNS said that nurses should have an aptitude to compassion before it can be nurtured.</td>
</tr>
<tr>
<td>Reflective practice helps to appreciate compassionate care.</td>
<td>NEs said that PQNS should be emotionally intelligent to be able to deliver compassionate care.</td>
</tr>
<tr>
<td>Compassionate care can be nurtured.</td>
<td></td>
</tr>
<tr>
<td>Holistic and individualised care is fundamental to compassionate care.</td>
<td>Mainly CMs and NEs viewed that compassionate care is a team effort.</td>
</tr>
<tr>
<td>Empathy and dignity are important ingredients to demonstrate compassionate care.</td>
<td></td>
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<tr>
<td>A compassionate culture developed and sustained by a leader is important</td>
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<tr>
<td>Targets, inadequate resources and poor skill mix negatively impact on compassionate care.</td>
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5.8 Chapter summary - what this study contributes to knowledge of compassion and compassionate care in adult nursing

From the incident in Mid-Staffordshire NHS foundation Trust and the publication of the Francis report (2010 & 2013), there has been many research articles published on compassion and compassionate care in the health care sector, a number based on the care of the older people. Some examples are Bray et al. (2014); Cornwell (2012); Kneafsey et al. (2015) and Rankin (2013). My study achieved positive outcomes in relation to exploring the concepts of compassion in the care of older people amongst key stakeholders in nursing education: pre-qualifying nursing students, nurse educators and clinical mentors using a qualitative approach.
Many important contributions have emerged from the theoretical and conceptual discussion in this chapter (see section 2.2). The study findings support evidence that role modelling by CMs, assisting students to reduce anxieties and providing social support in practice, can be helpful (Chandan & Watts, 2012). They also provide strong evidence to substantiate that role modelling by every single member of the multidisciplinary team including the NEs and the PQNSs is important. The most valued role models by PQNSs are those with humanistic elements rather than competence.

This research firmly resonates with the alarming dilemma that whilst they further get into their course and even after qualifying, nurses seem to become less compassionate and more distant from patients (Burhans & Alligood, 2010 & Maben et al., 2010). The reasons offered are organisational dynamics, staff shortages and poor skill mix.

Findings from this study reveal that newly qualified nurses, HCAs and students deliver fundamental care. Some CMs hardly have time to provide basic nursing care because they are too busy undertaking skills previously carried out by junior doctors (Sturgeon, 2010). CMs lack time to provide effective mentorship and complete PQNSs assessments. At the same time as nursing is moving more towards evidence based practice, the philosophy of compassionate is being compromised (Straughair, 2012a). Therefore, after qualifying nurses become more distant from patients. Whilst most participants agree that effective leadership is pertinent to the delivery of compassionate care, PQNS comment that these skills are more relevant at a staff nurse level. Findings from my research study suggest that good leaders foster a philosophy of compassionate care, whilst leading by example, and poor leadership is associated with a culture of uncompassionate care, complaints and unhappy staff.

This study supports and reiterates several claims made in various other research studies about compassion the delivery of compassionate care. For instance, effective communication; respect, genuineness, empathy, trust and confidentiality are some of the requirements to build a good nurse-patient rapport (Belcher and Jones, 2009); all are echoed in my study. Spending quality time with patients and
collaborative working positively impact on compassionate care is also evidenced in my study. Findings from this research study complement the above by suggesting that being truthful with patients and providing realistic expectations can reassure patients will enhance effective communication.

Whist acknowledging Roach (1984), Pusari (1998) and Cummings (2012), it can be argued that, not only the 6Cs, but the 8 Cs are also evidenced in this study, in particular care, compassion, competence and commitment elements. Pusari (1998) defined eight caring fundamentals for care in terminally ill patients: clinical competence, confidence, conscience, commitment, courage, culture, communication, and competent compassion. Whilst empathy remains obscure as a concept (Bray et al., 2014 & Hojat et al., 2009), findings of this research confirm its vital importance in the delivery of compassionate care (section 5.2.2). Empathy is important in all the five levels of compassion explored (section 4.8).

This study defines compassion by suggesting that compassion is the ‘ability to appreciate and empathise with an appropriate ‘action’ to ease suffering’. It argues that compassion has five levels (compassion-, compassion, compassion+, compassion ++ and compassion+++ ) and each level can be demonstrated based on the appropriateness of the situation (see section 4.8). Compassion does not always need competence, for instance, in some situations holding the sufferer’s hand might be enough. However, in other situations, whereby the sufferer might be critical, competence is vital, for instance, administration of right medication (section 4.8).

Evidence from this research study also resonates with others (Cummings & Bennett, 2012., Francis, 2010, 2013., NMC, 2010 & O’Driscoll et al., 2010) that clinical leadership is a core element in the support of compassionate care. It articulates the inadequate appreciation of leadership modules by PQNS. In many research studies, staff attitude is discussed as crucial in the delivery of compassionate care (Patient Opinion, 2011), and is confirmed as equally vital in my study. The outcomes of this research study strongly confirm that compassion is a combination of an inborn and nurtured trait (Goetz et al., 2010 & Kalish et al., 2010). It however, adds to the body of knowledge by suggesting compassionate
care can be nurtured, provided that the individual has an aptitude to be compassionate in the first place. The fact that participants hold this view is important enough and perhaps warrants interventions. Evidence from this study reiterates and participants agreed that compassionate care enhances quality, holistic and patient-centred care.

Chapter 6 explores the implications for practice, research and offers some recommendations for future research. It also critically reflects on the process of undertaking this endeavour.
Chapter 6: Personal reflections and conclusions

Many reflective models support the idea that to develop knowledge, practitioners should reflect on their experiences to enhance ways of managing difficult situations (Johns, 2004), or even to tackle problematic clinical issues (Schön, 1987). This chapter endeavours to give a brief insight on how my professional doctorate’s (PD) journey has been helpful in supporting my professional development. This chapter outlines the implications for research, practice and education. The development of PD programmes grew from the fact that critics suggested that traditional Doctor of Philosophy (PhD) only focused on preparation for an academic career (Scott et al., 2004). Therefore, PDs were distinguished from PhD by the fact they had a named focus title, such as nursing (Lee, 2009).

This research study attained its aim of exploring the concepts of compassion in the care of older people from three perspectives: PQNSs, CMs and NEs, using a generic qualitative approach. The objectives of the research study were to investigate the perceptions of compassion of first, second and third year PQNSs, NEs and CMs in relation to the care of older people, and to explore the factors that influence its development or inhibition in the academic and clinical environment. Having interviewed NEs, PQNSs and CMs, it is also important to recognise lessons learnt to inform education, research and practice.

6.1 Personal and professional development

The knowledge and skills that I have acquired during the Professional Doctorate programme have supported me in many ways. Being taught in a multi-professional cohort was beneficial as it enabled learning from and sharing concerns with each other (Powell & Long, 2005). Network building and peer collaboration was significantly supportive in the sharing of knowledge and expertise (Ellis, 2010). The PD has assisted me in developing my aptitude to analyse, advance and apply new practice knowledge in work settings (Lee, 2009). Having developed transferable skills, such as interviewing skills, the PD offered me the prospect to explore professional concerns, linking doctoral study with practice based enquiries (Smith, 2009).
Since the point that I started the data collection, I have lived and breathed this project and planning it to the finest possible detail. Despite having carried out qualitative methodology training as well as interviewing people in prior courses, conducting this research study has been a steep learning curve. As well as the development of new knowledge, the PD training programme helps in the understanding of research techniques (QAA, 2008). I have learned more about the intricacies of a qualitative research study informed by the generic qualitative approach (see section 3.4).

I felt privileged to have had the trust of the participants who shared some of their most telling personal stories about compassion and compassionate care. I now feel far more enlightened regarding the participants' experiences. Research undertaken potentially can improve practice for service and improve PQNSs and most importantly patients’ experiences of compassionate care.

To have a PhD or a PD is becoming one of the essential requirements for a NE working in a HEI. Conceivably and as I reflect on the journey of undertaking a PD, I can sincerely say that it has been challenging and with lots of ups and downs. Nevertheless, I have enjoyed it. I now look forward to developing new research projects as a more confident NE researcher.

6.1.1 Insight and understanding of methodology

Generic qualitative methodology is explored in chapter 3, section 3.4 and its strengths and weaknesses are discussed in section 6.4.2. Whilst only a small number of research studies have used it, generic qualitative methodology is now being utilised more in nursing. This approach is rarely used in the context of care for older people and compassionate care. Kneafsey et al. (2015) recently explored key stakeholders' perspectives on compassion in healthcare using the generic qualitative approach. In this study, the Donabedian's “structure-process-outcome” framework (Donabedian, 1988) was used to construct a framework for compassion (see figure 2.2). This fits with interpretivist framework and is the theoretical position that this study has taken (see sections 3.1 and 3.2).
In this research study, every attempt was made to be robust and rigorous. A pilot study, addressing any deficit in the interview schedule was conducted (see section 3.7). At the beginning of every interview an ice-breaking exercise was used to reduce the element of power during interactions (see section 3.4.3). I offered my position on compassion in section 3.4.1. To maintain objectivity, the researcher’s thoughts and feelings were bracketed from what the participants shared (see section 3.4.1). Field notes were taken following each interview to capture the context of what was said; factors such as facial gestures were noted. Critical reflection, with the help of a reflective journal, was part of the process of examination of the interrelationship between self and new knowledge (Alvesson and Sköldberg, 2000). Data saturation, which is when no new accounts are heard (Streubert Spezial & Carpenter, 2011), which happened when 6-8 participants from each cohort were interviewed using semi-structured interviews (see section 3.6.1). The transcribed interviews were returned to the stakeholders for validation (see section 3.4.3). A sample of initial transcripts were checked by my academic supervisor (see section 3.7.3). Thereafter the emerging themes were debated and an agreement was reached. As no specific approach to data analysis is prescribed for the generic qualitative method, the framework analysis of immersion (Pope & Mays, 2000) was used.

6.2 Dissemination of findings

Some literature claims that research dissemination, as the written or oral representation of project findings, usually happens at the end of a research project (Walter et al., 2003), and others suggest that several research projects remain on shelves and have no impact on practice, research or policy (Finfgeld, 2003). I believe that a pertinent part of the research process is dissemination of the findings that are tailored materials that have been converted into journal articles or conference papers, which generate a form of discussion (Walter et al., 2003). I have already presented my findings to various target audiences, namely NEs and researchers as well as PQNSs at four conferences (dissemination of the research findings schedule presented in Table 6.1).
Table 6.1: Dissemination of the research findings schedule

<table>
<thead>
<tr>
<th>Project</th>
<th>Time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract and Poster presentation at the North-West London Symposium</td>
<td>September 2014</td>
</tr>
<tr>
<td>Findings to research group at Buckinghamshire New University</td>
<td>September 2014</td>
</tr>
<tr>
<td>Poster presentation at Portsmouth University to Assessors</td>
<td>October 2014</td>
</tr>
<tr>
<td>Poster presentation at the Nursing &amp; Midwifery conference at Hammersmith Hospital, Conference Centre</td>
<td>November 2014</td>
</tr>
<tr>
<td>Presentation of findings to “Exploring Values in Healthcare Issues from Theory and practice” at Buckinghamshire New University</td>
<td>June 2015</td>
</tr>
<tr>
<td>Presentation of findings to Post graduation nursing students at Buckinghamshire New University (BNU)</td>
<td>December 2015</td>
</tr>
<tr>
<td>Presentation of findings at the BNU’s away day</td>
<td>July 2016</td>
</tr>
<tr>
<td>Presentation of paper at the NET conference</td>
<td>September 2016</td>
</tr>
<tr>
<td>Presentation of paper at the ‘Nursing Congress 2017’</td>
<td>October 2017</td>
</tr>
</tbody>
</table>

6.3 Future goals and aspirations

I consider this to be the beginning of an impetus to share my understanding about compassionate care with my professional colleagues, both at the university and in practice. I endeavour to become a more active member of the research club at work. Going through this process has enabled me to see the use and advantages of research in HEIs and the practice settings. I now feel I am a fully-fledged qualitative researcher and I will carry being involved more research projects. I will apply for funding to continue to research and improve the understanding of this subject. Being an expert in this area, I want to be one of the voices in the field, to use that knowledge to educate, not just on pre-qualifying nursing courses but to help others who do the same.
6.4. Strengths and limitations of the research

At the design stage attention was paid to the four elements of trustworthiness, which are credibility, transferability, dependability and confirmability (Table 6.2) in order to maximise the rigour of the methods used and counter some of the inherent potential limitations (Shenton, 2004). The very nature of qualitative study opens it to several weaknesses, such as its subjective nature. As subjectivity is influenced by culture, life experiences and time, it can be argued that a single event can change people’s perceptions (Ellis, 2013) (see section 3.2). This suggests that the findings of this study are difficult to generalise. Hence applying these findings away from the setting where the study was conducted is difficult to rationalise. However, qualitative researchers claim that the purpose of their enquiry is not essentially to generate generalisable findings, but those that can be related and applied to circumstances which are alike (Ellis, 2013). It is argued that an explanation is only valid if the researcher has confidence that the account is a precise illustration of participants’ perceptions (Streubert & Carpenter, 2011).
### Table 6.2: Provisions made by researcher to address Guba’s Four Criteria for Trustworthiness

<table>
<thead>
<tr>
<th>Quality criterion</th>
<th>Possible provision made by researcher</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credibility</td>
<td>Adoption of appropriate, well recognised research methods (semi-structured interview)</td>
</tr>
<tr>
<td></td>
<td>Development of early familiarity with culture of participating organisations</td>
</tr>
<tr>
<td></td>
<td>Tactics to help ensure honesty in informants (ice-breaking session prior the interviews)</td>
</tr>
<tr>
<td></td>
<td>Debriefing sessions between researcher and superiors (some of the interview transcripts were checked by the supervisors and regular meetings to discuss ongoing progress)</td>
</tr>
<tr>
<td></td>
<td>Peer scrutiny of project (present methodology, findings and the overall research at conferences and to peers (section 6.3))</td>
</tr>
<tr>
<td></td>
<td>Description of background, qualifications and experience of the researcher</td>
</tr>
<tr>
<td>Transferability</td>
<td>Provision of background data to establish context of study and detailed description of phenomenon in question to allow comparisons to be made (Being able to associate with all the themes as emphasised with all stakeholders taking part in the study).</td>
</tr>
<tr>
<td>Dependability</td>
<td>Could have used method triangulation, such as face-to-face semi-structured interview and focus group.</td>
</tr>
<tr>
<td></td>
<td>A thick methodological description that allows the study to be repeated</td>
</tr>
<tr>
<td>Confirmability</td>
<td>The identifications of shortcomings in study’s methods. For instance, the method of triangulation could have been used. Reflexivity and reflective diary were used. (See appendices 17-21 for audit trail via NVivo)</td>
</tr>
</tbody>
</table>

#### 6.4.1 Limitations of the research

Confirmability or auditability, refers to the paper-trail and the methods used in the study (Polit & Beck 2010 & Streubert-Speziale, 2011). Tools such as field notes and the reflective journal provided this paper-trail. One of the ways that confirmability was addressed in this study was by identifying the researcher’s position to the subject matter (Miles and Huberman, 2013) (see section 3.4.1). Field notes were taken following each interview to capture the context of what was said; factors such as facial gestures were noted. Critical reflection, with the help of
a reflective journal, was part of the process of examination of the interrelationship between self and new knowledge (Alvesson and Sköldberg, 2000). In this instance, critical reflection was an analytic process, which systematically focussed on personal, interpersonal, and contextual factors influencing what was discussed and carried out (Smith, 2008).

The reflective journal enhanced critical reflection and critical thinking. To maintain objectivity, the researcher’s thoughts and feelings were bracketed from what the participants shared (see section 3.4.1). In turn, this facilitated the interviewing process, whilst drawing on a range of pertinent knowledge and experience to enlighten this research study.

For this study, purposive sampling, whereby participants were selected based on the requirements of the study was used (Morse, 1991). As the study progressed, and as it became more challenging to recruit first year PQNSs, snowballing sampling technique could have been used. Snowballing which is a type of purposive sampling method is when a participant is used to find another (Streubert & Carpenter, 2011). Purposive sampling offered the commitment to observe and interview participants who have experience with or are part of the culture or phenomenon of interest (see section 3.6.1) (Streubert & Carpenter, 2011). However, looking at the sample (table 3.3), most participants were female and from the ethnic groups. It can be argued that more male and white participants could have influenced the data. The element of power during interviews (section 3.4.3), and the fact that the researcher was known to most of the participants could also be seen as weaknesses. The ultimate goal was to develop rich and dense data. The fact that no patients were interviewed, their perspectives which can offer authentic and valuable learning opportunities for PQNSs, CMs and NEs in relation to compassionate practice are missing. Exploring how similar or different patients’, PQNSs’, CMs’ and NEs’ perspectives of compassion might be influential to the curriculum. Due to the time constraint, it was difficult to get ethical approval for patients’ involvement (see section 3.5).

This study depended upon one method of data collection (semi-structured interview) and it was possible that participants would have disclosed different
information had other methods been used. Semi-structured interviews enabled the researcher to further explore some of the answers with the participants (Ellis, 2010). Confirmability could have been enhanced using method triangulation, such as the focus group and individual semi-structured interview (Marshall & Rossman, 1999). Triangulation is a process that enables corroboration of data through cross verification from two or more methods (Braun & Clarke, 2013). As discussed in section 3.4.2a, focus group interviews, which are very useful when dealing with sensitive issues were not used (Streubert & Carpenter, 2011). Focus group interviews could have brought a different dimension to the findings by exploring the multiple views of the participants. At the end of the focus group interview, the understanding of what the group said could have been checked and confirmed. Hence, involving the participants in the data analysis and establishing credibility (Ellis, 2013).

Focus group interview was not used in this study mainly due to the power difference amongst the three stakeholders. Not only some of the members could have been more confident making their perceptions echoed in the discussion, but other members, such as PQNSs might hesitate to criticise a CM or NE for being uncompassionate. Groupthink is a term which describes a group whereby “loyalty requires each member to avoid raising controversial issues” (Janis, 1982, p. 12). If focus group interview was used in this study, groupthink could have happened when stronger members, who could mainly be the NEs or the CMs have the foremost power than other members, such as PQNSs. Due to vested interest, mainly being assessed by NEs and CMs, PQNSs might even fear to suggest something controversial. Transcription of the focus group interview and capturing the body language, gestures and eye contact could have been challenging (Ellis, 2013).

It can be argued that an alternative method of triangulation may encompass an extensive variety of participants (Shelton, 2004). Together with the semi-structured interviews, focus group interviews which could be economical, flexible and able of producing rich data could have been used, if they were conducted within different groups (for instance, all PQNSs, all NEs and all CMs) (MacDougall
& Baum, 1997). Table 5.1 illustrates similarities and differences in the perspectives of compassionate care from the three stakeholders’.

Observation could have been used as one of the methods to collect data (see section 2.2.2). The Hawthorne effect, that is participants performing differently could have been a challenge (Jacobson et al., 2009). On the other hand, while spending time with participants, the researcher could have an inside perspective of the "culture" of that environment. The main reason for not using observations as a tool was due to ethical approval which should have been cleared from the outset (see section 3.5).

6.4.2 Strengths of the study

The main strengths of this work are its credibility, data collection and analysis procedures, and the potential for transferability of the process. In order to demonstrate credibility, Merriam (1998) suggests dealing with the question, “how congruent are the findings with reality?”, whilst it is argued that making sure that credibility is one of the most significant issues in establishing trustworthiness (Lincoln and Guba, 1985).

For this study credibility was met by using a well-recognised method, such as face-to-face semi-structured interview, short ice-breaking exercises, at the beginning of each interview to make the participants feel relaxed. It was important to gain participants’ trust as well as making them comfortable. Section 3.7.2 refers to participants’ validations which ensured transcripts were sent to participants for feedback and accuracy (Creswell, 2003). This gave them the opportunity to read and review their own transcripts and allowed them to make any additional comments to ensure the accuracy of their statements. It can be argued that an independent colleague/peer, who possibly has less or no contact with participants of the study has less ability to judge the credibility of the study (Cutliffe & McKenna, 1999). Lincoln and Guba (1985) refer to peer debriefing “as a process of exploring oneself to a disinterested peer in a manner paralleling an analytical session…for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer’s mind”, (p.308). For this study, some of the transcripts were sent to the academic supervisor to independently check validation.
of development. Debriefing sessions between researcher and the supervisors were organised (Table 6.2) (see section 3.7.3).

According to Streubert & Carpenter (2011), transferability or fittingness refers to the prospect that these findings make sense to others in similar situation. Transferability can be obtained by providing 'thick' accounts of the setting, participants and processes or adequate information for evaluating the analysis of data (Lincoln & Guba 1985). It is hoped to guide the reader towards transferring and making inferences about the findings in other areas. For transferability to be achieved, it is suggested that readers should judge their circumstances to be similar to that articulated in the study, to be able to relate the findings to their own positions (Bassey, 1981 & Firestone, 1993). According to Polit and Beck (2010), transferability is a shared business between the research and reader.

None of the natural settings were disturbed. From the thirty-nine participants, the eight CMs who were interviewed were from three main hospital Trusts in London whereas, the twenty-three PQNSs were based in as many as six. An attempt to meet the multiple variations sampling was made. Students from each academic year of the three-year BSc programme were interviewed. Table 3.3 suggests that participants were from different ethnic groups and from both genders. It is purported that the findings of a qualitative study need to be viewed and contextualised in particular settings as well as the geographical area in which the study was undertaken (Shenton, 2004). It can therefore be argued that these findings can be transferred to some of the main hospitals in London.

So far, many studies explored patients’ and clinicians’ perception of compassion (Crowther et al., 2013 & Graber and Mitcham, 2004). A few researchers explored nursing students’ perspectives of compassion (Bray et al., 2014., Curtis et al., 2012., Jack & Tetley, 2016 & Kneafsey et al., 2015). The gap that appeared in the literature as the perspectives of compassion from these three stakeholders was addressed. Therefore, this study is the first which addressed compassion from the perspectives of the NEs, CMs and PQNSs (first, second and third year).
One of the reasons to gain ethical approval (see section 3.5) was to safeguard that participants were minimised of risks of harm (Smith, 1999). It ensured that the rights and dignity of both participants and the researcher were protected. Mainly emails were used to recruit participants. Whilst the emails were clear and concise about the aim of the research, explaining that confidentiality and anonymity throughout and beyond would be maintained, it was challenging to recruit first year PQNSs (see section 3.6.2). Additional emails were sent to them. The final successful approach was when the researcher went to communicate with them in their classrooms. Therefore, this strengthened data by enabling recruitment. It was also clear from the consent form that participants were free to withdraw from the study at any time without question.

6.5 What this research adds to what is already known about compassion—a deeper and insightful understanding of compassion

Whilst the definitions of compassion are well documented, what compassionate care means to different patients remains complicated. After exploring several definitions from prominent writers, such as Chochinov (2007), Dewar (2011), Jormsri et al. (2005) & Schantz (2007), the three dimensions pertinent to compassion are ‘recognising when someone is in pain’, ‘show empathy’ and ‘act to relieve the pain’. However, after the findings from chapter 4 are examined in terms of what this term meant to PQNSs, CMs and NEs, ‘compassion is defined as the ability to appreciate and empathise with an appropriate action to ease suffering’. The emphases are on words ‘appreciate’, ‘empathise’ and ‘appropriate action’, that is understanding and actively doing something to help someone. Some of the participants articulate their meetings with patients and their families. For instance, the nurse who listens to the patient and then makes a request on the hospital radio to play the favourite song for a patient and his wife on their golden wedding anniversary at an appropriate time (see section 3.8.2). One can argue that in the above example, the appropriate action taken by the nurse would have contributed to making the patient and his wife feel better by boosting their psychological wellbeing.
The literature review revealed that some patients view compassionate care as a competent act requiring excellent nursing and medical skills. For others, it means receiving care from health care professionals with good interpersonal skills. It is however fair to suggest that most patients prefer competent health care professionals with good interpersonal skills (Badger & Royse, 2012., Bradshaw, 2011., Bray et al., 2014., Roach, 1992., Straughair, 2012a). This study explains compassion in term of five levels. Whilst level 1, that is ‘Compassion-’, is perceived as empathy without competence, level 5, that is ‘Compassion+++’, is perceived as appropriate and situational empathy with competence and with an action to ease suffering (see section 4.8). Delivering care with a smile is highly praiseworthy; however, to then measure compassion through that smile remains challenging (see section 1.2.2). Validated tools to measure compassion amongst health care professionals and nurses are being used in some care settings, but this is yet to be consistent across the NHS (Papadopoulos & Ali, 2015).

Compassion can be measured from many stakeholders’ perspectives; from the patients’, relatives’, PQNSs’, NEs’, CMs’, other health care professionals’ and managers’ (Papadopoulos & Ali, 2015). A tool that encapsulates peer and self-assessment of compassion can be devised. It can be argued that this can enhance accountability from both the staff and their peers. Tools to measure compassion at the point of recruitment and selection of PQNSs are more important as then the genuine candidates with the right attitudes to care can be selected (see section 6.6.1). This will be in line with recommendation 188 of the Francis Report (2013) (see section 1.6.3).

The literature reviewed also referred to reasons why compassion is lacking and suggested that compassion is a commendable trait that requires good interpersonal skills. Six of the seven main themes that emerged from chapter four, from the value of the role models to working practices, care philosophy, clinical leadership, staff attitude and quality care resonated with the Francis Report’s (2013) recommendations. This study also proposed that while compassion is difficult to teach, it can be nurtured, provided the individual has an aptitude for compassion in the first place. Whilst it can be difficult to demonstrate compassion to every PQNS in a class of more than twenty, it can be argued that NEs should
put more effort into empathising and showing compassion to PQNSs. Instead of assessment driven, which PQNSs claim to be ‘too academic’, the curriculum should be more student focussed (see sections 4.2.4, 4.3.1 & 4.7.2).

6.6 Implications of the findings

There are some original and unique perceptions that this research study provides which can be used to that inform research, education and practice.

6.6.1 Implications for research

One research study, in a similar vein that would be informative and improve the reliability of this work would be a longitudinal study exploring the concepts of compassion in the care of older people amongst key stakeholders in nursing education: patients, pre-qualifying nursing students, nurse educators and clinical mentors using a qualitative approach. This would add the patients’ perceptions to the study. At the same time, the same PQNSs can be interviewed in the first, second and third and final year of their course. Returning to the participants to explore changes can take time, show distinct changes and provide rich data, which can be helpful. On the other hand, longitudinal studies can be costly, can take a long time and participants can even drop out (Miles & Huberman, 2013). The longitudinal study might be able to identify whether the perceptions of the PQNSs of compassionate care shift the more that they progress into the course. On the other hand, it can also shed some light as to how the CMs view care with compassion as they move up the ladder or progress in their roles as CMs, whilst moving away from patient care (see section 1.6.4). It appears that in the future, there would be a demand to develop and appraise education programmes in assisting CMs to implement compassionate care.

Another study would be “an exploration of an effective tool to evaluate potential candidates’ emotional intelligence prior to commence the nursing course.” Emotional Intelligence has been presented in the literature as a valid and reliable forecaster of retention and performance (Goleman, 1998) (see section 2.4.2). A survey method could be used, whereby a standardised questionnaire could be
administered to a sample of participants from a couple of cohorts of PQNSs (population). The questionnaire could be completed online, using face-to-face, or telephone interviews. The study can explore the correlation between emotional intelligence, clinical practice and academic performances whilst enhancing compassionate care.

Given the fact that nursing requires an interprofessional approach and patients’ care is influenced by the whole team and not just by nurses, research in compassion needs to involve other disciplines. For instance, a report from the King’s Fund (Firth-Cozens & Cornwell, 2009) addresses questions in relation to the enhancement of compassion within healthcare, including factors that hinder compassion, such as the prominence of the biomedical model, fears of dying and stress and burnout. A clearer picture needs to be painted as to how each profession within the healthcare care system perceive compassionate care and whether specific models are needed. Collectively looking at these different models can produce significant result.

Comparing and contrasting the perceptions of compassion of nurses and other health care workers from acute and fast moving areas such as Accident and Emergency and long term care such as care of the older people would also contribute to improvements in practice. Dimensions of compassion, such as holistic care, patient-centred care, interpersonal skills and empathy need to be further explored and explained (see section 2.2).

6.6.2 Implications for education

One of the realisations was that the concept of compassion is hidden in the curriculum as no specific learning outcome is designated to address this. It is left to the discretion of the individual lecturer to incorporate and explore compassion in their teaching sessions (see section 4.2.4). One vital consideration is whether PQNSs are being prepared by NEs and CMs to deliver care with compassion. NEs should consider compassionate care as an integral part of each module of the whole pre-qualifying nursing course. They should understand the real meaning of
compassion and how it applies in practice to be able to teach students. Fundamental nursing care should be at the forefront of all skills being taught. Skills such as communication, washing and feeding patients, should be taught whilst exploring, discussing and developing compassionate care. In conjunction, empathy, which “is the condition for compassion” (Van der Cingel, 2014, p. 4) and a “reaction to compassion” (Kret, 2011, p.29) should be discussed. The definition of empathy can be extrapolated to get students to understand the real meaning of compassion. NEs, in particular personal tutors should use personal examples as well as those from books to explore compassion, and thereafter allow students to reflect on their own practices. Hopefully, students will learn and be skilled in recognising signs from patients who require compassionate care. If compassion is placed as a central concept to be taught in the nursing curricula, undoubtedly this knowledge will be transferred (Van der Cingel, 2014).

Compassion should be taught at all levels, starting from the first year of the programme. Stories narrated by PQNSs, having completed some clinical placements, need to be listened to as these can be valuable in their future professional development. Creative teaching strategies, whereby PQNSs can have ownership of their learning can be used to explore their experiences (see section 6.1.1). To boost support, HEIs should be proactive in responding to the students’ concerns of their clinical experiences (McIntosh and Gidman, 2012).

Keeping a formative reflective journal should be part of a curriculum strategy. The journal can help PQNSs in reflecting after clinical placements experiences. Whilst compassion should be introduced in the skills sessions, this concept should be reiterated in personal tutor sessions. For instance, in their first year, PQNSs should be introduced to the concept of compassion with other nursing principles such as empathy. Thereafter, in year two and three, PQNSs should write formative accounts reflecting on possible critical incidents from their practice placements and the university. Themes in relation to compassionate care (communication, role modelling) could be identified, explored and analysed. Appropriate skills can thereafter be developed in those personal tutor groups (see section 5.5).
6.6.3 Implications for practice

Fundamental care, which has always been an integral part of the role of every qualified nurse should be promoted. A curriculum toolkit could be devised that would fit in the programme and classroom teaching techniques. The intention would be to enhance compassion and could be evaluated over time. *Good mentors* should be consistently supported by ward managers (see section 4.1.1). Robust and reflective leadership that exemplifies care with compassion need to be at the forefront of every ward’s philosophy. Whilst enhancing quality care, working interprofessionally should be at the centre of care delivery and fundamental care should be celebrated as a core component of the nurse’s role (see section 4.2.3).

Prominent changes are taking place to pre-registration nurse education. Results of the NHS Bursary Reform, whereby PQNSs will not receive NHS bursaries (see section 1.6) remain to be seen. It is suggested that paying for tuition fees will result in less students applying for nursing courses (Sayburn, 2016), ultimately leading to more staff shortages (Imison & Dayan, 2016). Recommendation 187 of the Francis Report, suggests that prior to commencing the pre-qualifying nursing course, PQNSs should work in the care sector as a nurse assistant for up to a year (see sections 1.6 and 4.2.4). Therefore, the length of the nursing course could be increased from three to up to four years. This can also deter potential candidates from applying for the BSc in Nursing degree course. At the same time, the shift of the role of the qualified nurses towards being ‘mini doctors’ (see section 1.6.4) can move them away from providing fundamental care. This can foster a culture, whereby nurses are more involved in completing ‘mini doctors’ tasks or even promote a ‘too posh to wash’ ethos (see section 1.6.4). Hence, compromising on quality time that can be spent looking after their patients.

Whilst it is difficult to prescribe a specific culture that can be integrated in all clinical areas, it can be argued that practices encouraging constructive dialogues that work well should be reinforced. Effective leadership can promote and empower CMs in delivering care with compassion, thereby setting standards for PQNSs (see section 4.4). This however needs the support of link lecturers from HEIs (see section 4.1.4). It is about embedding compassionate care in the culture.
of the wards. The managerialist approach (see section 2.4.1) to care should be replaced by the mantra of compassionate care that should be used at the beginning of each shift. CMs should have the responsibility of leading and deliver compassionate care, whilst maintaining the safety of every member of the team and demonstrating best evidence in the care for older people.

6.7 Conclusion

Derived from the ancient theological ideals, compassion in nursing is not a new concept. It should be the business of everybody, mainly of some agencies and regulators which embed the core values and behaviours within the healthcare settings. Compassion can be defined as ‘ability to appreciate and empathise with an appropriate action to ease suffering.’ This is in line with the conceptual framework described in sections 2.2.1 and 2.2.2. Compassion can be demonstrated in five different levels (see section 4.8). Whilst this thesis has particularly explored perceptions of compassion in the care of the older people, it can be argued that suggestions from the findings’ chapter can be applied to all care settings.

The Department of Health should insist on maintaining a good skill mix in different clinical areas as Boorman (2009) found that there is a correlation between staff health, provision of patient safety and good patient experience. Compassion should not only be at the bedside, in a clinical environment, it should be the fundamental component that runs through the pre-registration nursing education (both at the HEIs and practice placements and beyond) (Bradshaw, 2014 & Willis Commission Report, 2012).

Whilst supporting PQNSs as well as embedding and fostering compassion, it is paramount that there is a good line of communication between HEIs and the clinical areas. With the help of NEs and CMs, universities and hospital trusts should provide core fundamental nursing values and behaviours at every level. For instance, PQNSs should be taught from the point of induction of the programmes and throughout the three years and beyond, after they qualify through jobs and post registration courses using the 6Cs (see section1.6.3). Compassionate care
can to be taught, learnt and cultivated. Participants added that PQNSs should have an aptitude in the first place (see section 4.7.1).

For PQNSs to benefit from this tripartite relationship, CMs, PQNSs and NEs should engage and work together. Compassionate and supportive CMs play a vital role in enabling PQNSs to embrace the role of a good nurse whilst creating positive feelings towards nursing as a career (Bradbury-Jones et al., 2007). Link lecturers who support the clinical areas and whose role is valued by both CMs and PQNSs should maintain weekly visits (see section 4.1.4). The choices of words, the choices of approaches are important, how NEs and CMs view the patient, how they engage with students and patients respectively are all powerful techniques to promote and enhance compassionate care.

Patient-centred care should be one of the most important themes that runs from pre-registration nursing education and beyond to the post registration education programmes (PREP) (Willis Commission, 2012). Preparing nurses to provide compassionate care with competence should be a vital role of the NEs and CMs, whilst the curriculum must reflect the needs of patients (The Patients Association, 2009). Whilst the recruitment and selection department at the universities should attract people with the right attributes as well as academic ability, NEs, CMs and other health care professionals should promote and maintain the values of the 6Cs. Emotional intelligence tests (Saldanha, 2006) and the input from service-users at recruitment and selection day should become common practice (NMC, 2008). Tools to measure compassion at the point of recruitment and thereafter when PQNSs qualify should be used (see section 6.1.1).

Validating the Code of Conduct (NMC, 2015), which is about treating patients with dignity and respect, should be the first concern of every nurse (DH, 2012a). Nursing education flourishes when health care professionals continuously have their skills updated using an inter-professional approach (Willis Commission Report, 2012). Leaders have a vital role in providing and maintaining an organisational culture whereby the patient, who is an equal partner, is at the centre of care (RCN, 2012b). Employers should also provide safe staffing levels which
will enable CMs to dedicate sufficient time with their students or newly qualified staff (see section 1.4.1).

The provision of compassionate care does not rest only on personal qualities such as being kind and helpful, but depends on other influences including working in a practice environment with a positive culture of care (See section 4.4.1). Until the organisation concerned has the culture of learning in a compassionate way, whereby learning is cherished, the importance of the good role models will not be recognised (McLean, 2004a). A culture facilitated by committed leaders at all levels, ward sisters and charge nurses, modern matrons, directors and executives is recommended to improve efficiency and raise quality care (RCN, 2009). That culture’s focus should be on compassionate care rather than targets. Employers should communicate with their employees, treat them with compassion, provide appropriate training and development and have an open culture, whereby employees feel free to express themselves (RCN, 2012b).

Overall, researching this topic has made me realise that spending quality time with students and patients is very important to promote compassionate care. However, at the HEI or the hospitals where this study was conducted, everyone seems to be in rush, there is no time to spend with patients, students and each other. This situation gets worse if there is poor skill mix in hospital wards. Insufficient nursing time leads to poor patient care and overworked staff which can be costly (Aiken, 2008). This conclusion highlights the importance of compassionate care in both practice and in HEIs.
References


Curtis, K. (2014) Compassion is an essential component of good nursing care and can be conveyed through the smallest actions. *British Journal of Nursing*. **18** (3), pp.95.


Department of Health (2013c) ‘*Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values: A mandate from the Government to Health Education England: April 2013 to March 2015.*’ DH: London.


*Psychological Bulletin.* 130, pp. 335–91.


Patients Association (2011) *We have been listening, have you been learning?* Harrow Middlesex. The Patients Association.


Willis Commission Report (2012) *Quality with Compassion: The Future of Nursing Education.* (online). Available from: 


Appendix 1: Pommier' (2011) Compassion Scale

<table>
<thead>
<tr>
<th>Item</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>when people cry in front of me, I often don’t feel anything at all</td>
</tr>
<tr>
<td>2</td>
<td>sometimes when people talk about their problems, I feel like I don’t care</td>
</tr>
<tr>
<td>3</td>
<td>I don’t feel emotionally connected to people in pain</td>
</tr>
<tr>
<td>4</td>
<td>I pay careful attention when other people talk to me</td>
</tr>
<tr>
<td>5</td>
<td>I feel detached from others when they tell me their tales of woe</td>
</tr>
<tr>
<td>6</td>
<td>if I see someone going through a difficult time, I try to be caring toward that person</td>
</tr>
<tr>
<td>7</td>
<td>I often tune out when people tell me about their troubles</td>
</tr>
<tr>
<td>8</td>
<td>I like to be there for others in times of difficulty</td>
</tr>
<tr>
<td>9</td>
<td>I notice when people are upset, even if they don’t say anything</td>
</tr>
<tr>
<td>10</td>
<td>when I see someone feeling down, I feel like I can’t relate to them</td>
</tr>
<tr>
<td>11</td>
<td>everyone feels down sometimes, it is part of being human</td>
</tr>
<tr>
<td>12</td>
<td>sometimes I am cold to others when they are down and out</td>
</tr>
<tr>
<td>13</td>
<td>I tend to listen patiently when people tell me their problems</td>
</tr>
<tr>
<td>14</td>
<td>I don’t concern myself with other people’s problems</td>
</tr>
<tr>
<td>15</td>
<td>It’s important to recognize that all people have weaknesses and no one is perfect</td>
</tr>
<tr>
<td>16</td>
<td>my heart goes out to people who are unhappy</td>
</tr>
<tr>
<td>17</td>
<td>despite my differences with others, I know that everyone feels pain just like me</td>
</tr>
<tr>
<td>18</td>
<td>when others are feeling troubled, I usually let someone else attend to them</td>
</tr>
<tr>
<td>19</td>
<td>I don’t think much about the concerns of others</td>
</tr>
<tr>
<td>20</td>
<td>suffering is just a part of the common human experience</td>
</tr>
<tr>
<td>21</td>
<td>when people tell me about their problems, I try to keep a balanced perspective on the situation</td>
</tr>
<tr>
<td>22</td>
<td>I can’t really connect with other people when they’re suffering</td>
</tr>
<tr>
<td>23</td>
<td>I try to avoid people who are experiencing a lot of pain</td>
</tr>
<tr>
<td>24</td>
<td>when others feel sadness, I try to comfort them</td>
</tr>
</tbody>
</table>

(to reverse score questions, subtract each answer from 6)

- Kindness (6, 8, 16, 24) =
- Indifference (2, 12, 14, 18 - reverse scored) =
- Common Humanity (11, 15, 17, 20) =
- Separation (3, 5, 10, 22 - reverse scored) =
- Mindfulness (4, 9, 13, 21) =
- Disengagement (1, 7, 19, 23 - reverse scored) =

**Total Score**

For more detail on scoring and on typical scores for men & women, and the relationship between compassion & self-compassion for students, adults & meditators, see the next page.

### Appendix 2- Example of grouping of terms using Boolean operators

<table>
<thead>
<tr>
<th>Key terms with Boolean operators</th>
<th>Hits from January 2000- November 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older people and compassion</td>
<td>44</td>
</tr>
<tr>
<td>Older people AND compassionate care</td>
<td>27</td>
</tr>
<tr>
<td>Older people AND patient centred care</td>
<td>405</td>
</tr>
<tr>
<td>Nursing AND patient centred care</td>
<td>7125</td>
</tr>
<tr>
<td>Nursing AND older people AND compassionate care</td>
<td>15</td>
</tr>
<tr>
<td>Nursing AND Nurse Education and patient centred care</td>
<td>52</td>
</tr>
<tr>
<td>Nurse education AND patient centred care</td>
<td>61</td>
</tr>
<tr>
<td>Nursing AND Nurse Education AND patient centred care AND older people</td>
<td>1</td>
</tr>
</tbody>
</table>
Appendix 3: CRITICAL APPRAISAL SKILLS PROGRAMME

Making sense of evidence about effective health care

10 Questions to help you make sense of

Qualitative Research

General comments

- The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions.

- A number of italicised hints are given. These are designed to remind you why the question is important. It is important to emphasise that all of these prompts need not necessarily be met.

- Several of the questions ask for a response on a scale ranging from 'yes' to 'no'. Where there are sub-questions, try to answer these first and then summarise the sub-questions into one overall response, by marking a cross on the scale.

- The 10 questions have been developed by the national CASP collaboration for qualitative methodologies.
## Screening Questions

### 1. Was there a clear statement of the aims of the research?

**HINTS:** What were they trying to find out?

- Why is it important?
- What is its relevance?

Yes | No

### 2. Is a qualitative methodology appropriate?

**HINT:** Does the research seek to understand or illuminate the subjective experiences or views of those being researched?

Yes | No

### Detailed Questions:

#### 3. Sampling strategy

Is it clear:

- a) from where the sample was selected and why?
- b) who was selected and why?
- c) how were they selected and why?
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>d)</strong> was the sample size justified?</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>e)</strong> is it clear why some participants chose not to take part?</td>
<td></td>
</tr>
<tr>
<td><em>HINT: consider saturation of data</em></td>
<td></td>
</tr>
<tr>
<td><strong>Was the sampling strategy appropriate to address the aims?</strong></td>
<td>Yes</td>
</tr>
</tbody>
</table>

### 4 Data Collection

Is it clear:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a)</strong> where the setting of the data collection was, and why that setting was chosen</td>
<td></td>
</tr>
<tr>
<td><strong>b)</strong> how the data were collected and why?</td>
<td></td>
</tr>
<tr>
<td><em>HINTS: focus group, structured interview etc</em></td>
<td></td>
</tr>
<tr>
<td><strong>c)</strong> how the data were recorded and why?</td>
<td></td>
</tr>
<tr>
<td><em>HINTS: recorded, made notes etc</em></td>
<td></td>
</tr>
<tr>
<td><strong>d)</strong> if the methods were modified during the process and why?</td>
<td></td>
</tr>
<tr>
<td><strong>Were the data collected in a way that addresses the research issue?</strong></td>
<td>Yes</td>
</tr>
</tbody>
</table>

### 5 Data analysis

Is it clear:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a)</strong> how the analysis was done?</td>
<td></td>
</tr>
</tbody>
</table>
b) how the categories/themes were derived from the data? Is there adequate description?

c) if steps have been taken to test the credibility of the findings?

d) are you confident that all the data were taken into account

_HINTS: Is there adequate discussion of the evidence both for and against the researcher's arguments? Have attempts been made to feed results back to respondents, and/or using and comparing different sources of data about the same issue where that is appropriate (triangulation). Was the analysis repeated by more than one researcher to ensure reliability?_

<table>
<thead>
<tr>
<th>Was the data analysis sufficiently rigorous?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

6 Research partnership relations

Is it clear:

a) if the researchers critically examined their own role, potential bias and influence?

b) where the data were collected and why that setting was chosen?

c) how the research was explained to the participants?

_HINT: Consider confidentiality, ethics, implications and consequences for research findings for all of the above_
| Has the relationship between researchers and participants been adequately considered? | Yes | No |

### 7 Findings

HINTS: What were the findings – are they explicit, easy to understand?

Is there a clear statement of the findings? | Yes | No |

### 8 Justification of Data Interpretation

a) Is there sufficient data presented to support the findings?

b) Do the researchers explain how the data presented in the paper were selected from the original sample?

HINTS: criteria for the selection of the quote, some details of the respondent, what is the role of the data - example, illustration, "nice" quote to share etc.

Do the researchers indicate links between data presented and their own findings on what the data contain? | Yes | No |
### 9 Transferability

**HINTS**

Consider:

- whether the context and setting in which the study was performed, is described in sufficient detail to determine similarities and differences to your own

| Are the findings of this study transferable to a wider population? | Yes | No |

### 10 Relevance and Usefulness

a) in terms of addressing the research aim?

b) in terms of contributing something new to understanding / new insight / different perspective?

c) in terms of suggesting further research

d) in terms of impacting on policy / practice?

**How relevant is the research?**

To your patient / problem / scenario / To you personally

| Very | Not at all |

How important are these findings to practice?

| Very | Not at all |
Appendix 4: Full search from MEDLINE, CINAHL Plus with Full Text, BNI, AMED and Information Science & Technology Abstracts

| S1 | nursing AND nurse education AND patient centered care AND older people | Limiters: Published Date: 200000/01-2015/1131; English Language | View Results (1) | View Details | Edit |
| S7 | nurse education AND patient centered care | Limiters: Published Date: 200000/01-2015/1131; English Language | View Results (61) | View Details | Edit |
| S6 | nursing AND nurse education AND patient centered care | Limiters: Published Date: 200000/01-2015/1131; English Language | View Results (63) | View Details | Edit |
| S5 | nursing AND older people AND compassionate care | Limiters: Published Date: 200000/01-2015/1131; English Language | View Results (15) | View Details | Edit |
| S4 | nursing AND patient centered care | Limiters: Published Date: 200000/01-2015/1131; English Language | View Results (7,125) | View Details | Edit |
| S3 | older people AND patient centered care | Limiters: Published Date: 200000/01-2015/1131; English Language | View Results (405) | View Details | Edit |
| S2 | older people AND compassionate care | Limiters: Published Date: 200000/01-2015/1131; English Language | View Results (27) | View Details | Edit |
| S1 | older people AND compassion | Limiters: Published Date: 200000/01-2015/1131; English Language | View Results (44) | View Details | Edit |
## Appendix 5: Appraised studies

<table>
<thead>
<tr>
<th></th>
<th>Qualitative studies</th>
<th>Quantitative studies</th>
<th>Mixed methods studies</th>
<th>Conceptual studies</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UK</strong></td>
<td>13</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td><strong>USA</strong></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td><strong>Canada</strong></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Netherlands</strong></td>
<td>1</td>
<td></td>
<td>2</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td><strong>Australia</strong></td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Malawi</strong></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18</td>
<td>2</td>
<td>3</td>
<td>12</td>
<td>35</td>
</tr>
</tbody>
</table>
## Appendix 6: Characteristics and results of the studies reviewed

<table>
<thead>
<tr>
<th>Study/number</th>
<th>Location, setting</th>
<th>Design</th>
<th>Sample</th>
<th>Exposure/intervention</th>
<th>Outcome</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adam &amp; Taylor (2013) Compassionate care: Empowering students through nurse education</td>
<td>UK</td>
<td>Evaluation of a teaching approach</td>
<td>30 students' formative reflective accounts</td>
<td>Reflection and class discussion</td>
<td>Initially the students tended to shift the blame the other nurse, the relative or the circumstances for their difficulties. They came to realise that they had the power to react differently in the future.</td>
<td>Important reflection and discussion to empower students to practice care with compassion. Reflection helped in identifying students' strengths and weaknesses in dealing with situations in practice. The fact that ethical approval was deemed unnecessary, is a weakness. It was stated that &quot;the evaluation of the teaching experience was part of the overall student learning experience rather than a research study and did not require ethical approval&quot;, p.1243,</td>
</tr>
<tr>
<td>Armstrong <em>et al.</em> (2000) An inquiry into</td>
<td>UK</td>
<td>Delphi method</td>
<td>N=26 in round one, decreasing to</td>
<td>To investigate nurse’s descriptions</td>
<td>Compassion was recognised as an important element in mental health nursing. Sixteen ways to</td>
<td>Importance of compassion in psychiatric nursing and meanings of compassionate care explored.</td>
</tr>
</tbody>
</table>
moral virtues, especially compassion, in psychiatric nurses: Findings from a Delphi study.

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Design</th>
<th>Population</th>
<th>Methodology</th>
<th>Findings/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Badger &amp; Royse (2012)</td>
<td>USA</td>
<td>A qualitative design with two focus</td>
<td>Burn survivors, primarily Caucasian</td>
<td>Investigate the concept of compassionate care</td>
<td>Data analysis yielded primary themes of: 1) Respect the person (subthemes: establishing an empathic connection, restoring</td>
</tr>
</tbody>
</table>

express compassion were recommended: “Give time and listen; show understanding about how they are feeling/behaving; compassion is caring and showing it; assisting others to make their own decisions; not to deny the client any rights; to always act in the client’s best interest.” Question asked the mental health nurses- “Is behaving and acting compassionately important to the goal of being an ethical psychiatric nurse?”, p. 297. 71.4% responded that acting compassionately is a part of the role of everyone, however, particularly important for nurses, who look after vulnerable people.

Consistently acting in a compassionate manner is important.

Relying on questionnaires can be a weakness for the data collection. One of the reasons could be because it may be difficult to tell how truthful the participants are with their answers.
Care: the burn survivor's perspective.

Groups at a Burn Survivors' unit were used. n=31 burn survivors’ accounts.

(77%), female (60%) with average age of 47.6 years

How it is described from the perspective of the burn survivor

Control through choice, providing individualized care, and going above and beyond,

2) Communication (subthemes: interpersonal and informational (educational and preparatory))

3) Provision of competent care.

The three primary themes were components of compassionate care; it was not defined by a single characteristic, behaviour, or skill but might be best understood as the convergence of the three themes.

As the mean age of participants was 47.6 years, this study did not completely represent the older people dimension. Some of the findings could be used in almost any care setting.
<table>
<thead>
<tr>
<th>Reference</th>
<th>Title</th>
<th>Country</th>
<th>Method</th>
<th>Sample</th>
<th>Findings</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bradshaw (2011a)</td>
<td>Editorial: the future of clinical nursing: meeting the needs of patients for compassionate and skilled nurses?</td>
<td></td>
<td></td>
<td></td>
<td>Interesting article. This article offers a glance into the role of the ‘good nurse’, devoting all their effort in looking after the old and the sick. Nursing being about fostering a caring attitude.</td>
<td></td>
</tr>
<tr>
<td>Bramley &amp; Matiti (2014)</td>
<td>How does it really feel to be</td>
<td>UK</td>
<td>A qualitative exploratory</td>
<td>A purposive sample of n=10 patients in a large</td>
<td>This study suggested a robust connection between compassion and caring. These two concepts were not differentiated.</td>
<td>To understand how patients’ experience of compassion within nursing and explore their perceptions of developing compassionate nurses.</td>
</tr>
</tbody>
</table>
in my shoes? Patients’ experiences of compassion within nursing care and their perceptions of developing compassionate nurses
descriptive approach.
teaching hospital. Female 50%. Age 18-91 years old.
interviews were used.
Participants frequently replacing “compassion” for “care” and “caring” throughout the interviews. Touch and treating patients as individuals were perceived as significant dimensions to compassion. Providing adequate time and encouragement were also seen as important. Important also was seen personalised care with nurse’s good attitudes.
Compassion being seen as individualised care; emphasis is on touch (a form of communication) and interaction.

Compassion was seen conveyed through the provision of fundamental care.

• The implications of the effects of inadequate compassion should not to be underestimated.
• For some, the act to provide compassionate care can only be short-term, instead of a rather than a long and established relationships between nurses and the patients they look after.

This is an interesting study. Some of its limitations are:

• The sample was small and did not include very ill and those with dementia.
Therefore, transferability of the findings is difficult.
- Despite the culturally diverse Britain, all participants were white.

| Bray et al. (2014) The role of professional education in developing compassionate practitioners: A mixed methods study exploring the perceptions of health professionals and pre-registration students | UK | Mixed method (surveys and semi-structured interviews) | Qualified health professionals (n = 155) and pre-registration students (n = 197) | Surveys and qualitative semi-structured interviews | Findings from survey data:
- Being warmth and empathetic were believed to be vital attributes of compassion for both qualified health professionals (66% n = 102) and pre-registration students (57%, n = 113), followed by providing individualised care (health professionals, 30%, n = 46; pre-registration students, 33%, n = 64).
- Findings from interviews:
- Most of those interviewed stated that knowledge was more important than compassion. |

Not nursing specific-health care professionals instead. Attributes to compassionate care being empathy and warmth. It was also suggested that knowledge and competence more important than compassion.

This is a very good article. It has many strengths, from the research methodology to the sample used. The research team was not connected to the educational course the participants were registered in. So, they could be more objective in the analysis.

On the other hand, the above could also be a weakness. This means that the researchers would not have an inside perspective (emic).
<table>
<thead>
<tr>
<th>Author(s) &amp; Year</th>
<th>Title</th>
<th>Methodology</th>
<th>Sample</th>
<th>Data Collection</th>
<th>Main Themes</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnell (2009)</td>
<td>Compassionate care: A concept analysis</td>
<td>USA</td>
<td>Interesting conceptual paper</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christiansen et al. (2015)</td>
<td>Delivering compassionate care: the enablers and barriers.</td>
<td>UK</td>
<td>Mixed method (interviews and questionnaires)</td>
<td>Sample: Health professionals (HP) (n=146) and Health Care Students (HCS) (n=166)</td>
<td>Questionnaire and face-to-face and telephone interviews</td>
<td>Main themes emerged are 1) individual and relationship factors that impact on compassionate care practice, 2) organisational factors that impact on the clinical environment and team, 3) and leadership factors that hinder or enable a compassionate care culture. This study discusses enabling factors that enhance a culture conducive to providing compassionate care.</td>
</tr>
<tr>
<td>Crawford et al. (2013)</td>
<td>The Language of Compassion in 2 studies combined. Two semi-structured interviews</td>
<td>2 studies combined. 1st study: 10 nurse practitioners</td>
<td>1st study: production language. Discourse analysis of</td>
<td></td>
<td>There is a language of compassion versus targets and production-line that enhances a language of threat in healthcare.</td>
<td>Interesting study, which is based in England, but the sample only considered nurse practitioners' perspectives.</td>
</tr>
<tr>
<td>Acute Mental Health Care</td>
<td>mental health wards in a hospital UK</td>
<td>the 10 interviews to determine the language of threat-working against the clock - the “production line mentality. Study 2: practitioner perspectives on compassion. 4 interviews were edited</td>
<td>the 10 interviews to determine the language of threat-working against the clock - the “production line mentality. Study 2: practitioner perspectives on compassion. 4 interviews were edited</td>
<td></td>
<td></td>
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<tr>
<td>----------------------------</td>
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<td>--------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crowther et al., (2013) Compassion in healthcare – lessons from a qualitative study of the end of life in the UK</td>
<td>Qualitative informed by Grounded Theory and In-depth narrative interviews</td>
<td>The results suggest that there are variances and difficulties whilst providing compassionate care in care settings. Excellent examples of compassionate care were experienced alongside very poor and inhumane practices.</td>
<td>The results suggest that there are variances and difficulties whilst providing compassionate care in care settings. Excellent examples of compassionate care were experienced alongside very poor and inhumane practices.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This is a clear example suggesting that universalising the best care is important laying emphasis on issues such as staff attitude, organisational culture and communication skills.
| Curtis et al. (2012) Student nurse socialisation in compassionate Practice: a Grounded Theory study. | UK. University in the north of England | Glaserian Grounded Theory study | Student nurses (n=19) at a university in the north of England during 2009 and 2010. Interviews were also undertaken with their nurse teachers (n=5) and data from National Health Service (NHS) patients (n= | In-depth digitally recorded interviews | This study showed that socialisation in compassionate practice was compromised by disagreement between ‘professional idealism and practice realism’, p. 790. Findings showed that socialisation in compassionate practice appeared to be compromised. Whilst fundamental nursing care was not provided by registered nurses, students viewed that qualified nurses should still be involved. The term ‘McDonaldisation’ appeared to refer to students' seeing targets being imposed on patient care. Task oriented care dehumanise care. Students felt the way that | Self-selection of participants presented bias and at the same time, most carers were female. This can be seen as a weakness. The study provided an in-depth exploration of student nurse socialisation in compassionate practice. Teachers were interviewed. Interesting study conducted in the north of England. Both students and nurse. This study being carried out in only one university in Northwest England can be seen as a weakness. Their perceptions may not ay not entirely mirror those of wider healthcare staff. |
nursing care was being delivered was different to the professional ideal that they thought prior entering the profession. Qualified nurses thought the same and they said that constraints, such as targets and stress were the main causes.

Curtis (2014)
Learning the requirement for compassionate practice:
Student vulnerability and courage
UK
Glaserian grounded theory
19 students were interviewed in the north of England during 2009–2010
In-depth interviews

The findings demonstrated that student nurses had fears of how they can involve in and sustain compassionate practice as they progressed towards the role of a qualified nurse. Students were concerned of being vulnerable emotionally and emotionally drained. The seemed to be a balance between the way that students managed feelings of vulnerability and uncertainty were and their intentions towards and away from engaging in compassionate care.

Students stated that inappropriate levels of emotion in nurse/patient relationships could have the opposite effect. It was important to avoid emotional labour to preserve the right balance.

It appeared that no provision was made to look after student nurses who felt susceptible and needed emotional support.
<table>
<thead>
<tr>
<th>Davison &amp; Williams (2009)</th>
<th>UK</th>
<th>Conceptual paper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion in nursing 1: defining, identifying and measuring this essential quality</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dewar (2011)</th>
<th>UK</th>
<th>Appreciative action research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring about caring: an appreciative inquiry about compassionate relationship centred care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| | The findings suggest that the process in developing a practice model to sustain practitioners to deliver compassionate relationship-centred care. This model recommends the involvement of people in the method of appreciative caring. Conversations to appreciate: 
| a) who people are and what matters to them; and 
| b) how people feel about their experience. “The findings support the notion of emotional support” |

<p>| | Interesting study, but the sample did not include any nursing student. Importance of engaging in a meaningful dialogue, emotional connection and active communication. As this study was only conducted in one ward, one of the implications would be limited transferability of the findings to other areas. |</p>
<table>
<thead>
<tr>
<th>Dewar &amp; Mackay (2010)</th>
<th>UK</th>
<th>Appreciative action research</th>
<th>Patients and their families</th>
<th>“Connection, be curious, collaborative, able to compromise, considerate of others perspectives, courageous and actively celebrate when practices have worked well to promote compassionate relationship-centred care”.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dewar &amp; Nolan (2013) Caring about caring: developing a model to</td>
<td>UK</td>
<td>Older people (n=10), staff (n=35) and Appreciative inquiry and a range of methods including</td>
<td>Findings suggest that compassion is only achieved through, multifaceted, interpersonal practices. They suggested that a definition of</td>
<td>The paper describes the development of a model of compassionate relationship-centred care developed in the UK but has global relevance. The paper also stipulates the sorts of</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Findings from this work propose several important methods that can assist people to provide compassionate care. These should be expressed, shared across practice.</td>
<td>This paper claims that using a good methodical analysis of caring practice that works well in care environments may be used as a template. Nursing students’ perspectives were not included. One of the weaknesses with the appreciative inquiry, used in this study is as it only focusses on the positives, underlying problems in practice may have been ignored (Reed, 2007).</td>
</tr>
</tbody>
</table>
implement compassionate relationship centred care in an older people care setting. Relatives (n=12) in agreeing a definition of compassionate relationship centred care and identifying strategies to promote such care in acute hospital settings for older people participant observation, interviews, storytelling and group discussions. 

compassion is lacking. However, some key attributes were identified, including; recognising vulnerability and suffering; relating to the needs of others; preserving integrity and acknowledging the person behind the illness. Compassion primarily involves an awareness of another’s feelings. 

relational information that supports compassion from the older people’s, staff’s and relatives’ views.

| Georges (2011) Evidence of the unspeakable: Biopower, Conceptual paper (USA) | Unspeakable for this article means the foundation/sustenance of biopolitical spaces in which compassion exists, importance of self-compassion and compassion for patients is getting difficult. It suggests that in academia research is more important than students’ needs. |
| compassion, and nursing | Demonstrating compassion to students is a necessary for nurse education and for future nurses. Proving uncompassionate manner, can lead students doing the same to their patients. “The day we stop valuing compassion as an essential of nursing practice or resisting the creation of biotoxic, compassionless environments, we cease to be nurses”, (p.134). Compassion for students and academics can become very low on the list of priorities in the academic ladder. | Graber & Mitcham, (2004) Compassionate Clinicians Take Patient Care Beyond the Ordinary | 2 hospitals in the south-easter USA | Phenomenological approach to explore the insider perspective of the clinicians lived experience | 24 clinicians from 2 hospitals | In-depth interview | Clinicians defined several actions or approaches to expressing care with compassion to patients, for example communication, attention to small, but important things, such as smile. To make the HCW-patient relationship meaningful. | Sample of 24 in-depth interviews of clinicians (including nurses, physicians) who had been identified as being highly caring and compassionate in their interactions with patients were used. For this reason, this research study could be bias as it did not look at all other HCWs who could be very uncompassionate. The study could have identified personal variables or predictors of compassionate behaviour. Study conducted in the United States and only considered the views of clinicians. This study explores 4 levels of clinician-patient interaction, “A preliminary model of affective clinician/patient interactions”. |
Level 1: Impersonal/practical: impersonal and practical relationship.

Level 2: Personal/social: Clinicians may seek out friendly relations with patients and other clinicians primarily from personal social needs.

Level 3: Personal/feeling: Applicable to clinicians who possess high levels of altruism.

Level 4: Transcendent: The transcendent nature of compassion being a force coming from the soul to help people. Compassion not just an emotion; it is a force.

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**Horsburgh & Ross (2013)**

*Care and compassion: the experiences of newly qualified staff nurses*

**UK**

A qualitative study. Data from newly qualified nurses (within first year of employment) and other healthcare professionals. Focus groups (n=6, total participants n=42) using a flexible agenda to guide the discussion.

Compassionate care was advocated by participants, stating that care without compassion is not care. Compassion as a concept was defined whilst looking at situations in which it was absent.

UK based study exploring the perceptions of the newly qualified nurses. Importance of emotional engagement with the patients was explored.

Whist this study did not explore the older people, it discussed relevance to...
Nursing was “more than just a job” but an occupation in which “emotional engagement” is not only desirable but vital in the delivery of quality care with compassion (p.1124). Words included: dignity, demonstrating respect, making someone feel as comfortable as possible, to treat others as you want to be treated yourself and working with the person were mentioned.

As this study was only conducted in one health board, transferability of the findings to other areas would be limited.

<table>
<thead>
<tr>
<th>Kneafsey et al., (2015)</th>
<th>UK</th>
<th>Exploratory, qualitative design.</th>
<th>Academic staff, health care students, clinicians and service users (n = 45),</th>
<th>Focus groups</th>
<th>Four themes emerged from the data. They were:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A qualitative study of key stakeholders’ perspectives on compassion in healthcare and the development of a framework</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Participants’ definitions of compassion</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Identification of compassionate behaviours.</td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td>- Threats to compassionate practice and</td>
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<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>Establishing meaningful connections with others as a vital component was one of the main findings. Participants recognised care with compassion at all times was improbable.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Communication skills are vital in improving compassionate care.</td>
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<td></td>
<td></td>
<td></td>
<td>Devoting quality time to develop a constructive interpersonal relationship was viewed as vital. Note that care</td>
</tr>
</tbody>
</table>
for compassionate interpersonal relations

- How to support compassion in practice?

given without personal touch was viewed as uncompassionate.

As this study was conducted in a small area, the views represented, may not generalise nationally to the UK.

Kret (2011) The Qualities of a Compassionate Nurse According to the Perceptions of Medical-Surgical Patients

| Winthrop University Hospital, Mineola, NY, USA | Descriptive study | 100 nurses and 100 patients | Questionnaires | Statistical significance was shown in the years of experience of the nurse and the compassion rating of cold-warm ($p=0.0378$). This implied the more experienced nurse is, the less compassionate they are likely to be towards the patient. This finding unfortunately implied the vigour and passion demonstrated by the newer nurse may diminish as the nurse becomes more experienced. This may be attributed to compassion fatigue. Statistical significance was shown between the nurses' shift (day or night) and the compassion ratings of |

Limitations:

- An uneven distribution of the day shift (61%) and night shift (39%) occurred due to the availability of data collectors.
- Most nurses within this study had 0-4 years of experience (76%). Contributing to this result is that a medical-surgical unit is often the point of professional entry for many new nurses. The inadequate correlation between time spent with the patient and the compassion the patient’s perception of compassion. The study is conducted in the USA and the sample is patients. There seemed to be a correlation with experience and uncompassionate care.
unpleasant pleasant (p=0.0233) and distant compassionate (p=0.0178). This suggested that patients viewed their nurses were pleasant and compassionate, irrespective of whether their nurses worked a day or night shift. This may be attributed to the fact that the nurses who took care of them were perceived to be consistently compassionate and pleasant towards their patients.

In the qualitative analysis, patients were asked to describe nurses’ compassionate qualities. The compassion themes found within the written descriptors included caring (54), attentive (35), dedicated (13), approachable (11), professional (9), and keeping the patient informed (7).

Qualities of compassionate nurses were found to be “attentive, dedicated, approachable, professional and keeping the patients informed”.
<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Country</th>
<th>Sample Size</th>
<th>Methodology</th>
<th>Data Collection</th>
<th>Findings</th>
<th>Generalisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Msiska <em>et al.</em></td>
<td>2014</td>
<td>Malawi</td>
<td>30 PQNS</td>
<td>Hermeneutic phenomenological</td>
<td>Conversational interviews</td>
<td>The study suggested that novice PQNS were fearful of contracting HIV infection. One of the main findings reveal with practice and education, there was the development of compassionate care among PQNS towards HIV positive patients.</td>
<td>Interesting study from Malawi. Difficult to generalise as it was conducted in only one school of nursing. However, it is fair to suggest that lack of knowledge, experience and possibly preconceptions can cause fear, hence emotional detachment. Experiential learning and knowledge can change those preconceptions into emotional engagement.</td>
</tr>
<tr>
<td>Perry (2009)</td>
<td></td>
<td>Canada</td>
<td>7 nurses</td>
<td>Descriptive phenomenology</td>
<td>Unstructured interviews and participants’ observations</td>
<td>Paying attention to little things (the ordinary essentials). It was about nurses doing the right small things, giving patient quality time.</td>
<td>The purposive sample seems insignificant and focuses only on nurses, why not other healthcare professionals or patients? Bias is an issue as only nurses who are compassionate could have taken part in the study. It seems that this study is very difficult to be generalised. Study conducted in Canada. Paying attention to little things as pertinent to compassionate care.</td>
</tr>
<tr>
<td>Rankin, B. (2013)</td>
<td>UK</td>
<td>The study employed a longitudinal survey</td>
<td>Student nurse applicants ($n = 307$)</td>
<td>Self-report scales</td>
<td>A considerable predictive link was found between emotional intelligence and the main three results of the study's agenda: practice performance; academic performance and retention, The importance of emotional intelligence in the recruitment and selection process. Emotional intelligence in enhancing compassionate care in nursing is important.</td>
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<td></td>
</tr>
<tr>
<td>Sanghavi (2006)</td>
<td>Massachusetts, USA</td>
<td>Narrative findings</td>
<td>54 hospitals</td>
<td>Questionnaire s and transcripts</td>
<td>Importance of communication, common ground and treating the patient as individual. Recommendations: ongoing support, role model, regular teaching, Based in the USA, the findings suggest that treating lack of compassion not as an acute trauma but as a chronic condition (such as, diabetes) require a lifetime of continuous support, regular guidance, repeated reinforcement, specific targeted outcomes, and more innovative care programs. This study did not completely fit the older people dimension. However, this study still presented some interesting findings, which could be applicable in all care settings.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Schantz (2007)  
Compassion : A Concept Analysis  
Pennsylvania (USA)  
USA)  
USA) | To clarify the meaning “compassion” and examine its relevance in the context of everyday nursing practice | Literature was generated from an electronic search. Key terms were “concept analysis”, and “compassion”. | The concept of compassion is neither clearly defined in nursing scholarship nor widely promoted in everyday nursing practice. - Nursing research that uses terms such as caring, empathy, sympathy, compassionate care and compassion interchangeably, implying that these words are synonymous, promotes assumptions.  
In everyday nursing practice words, such as “caring” and “empathy” are popular and commonly used. It was suggested that inherently nurses should have good quality and possess “an internalised motivation for doing good.  
Compassion is perceived as a necessary result of being human. Compassion requires an understanding of pain, entering places, where there is fear and | Interesting and comprehensive article. 
Conceptual paper |
<table>
<thead>
<tr>
<th>Reference</th>
<th>Institution</th>
<th>Participants</th>
<th>Methodology</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith <em>et al.</em> (2010)</td>
<td>Edinburgh, Scotland, UK</td>
<td>37 staff members (in senior position)</td>
<td>Observation, interviews and reflective account (multi method)</td>
<td>Following a relationship centred approach, outcome of care achieved was relevant and compassionate. Some participants may not have been completely honest in their discussions, particularly because of self-administered questionnaire. The sample is restricted to senior staff members.</td>
</tr>
<tr>
<td>Straughair (2012a)</td>
<td>UK</td>
<td>This part focusses on the origins of compassion from a theological and early professional nursing</td>
<td></td>
<td>Nightingale translated her personal Christian ideals into the nursing profession. Nightingale discussed the concept of suffering in the sick, highlighting that nurses must strive to alleviate this through acts of compassion. Good article. Conceptual paper</td>
</tr>
</tbody>
</table>
perspective. Specifically, the theological discussion will focus on Christianity as this was the prominent faith in 19th century.

| Straughair (2012b) Exploring compassion: implications for contemporary nursing. Part 2 | UK | Discussion around current political and professional drivers for compassion | As nursing became more evidence based, the traditional vocational image seemed to decline in favour of technical skills and the ethos of compassion as an essential professional nursing virtue appeared to have eroded. | In 2010 the Department of Health, London, published the NHS Constitution, which aims to establish the principles and values underpinning the health service and identify the rights of patients, public and staff with a series of pledges. | Good article. Conceptual paper |
n in contemporary nursing. Also, argue the appropriate recruitment and selection strategies need to be implemented. Nurses need to be supported to enable compassionate care. Leadership for compassionate care.
n is essential.

Sturgeon (2010) ‘Have a nice day’: consumerism, compassion and health

UK

Interesting conceptual paper.

One main contributing factor to poor standards of care at Mid-Staffordshire NHS Foundation Trust was that the Trust board had a big emphasis on meeting nationally set targets (Francis, 2010).

Note from Francis report: “pressure to meet these targets was sometimes detrimental to good care and patient welfare” (Francis, 2010, pp. 165).

League tables are clear indications of organisations that have achieved performance their set targets and those that failed.

Johnson (2008) suggested to have an official website to publish metrics that assess effectiveness and safety of nursing care as well as compassionately care has been delivered.

There is a shift in the balance of skills. Qualified nurses are expected advanced skills previously completed by junior doctors, such as cannulation, suggesting that more fundamental nursing care work will be passed down to other healthcare workers (Sturgeon, 2008; 2010). This can leave the patients to perceive these qualified nurses as less compassionate.


The Netherlands

To explore questions and contradictions in the debate on compassion

The paper reviews traditional theorists as well as contemporary scientists’ key

The origin of compassion is in the Aristotelian and justice theories, Christian-philosophical and Buddhist traditions, as well as Ethics of care theories, suffering (physical, psychological and social). Compassion,

Very interesting paper. Conceptual paper
<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Methodology</th>
<th>Sample Size</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Van der Cingel (2011)</td>
<td>Compassion in nursing practice: A</td>
<td>A qualitative analysis of in-depth interviews</td>
<td>Nurses n=30, and patients n=31</td>
<td>Compassion as per the participants’ narratives, have seven dimensions, mentioned in frequency sequence:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To understand the benefit of compassion for nursing</td>
<td></td>
<td>Interesting article, it contextualises compassion in nursing. It provides seven dimensions of compassion that can be used to enhance compassion.</td>
</tr>
<tr>
<td>Study</td>
<td>Practice within the context of long term care</td>
<td>• Attentiveness</td>
<td>Listening</td>
<td>Confronting</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Study on the nature and the significance of compassion for older people with a chronic disease</td>
<td>with nurses and patients in three different care-settings.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Van der Cingel (2014) Compassion: The missing link in quality of care</td>
<td>Conceptual paper. Interesting paper, which explores the importance of empathy to understand compassion. (the Netherlands)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Australia</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Appendix 7: Consent form

Title of Project: An exploration of the concepts of compassion in the care of older people amongst key stakeholders in nursing education: pre-qualifying nursing students, nurse educators and mentors—a qualitative study

Consent Form for Participants’ Identification Number for this research study:

Please tick the appropriate boxes

I have read and understood the project information sheet…………………………………………………

I have been given the opportunity to ask questions about the project……………………………………

I agree to take part in the project. Taking part in the project will include being interviewed and recorded (digital)……………………………………………………………………………………………………

I understand that my taking part is voluntary; I can withdraw from the study at any time and I will not be asked questions about why I no longer want to take part……………………………………

I understand my name will not be used in this project…………………………………………………...
I understand my personal details such as phone number or address will not be revealed to people outside of this project.

I understand that my words may be quoted in publications, reports, web pages, and other research outputs but my name will not be used unless I requested it above.

I understand that other researchers will have access to these data only if they agree to preserve the confidentiality of these data.

I understand that other researchers may use my words in publications, reports, web pages and other research outputs.

I agree to assign the copyright I hold in any materials related to this project to Sanj Nathoo.

On this basis, I am happy to participate in this study.

Name of Participant ......................

Signature ...................... Date......

Name of Researcher ......................

Signature ...................... Date......

If you have any queries or concerns, please contact: Sanj Nathoo on 01494522141; Ext: 4443; email address: sanj.nathoo@bucks.ac.uk

One copy to be kept by the participant, one to be kept by the researcher
Appendix 8: Ethical Approval from Portsmouth University & (FORM UPR16)

Sanj Nathoo
Sanj.Nathoo@bucks.ac.uk
19th April 2013

ETHICAL APPROVAL

Protocol Title: An exploration of the concepts of compassion in the care of older people amongst key stakeholders in nursing education: pre-qualifying nursing students, nurse educators and mentors—a qualitative study

Date Reviewed: 16th April 2013

Dear Sanj,

Thank you for resubmitting your protocol for ethical review and for the clarifications provided.

Your responses have been reviewed and I am pleased to inform you that your application has been given a favourable opinion by the Science Faculty Ethics Committee. Please notify us in the future of any substantial amendments that may be required and send us a final study report.

Good luck with the study.

Yours sincerely,

Dr Rebecca Stores
SHSSW Member of Science Faculty Ethics Committee

CC -
Dr Chris Markham – Chair of SFEC
Dr Jim House – Vice Chair of SFEC
Jody Salt – Faculty Administrator
**FORM UPR16**

**Research Ethics Review Checklist**

Please include this completed form as an appendix to your thesis (see the Postgraduate Research Student Handbook for more information).

<table>
<thead>
<tr>
<th>Postgraduate Research Student (PGRS) Information</th>
<th>Student ID:</th>
<th>470653</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PGRS Name:</strong></td>
<td>Bed Anand Nathoo (Sanj)</td>
<td></td>
</tr>
<tr>
<td><strong>Department:</strong></td>
<td>School of Health Sciences and Social Work</td>
<td><strong>First Supervisor:</strong></td>
</tr>
<tr>
<td><strong>Start Date:</strong></td>
<td>October 2009</td>
<td><strong>(or progression date for Prof Doc students)</strong></td>
</tr>
<tr>
<td><strong>Study Mode and Route:</strong></td>
<td>Part-time</td>
<td>MPhil</td>
</tr>
<tr>
<td></td>
<td>Full-time</td>
<td>PhD</td>
</tr>
<tr>
<td><strong>Title of Thesis:</strong></td>
<td>An Exploration of the Concepts of Compassion in the Care of Older People amongst Key Stakeholders in Nursing Education: Pre-Qualifying Nursing Students, Nurse Educators and Clinical Mentors—a Qualitative Study</td>
<td></td>
</tr>
<tr>
<td><strong>Thesis Word Count:</strong></td>
<td>54,955 (excluding patients’ citations)</td>
<td></td>
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</tbody>
</table>

If you are unsure about any of the following, please contact the local representative on your Faculty Ethics Committee for advice. Please note that it is your responsibility to follow the University’s Ethics Policy and any relevant University, academic or professional guidelines in the conduct of your study.

Although the Ethics Committee may have given your study a favourable opinion, the final responsibility for the ethical conduct of this work lies with the researcher(s).

**UKRIO Finished Research Checklist:**

(If you would like to know more about the checklist, please see your Faculty or Departmental Ethics Committee rep or see the online version of the full checklist at: [http://www.ukrio.org/what-we-do/code-of-practice-for-research/](http://www.ukrio.org/what-we-do/code-of-practice-for-research/))

a) Have all of your research and findings been reported accurately, honestly and within a reasonable time frame? | YES | NO |

b) Have all contributions to knowledge been acknowledged? | YES | NO |

c) Have you complied with all agreements relating to intellectual property, publication and authorship? | YES | NO |

d) Has your research data been retained in a secure and accessible form and will it remain so for the required duration? | YES | NO |

e) Does your research comply with all legal, ethical, and contractual requirements? | YES | NO |

**Candidate Statement:**

I have considered the ethical dimensions of the above named research project, and have successfully obtained the necessary ethical approval(s).

**Ethical review number(s) from Faculty Ethics Committee (or from NRES/SCREC):**

| Universities | Portsmouth | Buckinghamshire |

If you have not submitted your work for ethical review, and/or you have answered ‘No’ to one or more questions a) to e), please explain below why this is so:
Appendix 9: Ethical Approval from Buckinghamshire New University

22nd April 2013

Mr Bed Anand Nathoo
Pre-Qualifying Nursing
Buckinghamshire New University
Uxbridge Campus
106 Oxford Road
Uxbridge
UB8 1NA

Dear Sanj,

I am writing to confirm that Ethical approval was granted by the Society and Health Ethics committee of Buckinghamshire New University on the 20th of February 2013 for your project titled:

“An exploration of the concept of compassion in the care of older people amongst key stakeholders in nursing education: pre-qualifying nursing students, nurse educators and mentors—a qualitative study.”

I hope that your research project goes well.

Yours sincerely,

Dr M. Nakisa
Secretary to the Ethics Committee
Research Unit
Academic Quality Directorate
Appendix 10: Information Sheet for student Participants

Title: An exploration of the concepts of compassion in the care of older people amongst key stakeholders in nursing education: pre-qualifying nursing students, nurse educators and mentors—a qualitative study

Purpose of the research

There is very little consideration given of how compassion in care or lack of it impacts on pre-qualifying nursing students. This study aims to explore how exposure from university nurse educators and clinical mentors in practice influences the perception of compassion in care from the perspectives of first, second and third year pre-qualifying nursing students in an attempt to enhance and better develop future nursing curricula.

What is involved in participating?

Students, nurse educators and clinical mentors will be kindly requested to take part in semi-structured face to face and/or telephone interviews. Three cohorts of students, year one, two and three will be interviewed one to four weeks before being exposed to their practice placements and one to four weeks after. Clinical mentors and nurse educators will also be invited to take part in semi-structured face to face and/or telephone interviews. All data will be digitally recorded.

Benefits and risks
The aim is that the data collated will help nurse educators and healthcare providers to enhance and inform future curriculum development. There are no perceived risks connected to, in the participation of this study. Students have support and processes through the university should they experience negative emotional response in identifying their fears or recalling their experiences.

Students will be advised to report through normal channel of any unsafe practices prior to the commencement of the interviews, which can be accessed from the students’ handbook. For instance, students can access ward managers, Departmental managers, Patient Advice and Liaison Service (PALS), Link Lecturers, Lead Link Lecturers and recognised unions such as the Royal College of Nursing (RCN).

**Terms for withdrawal:**

You are free to withdraw from the research project at any time, without having to give any reason, by contacting me or completing and posting the withdrawal slip at the bottom of the consent form. Note that this withdrawal will in no way affect your studies. This project is completely separate from your education. If a student withdraws before data analysis has taken place, data collected will be destroyed.

**Usage of the data:**

All data collected will be coded and kept confidential during and after the research study. It will be kept in a locked cupboard and only accessed by the lead researcher and research assistant. The data that you provide will be combined with all participants to achieve the results of the study. Quotations may be used in the write up of the research project but they will be kept anonymous in order not to reveal participants’ personal identity. Coding used in the presentation of the findings will identify the group of participants not individuals. Note that the anonymised data will be seen by the University supervisor.

**Strategies for assuring ethical presentation of the data and findings**
All contributions will be kept confidential with each student coded SN 1, SN2 and so on, rather than name. Any participant names will be removed from the transcript. Once the data is downloaded on to the password protected laptop, it will be erased from the digital recorder.

_I would like to invite you to take part in the project named above. The following information is designed to help you decide whether you would like to participate. I would be grateful if you would take time to read it and agree to help me in my research. I will be happy to answer any further questions you may have about the project._

Thank you

Bed Anand Nathoo (Sanj)

Senior Lecturer in Pre-Registration Nursing
Buckinghamshire New University
Faculty of Society & Health
106 Oxford Road
Uxbridge
Middlesex
UB8 1NA
Tel: 01494 522141 Ext 4443

Web: www.bucks.ac.uk
Email: snatho01@bucks.ac.uk

Likely content of the interviews is:

1. What qualities do you consider essential for an effective nurse to possess?
2. How will you promote empathy and dignity?
3. When you hear the word “compassion,” what do you think of?
4. What does a compassionate practitioner mean to you?
5. Can you please tell me some of your experiences of compassionate care, where the patient/s had been actively listened to and effective communication were maintained?

6. How has the curriculum equipped you so far to appreciate and implement compassionate care?

7. What are your experiences of compassion as a student of this university?

8. How does your commitment to compassionate care affect how you treat your patients? (N/A to the 1st cohort before practice placement)

9. Can you describe any factors that may have prevented or contributed towards compassionate care (behaviour) in the delivery of patient care? (N/A to 1st cohort before practice placement)

10. What have you learned about how to provide compassionate care for your patients during clinical practice? (N/A to 1st cohort before practice placement)
Appendix 11: Information Sheet for clinical mentors

Title: An exploration of the concepts of compassion in the care of older people amongst key stakeholders in nursing education: pre-qualifying nursing students, nurse educators and mentors—a qualitative study

Purpose of the research

There is very little consideration given of how compassion in care or lack of it impacts on pre-qualifying nursing students. This study aims to explore how exposure from university nurse educators and clinical mentors in practice influences the perception of compassion in care from the perspectives of first, second and third year pre-qualifying nursing students in an attempt to enhance and better develop future nursing curricula.

What is involved in participating?

Students, nurse educators and clinical mentors will be kindly requested to take part in semi-structured face to face and/or telephone interviews. Three cohorts of students, year one, two and three will be interviewed one to four weeks before being exposed to their practice placements and one to four weeks after. Clinical mentors and nurse educators will also be invited to take part in semi-structured face to face and/or telephone interviews. All data will be digitally recorded.

Benefits and risks

The aim is that the data collated will help nurse educators and healthcare providers to enhance and inform future curriculum development. There are no
perceived risks connected to in the participation of this study. Clinical mentors will be advised to report through normal channel of any unsafe practices or experiences of any negative emotional reactions during the research prior to the commencement of the interviews, which can be accessed from the Trusts’ websites. They can contact the ward managers, the clinical lead or director of nursing.

**Terms for withdrawal:**

You are free to withdraw from the research project at any time, without having to give any reason, by contacting me or completing and posting the withdrawal slip at the bottom of the consent form. Note that this withdrawal will in no way affect your employment. If a clinical mentor withdraws before data analysis has taken place, data collected will be destroyed.

**Usage of the data:**

All data collected will be coded and kept confidential during and after the research study. It will be kept in a locked cupboard and only accessed by the lead researcher and research assistant. The data that you provide will be combined with all participants to achieve the results of the study. Quotations may be used in the write up of the research project but they will be kept anonymous in order not to reveal participants’ personal identity. Coding used in the presentation of the findings will identify the group of participants not individuals. Note that the anonymised data will be seen by the university supervisor.

**Strategies for assuring ethical presentation of the data and findings**

All contributions will be kept confidential with each clinical mentor coded CM1, CM2 and so on rather than name. Any participant names will be removed from the transcript. Once the data is downloaded on to the password protected laptop, it will be erased from the digital recorder.
I would like to invite you to take part in the project named above. The following information is designed to help you decide whether you would like to participate. I would be grateful if you would take time to read it and agree to help me in my research. I will be happy to answer any further questions you may have about the project.

Thank you

Bed Anand Nathoo (Sanj)

Senior Lecturer in Pre-Registration Nursing
Buckinghamshire New University
Faculty of Society & Health
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Web: www.bucks.ac.uk
Email: snatho01@bucks.ac.uk

Likely content of the interviews is:

**Semi-structured interview questions for clinical mentors**

1. What does a compassionate practitioner mean to you?
2. Can you please tell me some of your experiences of compassionate care, where the patient/s had been actively listened to and effective communication were maintained?
3. Why does enabling compassionate care matter to patients, students and staff members?
4. Describe how easy or rather difficult it is to mentor students to provide compassionate care.

5. Who will it be easier to mentor, first, second or third year students? Why?

6. How does your commitment to compassionate care affect the way you treat your patients?

7. Can you describe any factors that may have prevented or contributed towards compassionate care (behaviour) in the delivery of patient care?

8. How can compassionate care be nurtured amongst our students?

9. How do you see the teaching of compassionate care changing following the problems at Mid-Staffordshire revealed in the Francis report?

**Open and closed questions**

1. How do you see the purpose of nursing care of your patients?
   
   Probe: is it just addressing their medical/nursing issues or is it more than that. Can you elaborate?

2. Is compassionate care important to the health of your patients? Why or why not?

3. Has clinical practice changed the way you provide compassionate care? If so, how?

4. How long have you been qualified and how long have you been a qualified mentor?

5. From which institution did you complete your teaching course?
Appendix 12: Information Sheet for nurse educators

Title: An exploration of the concepts of compassion in the care of older people amongst key stakeholders in nursing education: pre-qualifying nursing students, nurse educators and mentors—a qualitative study

**Purpose of the research**

There is very little consideration given of how compassion in care or lack of it impacts on pre-qualifying nursing students. This study aims to explore how exposure from university nurse educators and clinical mentors in practice influences the perception of compassion in care from the perspectives of first, second and third year pre-qualifying nursing students in an attempt to enhance and better develop future nursing curricula.

**What is involved in participating?**

Students, nurse educators and clinical mentors will be kindly requested to take part in semi-structured face to face and/or telephone interviews. Three cohorts of students, year one, two and three will be interviewed one to four weeks before being exposed to their practice placements and one to four weeks after. Clinical mentors and nurse educators will also be invited to take part in semi-structured face to face and/or telephone interviews. All data will be digitally recorded.
Benefits and risks

The aim is that the data collated will help nurse educators and healthcare providers to enhance and inform future curriculum development. There are no perceived risks connected to in the participation of this study. Nurse educators will be advised to report through normal channel of any unsafe practices or any experience any negative emotional reactions during the research prior to the commencement of the interviews, which can be found on the university website, the departmental manager Karen Harrison-White on 5731 or Carol Pook, the Head of Department on extension 4446 (points 5 and 6).

Terms for withdrawal:

You are free to withdraw from the research project at any time, without having to give any reason, by contacting me or completing and posting the withdrawal slip on the bottom of the consent form. Note that this withdrawal will in no way affect your employment. If a nurse educator withdraws before data analysis has taken place, data collected will be destroyed.

Usage of the data:

All data collected will be coded and kept confidential during and after the research study. It will be kept in a locked cupboard and only accessed by the lead researcher and research assistant. The data that you provide will be combined with all participants to achieve the results of the study. Quotations may be used in the write up of the research project but they will be kept anonymous in order not to reveal participants’ personal identity. Coding used in the presentation of the findings will identify the group of participants not individuals. Note that the anonymised data will be seen by the university supervisor.

Strategies for assuring ethical presentation of the data and findings

All contributions will be kept confidential with each nurse educator coded NE1, NE2 and so on rather than name. Any participant names will be removed from
the transcript. Once the data is downloaded on to the password protected laptop, it will be erased from the digital recorder.

I would like to invite you to take part in the project named above. The following information is designed to help you decide whether you would like to participate. I would be grateful if you would take time to read it and agree to help me in my research. I will be happy to answer any further questions you may have about the project.

Thank you

Bed Anand Nathoo (Sanj)

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Tel: 01494 522141 Ext 4443

Web: www.bucks.ac.uk
Email: snatho01@bucks.ac.uk

Likely content of the interviews is.

1. What does a compassionate practitioner mean to you?
2. How does the curriculum equip students to appreciate and implement compassionate care? How can we improve?
3. Who will it be easier to teach, first, second or third year students? Why?
4. Can you please tell me some of your experiences of compassionate care, where the students had been actively listened to and effective communication were maintained?
5. Why does enabling compassionate care matter to our students and staff members?

6. How does your commitment to compassionate care affect how students treat patients in practice placements?

7. Can you describe any factors that may have prevented or contributed towards providing compassionate care to our students?

8. Can compassionate care be nurtured amongst our students? If yes, how? If no, why?
**Appendix 13: Dates for ethical approval from universities**

<table>
<thead>
<tr>
<th>University</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portsmouth University</td>
<td>16th April 2013</td>
</tr>
<tr>
<td>Buckinghamshire New University</td>
<td>22nd April 2013</td>
</tr>
</tbody>
</table>

**Appendix 14: Interview schedule per cohort**

<table>
<thead>
<tr>
<th>Interview cohort</th>
<th>Time period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot interview</td>
<td>3.6.2013</td>
</tr>
<tr>
<td>Nurse Educators</td>
<td>4.7.2013-27.7.2013</td>
</tr>
<tr>
<td>Clinical mentors</td>
<td>24.7.13-30.10.13</td>
</tr>
<tr>
<td>1st year pre-qualifying nursing students</td>
<td>2.10.2013-24.2.2014</td>
</tr>
<tr>
<td>3rd year pre-qualifying nursing students</td>
<td>2.10.2013-17.12.2013</td>
</tr>
</tbody>
</table>
Appendix 15: Learning Objectives and SWOT analysis

Learning Objectives

**For the PD programme:**

1. Present the results of their research to a standard equivalent to that of a peer-reviewed academic publication
2. Enhance my research technique skills (literature searching)
3. To develop a good command and understanding of statistics including the terminology and appropriate use of statistical tests. To aid in the understanding of quantitative research articles
4. To be able to use some forms of statistical software (i.e. excel and SPSS). To relearn the use of SPSS
5. To demonstrate a good understanding of statistical result interpretation
6. To develop a greater understanding of a variety of research methodologies
7. To be able to adequately use software package to manage references, such as Endnote.
8. To enhance my critical reflection skills.
9. To explore different models of reflection.
10. To improve academic analytical skills to meet the Professional Doctorate level.
11. To write publishable work.

**For the Thesis:**

1. To regularly complete literature searching to enhance technique
2. To regularly update and read materials relevant to research question
3. To define the research question, giving appropriate rationale for the research methodology proposed.
4. To complete literature review for the thesis
5. To complete methodology for thesis
6. To produce innovative and relevant work that is transferable to the workplace.
7. To be self-discipline and assertive

**SWOT Analysis** Professional Doctorate commenced October 2009
## Strengths

- Planning and organising work unsupervised.
- Analysing, assimilating and distributing information in a clear, concise and logical manner.
- Drive / energy / self-motivation / willingness to use initiative but also be a good team player.
- Communicating effectively with all levels of staff from both management and employee arenas. I can speak a minimum of 5 languages, but can understand a few more.
- I believe in fitting the man to the task.
- I have a number of years of experience as a nurse and a nurse lecturer
- I teach pre-reg students from the 1st to the 3rd year, from simple skills such as infection control, CPR, moving and handling and writing academic essay to management and looking after critically ill people.
- Just finished an E-learning course. So I am fairly confident with my IT skills
- Comfortable with the process of peer review
- I have a good working relationship with the clinicians in my department
- I have the support of colleagues, peers, friends and senior management
- I am a very self-motivated enthusiastic person

## Weaknesses

- Overwork, due to cover, marking in between teaching, weekends
- Always puts others request before mine
- Personally, I do not like asking (culturally influenced)
- Self-criticism
- I have a reluctance to take risks
- Fear of failure

## Opportunities

- Subject area has global influence
- Close link with practice area
- Interprofessional working
- Develop support networks with other students and tutors
- Chance to challenge own preconceptions and ideals in a safe environment
- Strong and supportive family ties
- I have the ability to network with peers and nursing leaders

## Threats

- Working study balance
- Funding
- Lots of expectancy to do more (for example cover other lecturers)
Appendix 16: Offer letters for Research Challenge grant

Sanj Nathoo
Adult Nursing

25th September 2013

Dear Sanj

Re: Outcome of the Faculty of Society and Health’s Research Challenge Bid 2013/2014

Following the review of proposals submitted for Research Challenge Funds for 2013/14 I am pleased to confirm that you have been awarded £5,000 to support your project titled “An exploration of the concepts of compassion in the care of older people amongst key stakeholders in nursing education: pre-qualifying nursing students, nurse educators and mentors—a qualitative study.”

1. Conduct interviews, transcribe and analyse data, working towards Professional Doctorate at Portsmouth University.
2. Conference attendance and presentation of preliminary data.
3. Peer-reviewed journal article.

Your award is conditional on achieving the outcomes specified in your proposal:

These outcomes must be achieved before you can be considered for any future Research Challenge Awards.

If you have requested funds for teaching cover, it is the shared responsibility of both you and your line manager to arrange cover. Staff salary replacement costs can only commence when appropriate cover has been agreed with the line manager and the necessary HR processes have been complete.

All costs associated with the research activity must be charged to your unique project budget code. You will be notified of your code once it has been set up. Expenditure will only be approved once signed off by both your Head of School and by myself. This budget code is unique to your project. If your Head of Department wishes to appoint one Associate Lecturer to cover staff time for more than one project, then this should be paid from the departmental budget with an internal recharge for costs associated with each project. Please note that all project funds awarded are only available until 31st July 2014; any funds not spent at this time will no longer be available.

Progress reports will be required to feed into Faculty Research AFMT meetings and will be available to all staff within the Faculty. These reports should include a summary of progress, expenditure to date and any problems experienced which could delay outcomes. Reports will be requested two weeks before each Research AFMT meeting due to take place on 19 February and 28 May 2014. A final report will be required on completion by 30th September.
Bed Anand Nathoo  
Department of Adult Nursing  
106 Oxford Road  
Uxbridge  
UB8 1NA

14th July 2014

Dear Sanj

Re: Outcome of the Faculty of Society and Health’s Research Challenge Bid 2014/2015

Following the review of proposals submitted for Research Challenge Funds for 2014/2015 I am pleased to confirm that you have been awarded £5,000 to support your Professional Doctorate titled “An exploration of the concepts of compassion in the care of older people amongst key stakeholders in nursing education: pre-qualifying nursing students, nurse educators and mentors: A qualitative study.”

Your award is conditional on achieving the targets specified in your Annual progression review of the academic institution with which you are registered for your degree. These outcomes must be achieved before you can be considered for any future Research Challenge Awards.

If you have requested funds for teaching cover, it is the shared responsibility of both you and your line manager to arrange cover. Staff salary replacement costs can only commence when appropriate cover has been agreed with the line manager and the necessary HR processes have been complete. To monitor teaching cover, you will be asked to provide details of hours teaching cover received per month at the end of every month.

Any costs must be charged to your unique project budget code: 41041. Expenditure will only be approved once signed off by your Head of School.

Please note that all project funds awarded are only available until 31st July 2015; any funds not spent at this time will no longer be available.

Progress reports will be required on the 1st November 2014, 1st February and 1st May 2015 and will be available to all staff within the Faculty. These reports should include a summary of progress, expenditure to date and any problems experienced which could delay outcomes. A final report will be required on completion by 30th September 2015 to include details of progress towards dissemination of outcomes (eg articles submitted, conferences planned, grant applications).

We strongly encourage all holders of Faculty Research Challenge Funds to contribute to monthly writing support group meetings and to present outcomes at seminars and Bucks Research events.
Appendix 17: Coding Phase using NVivo

Audit Trail: An Example

In order to describe the use of NVivo as an auditable management tool, an example is provided. This example illustrates the seven themes (nodes in NVivo)
Appendix 18: This example illustrates the five themes with their respective sub-themes.
Appendix 19: Coding for one of the main themes: Role model

Example of the sources (codes) for the theme "Role Model"
Appendix 20: Codes clustered by word similarity
Appendix 21: Word frequency count