Title: Determinants of compassion in the care of older people: educational implications.

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Determinants of compassion in providing care to older people: Educational implications

Abstract

Background: Care provision underpinned by compassion builds trust and ensures a deeper understanding of the health needs of older people. Yet nursing curricula in the United Kingdom focus on knowledge and skill acquisition rather than caring with compassion. This negatively impacts on the quality of care. Despite this, there is limited research on compassion in the care of older people.

Aim: To explore the views of nurse educators (NE), pre-registration nursing students (PNS) and clinical mentors (CM) of the determinants of compassion in the care of older people.

Methods: A generic qualitative research design was used. Data were collected using semi-structured interviews with 39 participants (NE = 8; CM = 8; PNS = 23). These were digitally-recorded, fully transcribed and analysed thematically using NVivo software.

Findings: Three main themes emerged from the data analysis**:** the meaning of compassion, extrinsic determinants of compassion in care, and intrinsic determinants of compassion in care.

Discussion: The outcome of this study suggests that nurses and students think that compassion speeds up older people's recovery and enhances the quality of care. NEs consider its application in clinical practice a demonstration of competence.

Conclusion: The inclusion of compassion in practical sessions of pre-registration nursing curricula and in the care of the older person may result in improved understanding of the latter and provision of holistic, safe and effective care.

Keywords: Compassion, compassionate care, clinical mentors, nurse educators, pre-registration nursing student, older people.

Introduction and background

Compassion is stimulated by a profound understanding of another's pain and the ability to relieve that pain (Dewar et al. 2011). Awareness of the pain initiates an action, which can be as simple as holding someone's hand, smiling or providing complex care (Dewar et al. 2011). Nurturing, a culture of care and compassion, is a leading principle of nursing theory since it enhances knowledge of the older person's needs and care (Richardson et al. 2015). It is argued that compassion is a significant element of care, key to quality care and promotes recovery (Van der Cingel 2014 & Nathoo 2017).

Compassion is a commendable trait that can assist with emotional connection, self-awareness and emotional intelligence (Burnell 2009) and is perceived as the ideal behaviour. Bradshaw (2009) argues that compassion is one of the main traits that gave nursing its philosophy. She postulates that it is "*a virtue to be cultivated as an aspect of individual character*" (p.466). Following their systematic review, Durkin, Gurbutt & Carson (2018: 2) identify eleven qualities of the compassionate nurse: the small acts; "*being professionally competent; involving patients; kindness of character; good communication skills; empathy; connecting to and knowing the patient; being aware of needs/suffering; using appropriate body language; and having emotional strengths and time for patients*."

High levels of compassionate care have been associated with patient satisfaction and compassion fatigue (CF), "*a unique form of burnout*" (Joinson 1992:116) causing patient discontent, unwell nurses (Hooper et al. 2010), and compromising compassionate ideals (Maben et al. 2007). Older people's care experiences are often determined by the degree of compassion shown (Department of Health [DH] 2013). Many caring frameworks include compassion as a key factor in safe, effective and holistic care. Roach (1984) identifies five traits in care, the five Cs: Commitment, Conscience, Competence, Compassion and Confidence. Pusari (1998), added three more, the eight Cs: Courage, Culture and Communication. Building on this, Cummings (2012) proposed a 6C Model: Care, Compassion, Communication, Competence, Courage and Commitment, which was incorporated into care in the United Kingdom (UK).

There are various views on the origin of compassion in the extant literature. Whilst not a new phenomenon, people find it difficult to understand the term (Van Der Cingel 2014). Roach (2002:14) refers to compassion as "*a gift and an inborn trait*". Goetz et al. (2010), describe it as a trait that can be nurtured. Research suggests that approaches to integrating compassion

into nursing curricula are limited (Curtis et al. 2012). Nathoo (2017) suggests this trait can only be developed if the nurse has the aptitude to care. Durkin, Gurbutt & Carson (2019) advocate a role for education in enhancing the traits that underpin compassion.

Termed '*intelligent kindness'* (Cummings and Bennett 2012: 13), compassion is paramount in patients' perception of care (van Leishout et al. 2015). It enhances holistic care and is fundamental to the therapeutic relationship (Youngson 2014). "*Compassion is about the very way in which we relate to others*" (Dewar and Mackay 2010: 301). Compassion is associated with concepts such as 'sympathy', 'empathy', 'kindness', holistic care, and relationship-centred care (Dewar et al. 2011). The complexities of compassionate care lead to various elucidations, ranging from a smile (Graber & Mitcham 2004), calmness and helping patients (Christiansen et al. 2015).

Compassion can be instilled through role modelling, vital in developing professional character (Nathoo 2017 & Wear and Zarconi 2008). Francis (2013) advocates acquiring practical experiences whilst working as a nursing assistant, ideally with older people, to better prepare students in providing compassionate care. This paper adopts Gilbert's (2009) view of compassion, which highlights the need for nurses to protect, care and demonstrate acceptance of older people irrespective of health status and socioeconomic background. It views compassion as a "*behaviour that aims to nurture, look after, teach, guide, mentor, soothe, protect, offer feelings of acceptance and belonging in order to benefit another person*" (2009: 127). This suggests that compassion is a collaborative nurse-patient activity, involving a partnership between the nurse and the patient with the former conveying understanding of the latter's suffering with the view to alleviation (Low et al. 2013).

In the last few decades, there has been a decline in compassionate care provision in the UK, partly as a result of adopting evidence-based practice (Ramluggun & Nathoo 2019). Thus, the pre-registration curriculum shifted its emphasis away from caring with compassion (Bray *et al.* 2014) towards a focus on knowledge. This is inconsistent with the Nursing and Midwifery Council (NMC) Code of professional conduct, which requires nurses to provide care with compassion (NMC 2018).

The Patients' Association (2011) states that several UK organisations have reported poor elderly care due to lack of compassion, as highlighted by several exceptional well-documented events. These include the Winterbourne View, a private care home and the Mid-Staffordshire

Hospital, where lack of compassion was the common denominator for cases in patients' neglect (Francis 2013). An official review of the latter stated that many older people were demeaned by poor pain relief, feeding assistance and access to toilet facilities (Francis 2013). Similar outcomes have been reported in the United States of America (Kagan et al. 2018) and European countries such as Sweden and Belgium (Melchiorre et al. 2013). Given the increasing number of older people worldwide, many requiring care (World Health Organisation [WHO] 2015), hence, there is an international quest to improve care and prevent negative experiences (Tolson et al. 2011). Compassion is accorded prominence and influences health policies nationally and internationally (Cummings and Bennett 2012). This quest can be successful if older people are cared for compassionately (DH 2013), making compassion a commanding principle in healthcare settings.

The literature notes several approaches to improving care outcomes. Compassion-focused therapy, though designed to assist people with mental health problems with high levels of self-blame and shame achieve compassion (Gilbert 2009); has potential for older people. For example, older people admitted to care homes with a diagnosis such as dementia and associated emotional responses might be soothed by compassion-based skills. Introduced to the NHS in 2009, Schwartz Rounds aim to promote compassionate care by offering staff a safe place to express and reflect on emotional, social and ethical challenges faced at work (Taylor et al. 2018:2), thus aiding emotional connection with patients and affective self-awareness. Notwithstanding these piecemeal initiatives, much more information is needed about compassionate care and the present starting point is to explore stakeholder views on its determinants.

Methodology

Aim of the study

The aim of study was to explore the views of NEs, PNSs and CMs on the determinants of compassion in the care of older people.

Research design

Given the practical difficulty of measuring people's subjective opinions (Percy et al. 2015), and consistent with the aims and philosophical stance adopted, this study adopts a generic qualitative methodology.

Generic qualitative research is eclectic and declines to adhere to any specific methodology (Kahlke 2014). Merriam (2009) states that generic qualitative research is epistemologically social constructivist and theoretically interpretive, arguing that it enables a focus on understanding how participants experience events, interpret and attribute meaning to them. This approach and its philosophical underpinnings fit well with the research aim.

Study settings and sampling

The study was carried out in three settings in the London area: an acute general hospital, an acute mental health hospital and a university. The university provides pre-registration nursing education while the two hospitals provide student placements. CMs were experienced in providing clinical support to PNSs, and NEs were experienced in teaching PNSs.

Following ethical and managerial permissions, CMs and the PNSs were approached individually in clinical areas, and NEs were addressed *en masse* at the university. Information was given, verbally and in writing, and questions answered. Potential participants were invited to opt in by contacting SN. None of the NEs or CMs had a hierarchical relationship with SN. Only three PNSs had any connection with SN, who assured these individuals that non-participation and disclosure would have no bearing on their educational progress. Thirty nine individuals actively opted in. From these, 8 NEs, 8 CMs and 23 PNSs were purposively selected based on the inclusion criteria (Table 1).

Table 1: Eligibility criteria of the study

Inclusion criteria
Pre-registration nursing students • Pre-registration students who are in their third year of nurse training.
Clinical mentors • Clinical mentors with at least two years experience of mentoring pre-registration nursing students who hold a certified teaching qualification (such as mentorship in practice), and have experience of working with older patients.

Nurse educators

- Nurse educators involved in the delivery of pre-registration nursing curriculum, who hold a certified teaching qualification (e.g. diploma in education), and have at least two years experience delivery of pre-registration nursing curriculum.

Exclusion criteria

Pre-registration nursing students

- Pre-registration students who are not in their third year of nurse training.

Clinical mentors

- Clinical mentors with less two years experience of mentoring pre-registration nursing students, who do not hold a certified teaching qualification, and who do not have experience of working with older patients.
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Nurse educators

- Nurse educators with less than two years of delivering the pre-registration nursing curriculum, and who not hold a certified teaching qualification.

Data collection

Consent was obtained from individuals before data collection. Participants were assured of strict confidentiality and anonymity. A semi-structured interview schedule was developed, piloted on a sample of non-participating individuals and some minor revisions made. The interviews lasted for about an hour, were digitally-recorded and field notes were taken.

Data analysis

Data were transcribed and analysed using the framework approach (Ritchie & Spencer 1994). NVivo qualitative analysis software (version 10), which has framework matrices, was used in support. Like generic qualitative design, the framework approach is not aligned to any philosophical underpinning and can thus be used to analyse data arising from a range of qualitative designs (Gale et al. 2013). It provides a clear step-by-step guide on textual data management and analysis. It has six distinct but inter-related stages (see Figure 1) (Ritchie & Spencer 1994) and culminates in the development of a thematic framework enabling researchers to code and organise data into main themes and sub-themes (Spencer et al. 2010).

Independent coding by members of the research team was followed by comparison and discussion leading to an agreed coding system and ultimately the working thematic framework. Consequent thematic charts included references, in the form of keywords or phrases, and

illustrative quotations from the transcripts were developed. In the last stage of analysis, similarities and differences were sought across thematic charts, thus developing the final thematic framework with main themes and sub-themes (see Table 2). Checking for dependability and collaboration throughout the analysis, along with member checking, contributed to methodological rigour.

Figure 1: Analytical stages of the framework approach (Ritchie & Spencer 1994)

Stage 1: Transcription: Verbatim transcription of audio-recorded interviews.

Stage 2: Familiarisation: Listening to the audio-recordings, reading transcripts and field notes, and making notes of interesting issues about participants' account.

Stage 3: Developing a thematic framework: Reading a transcript or a set of transcripts, including field notes, study's aims and objectives, and interview guide to develop the analytical framework.

Stage 4: Applying the framework (indexing): Reading each subsequent transcript line-by-line, interpret its meaning and decide which code (label) to apply.

Stage 5: Thematic charts: Recording information from each transcript by themes with keywords or phrases and comments into thematic charts.

Stage 6: Mapping and interpretation: Searching for connections of emergent themes across thematic charts to develop main and sub-themes, and write analytical memos.

Table 2: Thematic framework

The meaning of compassion • A learnt behaviour • An innate human trait • A skill • Unconditional acceptance • A natural desire to care
***Extrinsic determinants* of compassion in care** • Role modelling • Clinical leadership • Care philosophy and clinical culture • Training and education • Policies and procedures • Mentorship
Intrinsic determinants of compassion in care • Self-efficacy • Commitment to respond compassionately • Feelings of anxiety and stress

Findings

Three main themes emerged from the data analysis**:** the meaning of compassion, extrinsic determinants of compassion in care and intrinsic determinants of compassion in care (see Table

2). Each theme contains several sub-themes, indicated in bold, which are illustrated with excerpts from participants' narratives.

The meaning of compassion

This main theme relates to the meanings that participants attributed to the concept of compassion. Some referred to it as a ***behaviour that can be learnt***, which, they stressed, would require nurturing once acquired.

> Nurses and other healthcare workers can learn about compassion and how to offer compassionate care. They can also strengthen their compassion when caring for older people (NE).

Whilst the above excerpt indicates that compassion can be learnt and reinforced during clinical interactions, many participants described it as ***an inborn trait*** that can be expressed in both clinical and non-clinical environments.

> Every human being is born with compassion and the ability to express it. Nurses take with them their innate compassion to the clinical environments, which they manifest during their interactions with patients (NE).

Some participants referred to compassion as a ***skill to care and relieve pain***, and as an attitude of ***unconditional acceptance*** of the older person.

> Compassion forms a significant part of the foundation of nursing care. It is a skill that enables nurses to connect with older people, care for them and alleviate their suffering (CM).

Participants asserted that compassionate care is influenced by multiple factors.

Extrinsic determinants of compassion in care

This main theme relates to factors residing outside nurses that may influence their care of older people. ***Role modelling*** was the most commonly cited extrinsic factor and is of two types: positive and negative. Positive role modelling is a compelling factor in instilling care-related knowledge and skills, including compassion.

> Positive role modelling is probably the best way to show compassion in nursing. CMs act as positive role models for PNSs. Their vast clinical experience and knowledge enable them to assist this category of students show compassion to patients (CM).

Participants raised concerns that nurses in authority are not always willing to care and support older people. This negative role modelling may lead junior nurses to behave in an uncompassionate manner.

> Ward managers not being involved in the caring activities of the ward and not showing positive caring attitudes often extinguish the intrinsic desire, in other words, the compassion in junior staff (NE).

Related to this was the theme of ***clinical leadership***, frequently discussed in relation to nurses' intrinsic desire to care for and alleviate the suffering of older people. Apparently, clinical leaders could instil, facilitate, and enhance compassionate care.

> Nursing staff often adopt the values and clinical behaviours of their managers, particularly if they had worked together. So, if a ward manager is compassionate and caring, it will influence …. caring behaviour towards the direction of being compassionate (CM).

Participants thought that most nurses are compassionate. Nevertheless, their ability to show compassion to older people could be reduced if they were exposed to poor clinical leadership.

> Not listening to the views of nurses, telling them what to do, not involving them in decision-making about patients' care, and not appreciating their efforts often prevent them from providing care with compassion (PNS).

Participants discussed the importance of a ***shared care philosophy and clinical culture***, noting that nurses require a care philosophy and a clinical culture promoting respect for, and engagement with, older people.

> The care philosophy and ward culture should focus on understanding older people's personal experiences …. would enable nurses to engage with older people and identify their needs and wants… (NE).

A shared care philosophy and ward culture is a call for nurses to work together and share their clinical responsibilities. Such a stance, participants claimed, discourages a blaming culture, instead promoting patient-centred compassionate care, and increasing patients' satisfaction with care.

> Giving choice and asking older people about their wants, including their expectations, is critical for the provision of compassionate care (PNS).

> Some nurses are unfamiliar with approaches to provide compassionate care …. may require training in this area …. how to prevent patient-nurse apartheid, which is simply, a 'them and us scenario' (CM).

Most highlighted the need for nurses to be ***trained and educated*** in compassion and ward philosophies, stressing that education on approaches such as compassion-focused therapy and Schwartz rounds, would enable better patient-centred care.

> Compassion is a high-skilled activity. Compassion-focused therapy and Schwartz Rounds serve as powerful tools for instilling and nurturing compassion in nurses. So, nurses need to be trained in these approaches (NE).

Numerous participants argued that compassion education should be ongoing and should include input from older people and their relatives since this would lead to a better understanding of older people's experiences of care, thus promoting compassion.

> We need to be aware that older people are experts in their needs, wants and experiences of care …. therefore, better placed to teach and educate nurses in how they would like to be cared for (CM).

Some participants reported that compassion-related ***policies and procedures*** applying to older people were not easy to understand and that these should be integral to education.

> Discussions of policies and procedures during training, particularly if training adopts a multi-disciplinary approach, would ensure consistency in the provision of compassionate care (NE).

Some participants advocated other support systems for clinicians, such as ***mentorship***, to enhance understanding of compassion-related policies and nurture the provision of compassionate care.

> Mentorship is critical for the provision of safe, effective and compassionate care. Prolonged exposure to experienced mentors will help shape attitudes toward the older person. So, training and education in the classroom need to extend into clinical practice and involve mentors (CM).

Intrinsic determinants of compassion in care

This main theme relates to factors residing within nurses that may influence compassionate care provision. Many said that ***self-efficacy*** is linked with compassionate care.

> Feelings of self-confidence in one's ability …. respond compassionately to older people (PNS).

But self-efficacy alone is not sufficient and needs to be complemented by a ***commitment to respond compassionately*** to older people's needs and wants.

> …. nurses also need to be committed to care for older people and relieve their suffering. …. it is the cumulative effect of nurses' commitment and self-efficacy to care that may lead to the provision of compassionate care (NE).

There was overwhelming agreement that elderly care is taxing due to the multiplicity of roles that nurses must perform. These demands lead nurses to ***feel stressed and anxious,*** which subsequently inhibit compassionate care.

> When staff are stressed and anxious about work, their resourcefulness and compassion are stifled because of the need to re-direct their intrinsic energy to alleviate their experiences of stress and anxiety (CM).

Discussion

This study explored an important but neglected area of clinical practice: the determinants of compassion in the care of older people. It's findings, along with prior research, indicate no

universal conceptualisation of compassion. Here, participants viewed compassion as both a natural innate desire (intrinsic) and as a learnt skill (extrinsic) to relieve the pain of others. This is consistent with the qualitative findings of Durkin, Gurbutt & Carson (2019: 2915), which argue that compassion is "*either fixed or fluid*". The idea of compassion as innate reflects the difficulties nurse educators encounter when teaching it, a view consistent with prior authors (eg Roach 2002). The notion that compassion is learnt is consistent with others (eg Goetz et al. 2010). The extant literature, including the present study, suggests that compassion is best viewed as having elements of both, indicating that nurses can build on the compassion they bring to clinical practice.

If, as suggested here, compassion is influenced by intrinsic factors such as character, empathy and emotional state, then there are implications for recruitment, selection, and education. NEs should harness strategies to develop self-efficacy and resilience. Durkin, Gurbutt & Carson (2019) report similar findings and argue that caring should be the main motive to enter nursing and that seeing it as "*just a job*" (p.2915) restricts the likelihood of developing underpinning traits of compassion.

The pedagogical literature provides clear pointers for NEs to develop strategies that engage the whole person through experiential learning (Jarvis & Gibson 1997) and it is likely that the input of older people in all aspects of curriculum would assist in this. It is claimed that approaches for implementing compassion in nurse curriculum is inadequate (Bray et al. 2014). Following a review, Richardson et al. (2015) argue that compassionate care can be taught using a nursing therapeutics model (Muetzel's 1988), which proposes three components of therapeutic relationships: partnership; intimacy; and reciprocity. Partnership can be developed through trust, understanding, respect and good rapport (Canning, Rosenberg & Yates 2007), whilst intimacy can be achieved through empathy, caring and compassionate care, making the patient feel comfortable and simply being present for them (Shattell, Starr & Thomas 2007). Shattell, Starr & Thomas (2007) further note that reciprocity can be achieved by interpersonal collaborative relationships that benefit both patient and nurse.

Durkin, Gurbutt & Carson (2019) also make reference to the (Why, What, How, from Whom and Where) compassion needs to be taught to students. For instance: Why NSs should learn about compassion; What they need to be taught; How to apply teaching methods, for example

simulations or role models; being taught by motivating and inspirational lecturers (Whom); and in both clinical and educational settings (Where).

As nurse education has developed, compassion has been linked with academic proficiency and good moral values (Bradshaw 2011). Demonstrating genuine human encounters alongside other skills is advocated by Williams and Stickley (2010) and teaching compassion through role modelling is advocated by Dewar et al. (2011). Young et al. (2019) argue that the emotionally intelligent role models need to be caring and genuine people. They further highlight the power of negative experiences caused by toxic role models, which can lead to an uncaring and uncompassionate culture.

A safe and trusting environment whereby the PNSs, NEs and CMs are viewed as equal partners is important. Nathoo (2017) and Durkin, Gurbutt & Carson (2019) recommend reflection and analysis of critical incidents based on recent practice experiences. Skills needed to deliver compassionate care can then be identified and addressed (Adam & Taylor 2013). Students can thereafter develop individual '*toolkits*' to empower them to meet those learning needs (Adam & Taylor 2013: 1243). Other more discursive approaches to building empathy and self-confidence, such as the use of literature and poetry, have been proposed (Jack and Tetley 2016).

Regarding extrinsic influences on compassion, the present study highlighted clinical role modelling. Clinical staff have a powerful influence as both positive and negative role models. Nonetheless, even negative experiences can be harnessed in the classroom as a vehicle for reflection to enhance learning. This theme also speaks to clinical managers since compassionate behaviour is also modelled in clinical teams. For example, whether staff set a good example by treating each other, their juniors and indeed students with compassion.

A requisite skill set reported widely in the present study and supported by the voluminous prior literature is communication, which plays a significant role in compassionate care of older people (Curtis 2014). Communication and care-involvement demonstrate mutual respect and enhance satisfaction in older patients (Norouzinia et al. 2016).

Acting compassionately implies emotional engagement, which is essential in making the patient feel reassured and safe but this adds to emotional labour (Hochschild 1983), which is a

fundamental but frequently unacknowledged part of nursing. Hochschild (1983) states that emotional labour ultimately leads to emotional exhaustion, a characteristic of burnout that results in physical and psychological fatigue (Maslach, 1982). Bradshaw (2011) argues that emotional engagement and compassion serve only the patient. However, Dewar et al. (2011) claim that caring provides job satisfaction and is not a burden. Likewise, Youngson (2008) argues that emotional work is associated with positive outcomes and not fatigue. Further, emotional intelligence is associated with staff performance (Goleman, 1998) and successful practice (Rochester et al. 2005). In supportive clinical areas, caring attitudes can be maintained and signs of compassion fatigue identified early (Hooper et al. 2010)

There is a question of where compassion should be positioned within the curriculum; whether it should be taught as a stand-alone module in order to protect it; or whether it should be integrated throughout. Nathoo (2017) argues that if compassion is invisible in the curriculum, with no explicit learning outcomes, individual lecturers use their discretion in integrating it into their teaching, and there is a danger of inconsistency.

Dewar and Mackay (2010) argue that compassion can be embedded within the curriculum using appreciative enquiry, querying patients and other team members on good practice. They also recommend Action Research to identify, reflect, evaluate and take action to promote compassionate care. In education, relationships that are genuine, supportive, reflective and appreciative are crucial in promoting compassion in the curriculum. Durkin, Gurbutt & Carson (2019: 2118) devised the Compassion Strengths Model based on research into the perspectives of nurses, nursing students and educators. This model comprises eight qualities (enumerated above) that underpin compassionate care and offers a means by which compassion may be developed in students.

This study adds to the modest literature on the determinants and application of compassion in nursing. It raises important issues for consideration by NEs, CMs and clinical managers. The use of framework analysis with methodological coding and labelling added research rigour by making the process of data analysis explicit and providing a transparent audit trail. Its main limitation is that the findings relate to stakeholder perspectives and it is recommended that future research should elicit the views of older people themselves.

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