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Genuinely Caring: Compassion and the Healing Nature of the Therapeutic Relationship

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Portfolio for the Professional Doctorate
in Counselling Psychology

City University London
Department of Psychology
September 2015





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pp 249-276: **Part 3.** Publishable paper: 'This isn't just an item in a factory': using grounded theory to conceptualise compassionate nursing care in the NHS.

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Introduction to Portfolio

Compassion and the Healing
Nature of the Therapeutic
Relationship

This portfolio comprises of three pieces of work that bring together three aspects of my training in counselling psychology. First and foremost it presents an original grounded theory research study, which explores the concept of compassion in nursing care. The second piece is a publishable paper reporting the findings of the research study. The final piece is a case study of work I conducted with a client, which critically explores the use of the therapeutic relationship in supporting his engagement in the therapeutic process.

These three pieces fit together as a collective body of work linked through a theme of compassion and healing relational care, and as such contribute to the body of knowledge of compassion in healthcare. The theme represents an endeavour I see as a quality engendered in counselling psychology therapy and one that requires support to flourish within an increasingly overstretched National Health Service (NHS). I did not originally intend to compile work around this theme but I have come to recognise my personal and professional interests in this subject area have pulled me in the direction to explore and understand the healing processes at play in physical and mental health care relationships.

My motivations for the topic of compassion are various but I first became interested whilst working within an occupational health psychology service for an NHS trust. A number of healthcare workers attended due to burnout and reported their desire to do their best and give patients relational high quality care whilst at the same time feeling increasingly overwhelmed by workplace pressures such as understaffing and restructuring. The passion these staff members had and the pressure and challenge they faced seemed to be underpinned by accusations and narratives in the media and politics at the time that nurses and practitioners of lacked compassion. Compassion and relational care became a focus of inquiry and I was interested in

how compassion in healthcare could be positively influenced by psychological research and theory.

Cooper (2009) compared the values of counselling psychology as aligning with Levina's concept of 'welcoming the other'. The task of welcoming the other requires one to see the person beyond their diagnosis, to recognise their uniqueness and in turn endeavour to enhance responsiveness towards them (Cooper, 2009). These tasks transcend the more obvious client-therapists dyad and apply to many disciplines across healthcare professions. Cooper (2009) also stated that counselling psychologists are tasked with 'giving psychology away' in order to help communities and individuals learn relational skills. In this respect it is my belief that developing an understanding of other healthcare professions through the lens of psychology is an endeavour closely aligned to the values of counselling psychology, one that promotes and supports all relationships not just the traditional client-therapist relationship.

Although I have arranged the portfolio around the theme of compassion and relational care, there are a number of broad themes woven throughout including the therapeutic relationship, authenticity and organisational factors in care. In compiling these pieces I was curious about the answers to many questions such as: What does compassion look like in the context of healthcare? How can nurses and healthcare professionals create meaningful compassionate relationships within their brief encounters with patients? What does it mean to genuinely care? What gets in the way of compassionate care? What role does the therapeutic relationship play in caring and recovery? What can counselling psychology learn from other caring professionals and vice versa?

The first piece included in this portfolio is a research study, which used grounded theory to conceptualise compassion in nursing and explores what makes it possible. My aim with this study was to add to the understanding of the nature of compassion within nursing, which could contribute to useful strategies for supporting the cultivation and appraisal of compassion in healthcare workers. I was also interested in thinking about the role for applied psychology in helping to design and deliver interventions that supported compassion within the NHS. I hoped that findings of the research could help to increase the sensitivity of psychologists and healthcare workers working with clients facing physical health issues and those working with nurses within Multi Disciplinary Teams. A social constructivist approach to analysis was taken to acknowledge that data and analysis are created subject to a collaborative process between researcher and participant (Charmaz, 2006). In addition it was hoped that a social constructivist approach would contribute toward a greater depth, meaning and understanding of compassion in order to bring into focus the role and importance of compassionate caring relationships amidst an arguably testing time for the NHS.

The second piece of work included in this portfolio is a case study of clinical work conducted with a man who struggled with anger, depression, self-harm, and interpersonal problems. The account provides a description of our therapeutic work and how we navigated the creation of a trusting therapeutic relationship in the context of his severe mistrust and rejecting experience of others. The case study goes on to describe the negative impact of another member of staff from the wider organisation on the process of therapy. Although this member of staff was not a member of the therapeutic team, a negative interaction with him caused the client to become mistrustful of the service and as a result he temporarily disengaged from therapy.

The case study exemplifies the impact of members of staff across a healthcare organisation on the experience, engagement and recovery of a client. The need for patients and clients to experience all staff as compassionate paralleled key findings from the research study. The research study findings suggested that all members of staff regardless of their role can have a substantial impact on a patient's experience and recovery process. The importance of this impact on physical and mental healthcare is therefore, a key conclusion shared by these pieces, which suggest that compassionate caring relationships need to be present throughout healthcare organisations.

The case study was also chosen for inclusion as an illustration of the power of the therapeutic relationship on engagement and client recovery. This was also a key finding in the research, which suggested that despite a nurse's physical healthcare role, even in very brief encounters it was possible to have a powerful impact on a patient's emotional and physical wellbeing. The findings of the research and the case study therefore, demonstrate the powerful and healing nature of compassionate relational care. It is hoped that the portfolio may be an encouragement to healthcare professionals, that despite the challenges of working for organisations that are under immense pressure (such as the NHS) it is still possible to have a tangible healing effect through even the briefest moments of compassion and relational connection with patients.

The final piece is a journal article written for submission to the Journal of Compassionate Healthcare. It offers a summary of the research findings focusing on findings that relate to outcomes of compassionate care and organisational culture in particular and their implications for clinical practice and organisational management. This article demonstrates the potential for the findings of the research to be condensed ready for publication in order to disseminate to the wider academic

community.

I have found my training as a counselling psychologist immensely rewarding and I am invigorated by the prospect of using the knowledge I have acquired during the course to continue to 'give psychology away'. I hope that readers of this portfolio may find something here that is encouraging and relatable to their own practice across healthcare disciplines.

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Part 1: Research

Caring For and About Patients:
A Grounded Theory
Construction of Compassion
In Nursing Care

Abstract

Compassion is frequently discussed in relation to nursing. However, to date, research in this area has been largely theoretical, and empirical investigation has been limited. This qualitative study aimed to construct an understanding of the nature of compassion in nursing and what makes it possible, in order to address the paucity of research and lack of consensus in this field.

Semi-structured interviews were conducted with six nurses and six patients across three hospital departments, with the resulting data systematically analysed and categorised in accordance with principles of constructivist grounded theory.

This study has facilitated a broad and multifaceted understanding of the construct of compassion, which emphasised the delicate interpersonal nature of compassionate care that occurs between the nurse and patient. Study findings suggest some factors that inhibit and facilitate compassion which play a powerful role in a nurse's ability to care compassionately.

The findings of the present study challenge the suggestion that feelings-based care practices for patients should be abandoned in favour of etiquette-based approaches; it also contests contemporary wisdom that the best cost-effective measures are achieved through driving for efficiencies.

Suggestions are made regarding the role of counselling psychology in supporting the emergence of compassion in healthcare and implications for nursing practice and future research directions are explored.

Chapter 1: Introduction

1.1. Overview

This chapter contextualises and outlines the rationale for this study into the nature of compassion in nursing. It begins with an overview of the background to the research, followed by a history and definition of key terms within nursing literature. It then explores existing research that attempts to conceptualise compassionate care in the context of nursing and outlines the rationale for the premise of this grounded theory (GT) study. My personal relationship to the topic is explored reflexively in the final part of this chapter.

It is pertinent to note that GT researchers have differing opinions about the timing and use of the literature review within GT research, leading to ambiguity about its use. I outline this debate in more detail and outline my stance in relation to it in the methodology chapter two section 2.9.1. For the present study I chose not carry out an extensive literature review until after the analysis phase. Instead only a brief literature review was utilised prior to commencing the study in order to assess the necessity of the research and create a convincing rationale within the research proposal.

The decision was made to delay an extensive literature until after the analysis was undertaken and written in order to, where possible, limit imposing preconceived ideas onto the analysis and enable an articulation of ideas without the restrictions of existing theories (Charmaz, 2006). Therefore, the majority of literature reviewed in this chapter was collated after the analysis phase of the research and as such some literature included was published after the study was conceived and completed. Literature has been used in this study to further illuminate and validate the findings of the study rather than to inform the study design or data analysis.

1.2. Background and Rationale

Following high profile failings in the National Health Service (NHS) providing quality care to patients at two hospitals in Mid Staffordshire between 2005 and 2009, it was identified that some nurses “lack fundamental attitudes to care” (Care Quality Commission as cited in Smith, 2012, p. 1). Robert Francis, the chair of the Mid Staffordshire NHS Foundation Trust Public Inquiry that followed, stated that the incidents in Stafford hospital were “a story of appalling and unnecessary suffering of hundreds of people” wherein up to 1200 patients may have died due to routine failings in care (Francis, 2013, p. 1). Some hospital patients reportedly resorted to drinking water from flower vases due to severe dehydration, some received incorrect medication whilst others lay hungry in soiled bedclothes for many hours (Campbell, 2013). These controversial findings have led to wide scale debates about how to address these issues.

The NHS in the United Kingdom (UK) employs approximately 1.6 million staff today, making it one of the five largest workforces in the world (NHS Choices, 2015). In 2010, a coalition government was elected into power in the UK and implemented wide scale reforms to the NHS, aiming to increase excellence and efficiencies and promote patient choice (HM Government, 2010). The reforms included the passing of the Health and Social Care Bill which some believed marked the beginning of the end of the NHS (Ham, Baird, Gregory, Jabbal & Alderwick, 2015).

The NHS faced complex organisational changes within the coalition government reforms, which were purported to put unnecessary pressure and demands on NHS staff (Ham et al., 2015). It could be argued that NHS staff members faced destabilising change and greater stress than ever before, without a substantial increase in supervision and support for their emotional welfare. Despite this, the

government remained determined to deliver its pledge for “high quality compassionate care” to the approximately three million patients treated weekly in the service (COI, 2010, p. 3; NHS Jobs, 2013). A failure to recognise the key role that organisational culture can play in the quality of care is evident, despite Health Secretary Jeremy Hunt’s response to the Francis report “most nurses are angels, yet the system can just crush the compassion out of them” (Winnett & Brogan, 2013, p. 1).

The need for compassionate care within the NHS has been repeated on multiple occasions and has become somewhat of a catchphrase in healthcare discourse (de Zulueta, 2013). A report by the Prime Ministers Commission (PMC) on the future of nursing and midwifery mentioned ‘compassion’ on fifty occasions and stated that “compassionate care is skilled, competent, value-based care, that respects individual dignity” (COI, 2010, p. 3). In a joint statement of professional values, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) highlight the need for health professionals to demonstrate compassion and kindness, and for senior staff members to act as role models to junior staff members (NMC & GMC 2012). However, despite their emphasis on compassion, the PMC, NMC and GMC fail to provide a clear definition of what they deem to be compassionate care in practice.

An explication of the centrality of compassion in values-based care was outlined by the Department of Health (DOH, 2012) in a document called “Compassion in Practice”, which outlined the six Cs that encompass the values and behaviours underpinning professional care within the NHS. The six Cs include care, compassion, competence, communication, courage and commitment. The DOH defined compassion as “how care is given through relationships based on empathy, respect and dignity - it can also be described as intelligent kindness, and is central to how

people perceive their care” (DOH, 2012, p. 13). Despite the centrality of the concepts of the six Cs to the idea of compassion, researchers argue they are not easily defined (Flynn & Mercer, 2013).

The perception of care by patients and the public is placed as one of the most important factors for restoring confidence in NHS care and the DOH set out a call to “support the measurement of care that we and others provide in order to learn, improve and highlight the positive impact we have on the patients and the people we care for” (DOH, 2012, p. 19). The present study is an attempt to begin to address this call by elucidating the nature of compassionate care in nursing practice. It is also a response to Kleinman’s (2008) supposition that healthcare professionals need “to be more critically concerned with the details of caregiving, with its experience in everyday practice, and obstacles that inhibit physicians and others caregiving” (p. 23).

Compassion is a concept that remains ambiguous in this context thus leaving what constitutes compassionate care open to interpretation. Without a clear definition it is unclear how the government could assess whether the NHS is successful in delivering their stipulated aim of quality compassionate nursing care. In order to shed light on this topic I will turn to the literature in the field of nursing to clarify key terms and critically explore pertinent empirical research.

1.3. Nursing Theories

Historical practice values of the nursing profession are grounded in religious ideas of compassion and suffering (Aita, 2000). Until the 19th century, caring was predominately situated within an empathic and compassionate approach due to the lack of active scientific treatments available (Fricchione, 2011). As such it is only relatively recently, in historical terms, that caring in physical health became

increasingly medicalised. Koch and Pasteur propelled the scientific method of treatment forward when their conceptualisation of germ theory in the 1870's led to the development of medicines and procedures (Fricchione, 2011).

Modern-day nursing theories were greatly influenced by Florence Nightingale's environmental model of care proposed in her book 'Notes on Nursing: What It Is and What It Is Not' (Nightingale, 1852). Nightingale conceptualised the body as a dynamic system which was either in balance and healthy, or in disequilibrium and thus diseased (Rosenberg, 1992). Her work reforming sanitary conditions, including advocating the need for irrigation canals, played a significant role in the promotion of health. Although she remained skeptical about the importance of germ theory and the specificity of disease, her conceptualisation of nursing as an art and a science still has relevance today (Parker & Smith, 2010; Rosenberg, 1992).

Nightingale's work attempted to delineate the differences between medicine and nursing and placed nurses within an active, practical role (Murphy & Smith, 2014). Pervading traditional stereotypes of the time assigned doctors with the task of curing patients and nurses with that of caring (Jecker & Self, 1991) and much like the trend in medicine, nursing saw a move towards scientific notions of care and empirical knowledge, and away from traditional values of nursing, such as treating suffering with empathy and compassion (Aita, 2000). A scientific industrialised model of care that broke down nursing care into components and took a task orientated care-giving perspective, dominated understandings of nursing during this time (Murphy & Smith, 2014).

A medical perspective of care dominated nursing practice well into the mid 20th century until Hildegard Peplau challenged this view in the 1950's (Peplau, 1952). Peplau's (1952) theory of nursing had a psychodynamic underpinning and defined

nursing as a significant interpersonal, and often therapeutic process. Peplau's model of care proposes four overlapping phases of the nurse-patient relationship that enter into every nursing situation in which the nurse and patient learn to cooperate to resolve difficulties: orientation, identification, exploitation, and resolution (Peplau, 1952). The orientation phase occurs when the nurse and patient first meet, get to know each other, build trust and develop an understanding of each others roles, boundaries and expectations. The identification and exploitation phases are considered the working phases of the relationship (Peplau, 1997) in which the patient is able to identify those who can help and the nurse permits the patient's exploration of feelings. The nurse is able to use the working phase to support the patient to focus on the achievement of new goals. Finally, the resolution phase represents the termination of the working relationship wherein the patient adopts the new goals and frees him or herself from the identification with the nurse (Peplau, 1952, 1997).

Peplau's model sheds light on the varying demands placed on a nurse due to the identification of distinct roles nurses typically occupy: a stranger, a resource person, a teacher, leader, surrogate and counsellor (Peplau, 1952). The diversity of these roles represents an inherent challenge for nurses who endeavour to meet the various expectations placed on them whilst concurrently meeting their patients basic care needs. Peplau's conceptualisation of nursing as a process helped to further delineate nursing from medicine and was revolutionary in comparison to traditional ideas of the time (Murphy & Smith, 2014).

Virginia Henderson (1966) provided a further landmark conceptualisation of nursing in the 1960's and is often described as the "modern day Florence Nightingale" (Murphy & Smith, 2014; Parker & Smith, 2010, p. 57). Henderson's contributions to nursing theory included her conceptualisation of 'basic nursing care', in which she identified fourteen components of patient needs relating to healthful living, personal

hygiene and the successful completion of prescribed care plans (Henderson, 1997). Additionally, Henderson strived to identify the unique contributions to health embodied within a nurse's role, which she indicated was very subjective and qualitative (Watson, 1999). She believed a nurse should "...get inside the skin of each of (her) patients in order to know what (he/she) needs" (Henderson, 1964, as cited in Watson, 1999, p. 14).

Nightingale, Peplau and Henderson's pioneering publications are similar in their drive to delineate medical care from nursing care and in so doing take varying perspectives towards the definition of nursing (Murphy & Smith, 2014).

The body of literature above highlights that nursing lacked possession of a unique body of knowledge and often used knowledge and theoretical assumptions from other disciplines to guide its practice (Murphy & Smith, 2014). In addition, nursing knowledge relied heavily on the collective wisdom of experienced nurses and lacked a tested, comprehensive theory base (Murphy & Smith, 2014). Theory development with the view to define nursing and contribute toward nursing knowledge and evidence-based practice became a focus of research in order to develop nursing as a distinct discipline (Donaldson & Crowley, 1978; McFarlane, 1976). Many nursing theories have since been published which range from being broad in scope (grand theories) and narrow in scope (middle-range theories) (Fawcett, 2005; see also Murphy & Smith, 2014). Nursing theories and models vary in the extent to which they add to 'nursing science' with each theory articulating and providing a study of a different perspective or understanding of nursing (Masters, 2012).

It is commonly agreed that there are four central theoretical areas within the discipline of nursing which are: "the person receiving the nursing, the environment within which the person exists, the health-illness continuum within with the person

falls at the time of the interaction with the nurse, and finally nursing actions themselves” (Flaserud & Holloran, 1980, as cited in Masters, 2012, p. 5). Jean Watson’s theory of human caring science (1979; 1999; 2001; 2008; 2010) is a prominent example of nursing theory that addresses the last of the four areas, nursing actions, specifically in relation to caring.

Watson’s theory of care evolved significantly over time, but in essence described the core of nursing as containing clinical *caritas* processes (Watson, 2008). The word *caritas*, meaning to appreciate, cherish and give special attention was utilised as a way to convey the concept of love (Watson, 2001). Watson described the *caritas* processes, such as “being present to, and supportive of the expression of positive and negative feelings” as guidelines for putting heart-centred caring into action (Watson, 2010, p. 2). Similarly to Peplau, Watson placed emphasis on the relationship between the nurse and patient but extends this into a spiritual and philosophical understanding. She described a transpersonal caring relationship whereby one goes beyond the ego and a higher spiritual caring experience is created through caring moments (Watson, 2008). In more recent developments of the theory, Watson described the necessity of an authentic caring presence evidenced in a nurse’s intentionality to care and promote healing (Watson, 2008; Watson & Woodward, 2010). In addition, a sense of connectedness and “being” within the caring environment, which recognises the wholeness of the mind, body and spirit is necessary (Watson, 2008; Watson & Woodward, 2010).

The need to balance scientific medicalised care with the art of caring is seen as a key challenge in modern day medicine and care. Kleinman described “contemporary medicine’s caregiving paradox” in which he posits the “structure of training and of service delivery discourages and even disables the art [of caregiving]” (Kleinman, 2008, p. 22). Despite the inherent challenges in caring in contemporary care setting

Leininger (1985, 1995, 2006, as cited in Fitzpatrick & Wallace, 2006) asserted that caring remains the unifying construct of nursing which differentiates it from other professions and is essential to curing healing, health wellbeing and survival.

1.4. Conceptualisations of Nursing and Compassion

As demonstrated by Watson's (2008) theory of care, contemporary nursing literature has seen a shift back to placing historical moral values at the foundation of care. Compassion is one such value emphasised in modern nursing, which alongside caring, was found to be an inherent nursing value in a systematic review of core professional nursing values by Flynn and Mercer (2013).

Compassion has deep historical roots and plays a central role in many religions such as Christianity, Buddhism and Judaism. Many philosophers of note also discuss compassion. Aristotle, for instance, is most commonly identified as the originator of virtue ethics in relation to human actions, which include compassion, as well as courage, fairness, generosity, honesty, honour and temperance (Yoak & Brydon-Miller, 2014). Compassion in the context of nursing care is often discussed in relation to the phenomenon of compassion satisfaction and compassion fatigue, terms that address the implications of the emotional demands nurses experience when caring for patients. Until relatively recently these were the most common ways that nursing and compassion were associated within nursing literature. I will now outline a definition of these terms and go on to explore how the emphasis of compassion within nursing literature has evolved, particularly since the publication of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

1.4.1. Compassion Fatigue and Compassion Satisfaction

A duty of care inherent in the nursing profession is to care for the sick, wounded and traumatised, meaning nurses are personally exposed to pain, trauma and suffering

on a daily basis (Coetzee & Klopper, 2010). This exposure can lead to the phenomenon of compassion fatigue, when the stress of meeting the needs of suffering patients and their families becomes overwhelming and the nurse experiences burnout (Lombardo & Eyre, 2011). Compassion fatigue was first coined by Joinson (1992) and is the principle way the concept of compassion is discussed in nursing publications.

Figley (1995) extended Joinson's (1992) definition of compassion fatigue beyond its original conception by suggesting that those who help others in distress are at risk of secondary traumatisation due to frequent encounters with death and tragedy. It was suggested that compassion fatigue affects nurses in many of ways, including their emotional and physical health, and results in decreased job satisfaction, reduced productivity, and lowered organisational retention rates (Lombardo & Eyre, 2011). Badger (2001) suggested that the stressful situations encountered by nurses demand extraordinary coping mechanisms and nurses can end up engaging in self-sacrificing and inadequate self-care behaviours (Lombardo & Eyre, 2011).

There is an apparent tension between the intrinsic nature of compassion, which requires a nurse to be sensitive to the suffering of patients (Schantz, 2007), and the compassion fatigue which can result from the stress of the burden of caring for suffering patients (Joinson, 1992). Therefore, without appropriate personal and professional resources to manage feelings that arise from the suffering of others, nurses may emotionally detach from patients as a coping mechanism to defend against the overwhelming distress. It has been suggested that the contents of nursing literature also demonstrates a progressively detached emotional engagement with patients, wherein the increased use of the term 'empathy' in place of 'compassion' may be a similar attempt to dehumanize the suffering of patients (Jull, 2001),

Despite the similar working conditions of nursing in the western world not all those exposed to the same risk factors get compassion fatigue. Stamm (2005 as cited in Phelps, Creamer & Forbes, 2009) explained this by suggesting some workers have mechanisms that protect their wellbeing; and as such, 'compassion satisfaction' is a term used to reflect the positive aspects of caring. Slocum-Gori et al. (2011) defined compassion satisfaction as the "emotional rewards of caring for others in a health care context; clinicians felt a sense of return or incentive by seeing a 'change for the better' in patients and families" (Slocum-Gori et al. 2011, p. 173).

1.4.2. Compassion Post the Mid Staffordshire NHS Foundation Trust Public Inquiry

The shift back to moral values within nursing care has been significantly emphasised in recent years, particularly following the Mid Staffordshire NHS Foundation Trust Public Inquiry. The need for compassionate care has been a focus of many reports that followed the inquiry. Compassion is frequently discussed in relation to nursing care in a theoretical manner however, a consensus on the definition of compassion is lacking (Dewar & Nolan, 2013). I will therefore, explore the concept of compassionate care within nursing literature in more detail.

1.5. The Concept of Compassion in Nursing Care: A Review of the Literature

Researchers have emphasised the relational dimension of compassion in patient care (Von Dietze & Orb, 2000) and suggest that an ambiguity surrounding this concept exists due to its intangible nature (Liaschenko & Fisher, 1999). In addition, Pearson (2006) argued that the characteristics and idioms of caring have become subsumed into common sense to such an extent that they are now invisible. Although caring characteristics, such as compassion, are recognised as important,

Pearson asserted that caring characteristics are not seen as complex and central to care but as basic in nature and as such have been decentralised from understandings of a nurse's role (Pearson, 2006). This is echoed by Schantz (2007) who argued that although compassion is one of nursing's most valuable assets it is often seen as optional and in some cases an idealistic notion. Dewar (2012) suggested that in practice compassion is expressed in small invisible acts which are often more noticeable in their absence, and frequently hold little status to those managing and developing healthcare services.

The idea of compassion as relational and requiring action by nurses aligns with a seminal paper on the concept of compassion by Von Dietze and Orb (2000). The researchers argued that compassionate care goes beyond a nurse establishing an emotional connection with a patient and also beyond an emotional affect state, as it is a shared experience that demands action from the nurses. Schantz (2007) complemented this definition and stated that compassion goes beyond caring, sympathy and empathy as "only compassion impels and empowers people to not only acknowledge, but also act toward alleviating or removing another's suffering or pain" (Schantz, 2007, p. 51).

Von Dietze and Orb (2000) argued that there is a moral and ethical dimension to compassionate care that requires nurses to treat a person as an individual, placing emphasis on addressing the needs of the whole person; physical, emotional and spiritual. The outcome and benefit of this type of care is highlighted by Benner (1984) and Stoter (1995), who provided evidence of the healing power of compassion and suggested that patients' needs are more effectively addressed when compassion is present (as cited in Von Dietze & Orb, 2000).

Compassionate care is akin to intelligent kindness, which is given through a relationship based on respect and dignity (DOH, 2012). Liaschenko and Fisher (1999) highlight the need for researchers to recognise the relational practices they deem to be essential for high quality compassionate care. This is particularly pertinent because relational practice is not readily recognised as central to nursing work (Dewar, 2012).

Dewar (2011, as cited in Dewar & Nolan, 2013) attempted to address this gap and identified attributes of compassion, which included “recognizing vulnerability and suffering; relating to the needs of others; preserving integrity and acknowledging the person behind the illness” (p. 1248). However, there is consensus in the literature that a conceptualisation of compassion in relation to everyday practice remains unclear (Dewar & Nolan, 2013; Schantz, 2007). In the next section, I will move from discussing theoretical knowledge to discuss empirical literature in the field that attempts to conceptualise compassion.

1.5.1. Empirical Studies of Compassion in Nursing

There are a number of conceptual papers attempting to theoretically define compassion (e.g. Burnell, 2009; Shantz, 2007; van der Cingel, 2009). However, there is minimal research linking the concept of compassion and nursing empirically (Kret, 2011).

An attempt to investigate the effects of compassion within a healthcare setting was undertaken by Fogarty, Curbow, Wingard, McDonnell and Somerfield (1999) who investigated whether it could reduce patient anxiety. To carry out the study Fogarty et al. (1999) developed a compassion scale, which demonstrated high statistical reliability. The scale deduced an overall level of compassion by measuring ten characteristics on five scales from 0 to 10: cold to warm; unpleasant to pleasant;

distant to compassionate; insensitive to sensitive; and uncaring to caring. However, its use of compassion as an item within the scale was a significant limitation.

Participants were recruited from a sample of female breast cancer survivors and were shown a dramatised videotape interaction of a patient being given information by a consultant regarding two choices of treatment for breast cancer with the associated risks and benefits. A control group saw the video without clips of the consultant displaying compassionate concern for the patient, and the experimental group saw a video that included compassionate concern for the patient and an offer of comfort (touching the patient's hand). Findings showed that when the short additional clips, termed "enhanced compassion", were included, consultants were rated more positively and compassionately (Fogarty et al., 1999). In the enhanced compassion group participants were also significantly less anxious than the participants in the control group after watching the extract (Fogarty et al., 1999). These findings appear to demonstrate the therapeutic effect of compassion in a healthcare interaction.

Whilst acknowledging the limitations of the compassion scale designed by Forgarty et al., (1999) Kret (2011) could not find an alternative in the literature and therefore, used the same measure to evaluate nurse's levels of compassion. The scale was updated to apply to nurses and to provide measurable increments for each of the five pairs of compassion characteristics. One hundred patients from medical-surgical units were recruited to rate one hundred nurses level of compassion using the compassion scale. They were also asked provide an example of something that their nurse had done that they considered to be compassionate.

Kret's findings revealed that the level of experience a nurse had was negatively associated with their levels of compassion, suggesting that as nurses progress their

compassion decreases and they become increasingly colder (Kret, 2011). This implied that although a nurse's skill may improve with experience this does not necessarily equate to an increase in compassion. This supposition is tentative due to the majority of nurse participants sampled having between only 0-4 years experience, which was a limitation of the study.

Analysis of the patients' descriptive data was limited to the use of computerised method, looking at word frequencies. Findings showed that the most frequent compassion descriptors used by patients were 'caring', 'attentive' and 'dedicated'. Despite stated limitations, Kret's study highlights the "many unanswered questions" that remain due to the complexity of the concept of compassion (p. 36). The author suggested that additional research would be beneficial in order to "lead to a better understanding of what it means to be a compassionate nurse" (Kret, 2011, p. 36). In addition, she suggested that it would valuable to explore the difference between the length of time that nurses spend with patients and the quality of the time in relation to the perception of compassion.

There are a number of studies that explore compassion in nursing indirectly. For example, Williams, Dean, and Williams (2009) investigated the supposition that nurses are more caring and compassionate than average individuals. A ten-item personality inventory questionnaire (TIPI) that measured five major facets of personality was utilised to compare female nurses and non-nurse females. The researchers asserted that the personality facet of agreeableness was akin to caring due to its associated tendency to be compassionate, considerate and cooperative, and therefore used it as a proxy measure for caring. Findings demonstrated that nurses were significantly higher in the personality trait of agreeableness as well as extroversion, conscientiousness and emotional stability in comparison to the non-nurse control group (Williams et al., 2009). The findings suggest that in comparison

to non-nurses, nurses have greater self-reported traits associated with caring and have higher resilience. However, this study is limited by the conflation of the terms compassion and caring and the use of a self-report personality measure to test for caring. The assumptions that care and compassion are the same and that compassion can be represented by a personality trait means that it is unclear to what extent the findings tapped into the desired concept of compassionate care.

In a qualitative study, Hudacek (2008) analysed two hundred stories written by nurses in an attempt to clarify the caring practices of professional nursing. The study benefited from a diverse sample pool, with 25% of the participants being nurses who cared for patients in countries other than that of the researcher. Nurses were posted a research pack in which they were asked to recall and describe in writing “one caring practice that made a difference in your life and in the life process of a patient you have cared for in your nursing career” (Hudacek, 2008, p. 125). Data was analysed within an existential phenomenology and seven dimensions of caring in nursing were identified: compassion, spirituality, providing comfort, going the extra distance, crisis intervention, community outreach and caring (Hudacek, 2008). A limitation of the findings was the use of caring as one of the dimensions used to describe the dimensions of caring in nursing.

All two hundred nurses sampled in the study cited aspects of compassion in nursing care irrespective of their global location, which the researcher suggested was reflected in their expression of deep concern for patients: “Compassion requires nurses to go beyond hands-on skills and techniques and focus on alleviating suffering and pain through empathic concern. Compassion requires that nurses be present emotionally and physically” (Hudacek, 2008, p. 126). These results suggest that compassion is a vital part of a nurse’s caring role requiring nurses to be available to patients emotionally and physically, suggesting constant openness to the

suffering of their patients.

Van der Cingel (2011) utilised an in-depth qualitative methodology to explore how compassion is perceived within the relationship between nurses and older persons with chronic disease. The aim of the study was to understand the benefit of compassion within the context of long-term care. The researcher took the stance that compassion is a phenomenon that takes place within relationships and as such interviewed both nurses and patients (van der Cingel, 2011). In-depth interviews asked participants to free associate what the concept of compassion meant to them and went on to explore questions such as “does compassion connect with thoughts, what thoughts?” (van der Cingel, 2011, p. 674). A mixed analytic approach was utilised which adopted elements of grounded theory and an emergent fit model. Findings suggested the nature of compassion could be demonstrated within seven dimensions: listening, confronting, involvement, attentiveness, helping, presence and understanding (van der Cingel, 2011). The study was limited by the specificity of the phrasing within the interview schedule, which could have influenced participants’ articulation of their views of compassion. Grounded theory enquiry utilising less leading questions within the interview schedule would have allowed for categories to emerge from the data. In addition delaying emphasis on existing literature in theory formation would be beneficial for future study. Van der Cingel (2011) suggested further explorations of the dimensions found would benefit from exploration in other settings in order to strengthen the framework of compassion proposed.

Other empirical studies have attempted to conceptualise compassionate care include research by Dewar (2012), who highlighted the challenge researchers face in making explicit what compassionate care constitutes due to its relational nature. In order to overcome some of the difficulties associated with conceptualising compassion, Dewar (2012) used creative methods such as photo elicitation and poetry to attempt

to uncover implicit knowledge relating to caring compassionate actions. The study used a participatory inquiry focus and as such involved the staff and patient participants in co-analysis throughout the research process. The results of the study were represented by the researcher in the form of poetry in order to make them easily accessible to nurses, patients and families, thereby further engaging participants in the research process. The content of the poem focuses on the need for nurses to be wary of making assumptions about patients, asks nurses to tailor their care to individual patients, and emphasises the relational nature of care, which includes taking time with patients, talking to them and thinking about their emotional experiences (Dewar, 2012). The poem legitimatises the need for nurses to spend time with patients in order to achieve this. This study helped participants find creative ways to express tacit meanings in relation to compassion however, it left the process by which the researcher analysed the data and assimilated the various methods unclear, making the replication of this study impossible.

A significant contribution to the conceptualisation of compassionate care and factors associated with its facilitation has been made by Dewar and Nolan (2013). The researchers used appreciative inquiry and action research with a variety of methods such as story telling and participant observation to elicit the intricacies of compassion in daily care and build on what was working well. Central to their findings was the need for appreciative caring conversations in which practitioners had the courage to step outside of established practices and engage emotionally with patients in order to create connections between people (Dewar & Nolan, 2013). Dewar and Nolan developed their findings into what they termed a '7 C's' model which outlined seven essential attributes for caring appreciative conversations placed at the centre of compassionate relationship-centred care. These are as follows: "being courageous, connecting emotionally, being curious, collaborating, considering others perspectives, compromising and celebrating" (Dewar & Nolan, 2013, p. 1253).

Although this study goes some way to inferring how compassion can be achieved in day-to-day practice, the use of appreciative inquiry may have polarised findings by exploring positives without acknowledging that what is positive for some may be negative for others. By pre-assigning the experience as positive the researchers are in conflict with AI's social constructionist stance which denotes that meanings are multiple and created through jointly constructed understandings of the world (Oliver, 2005, as cited in Bushe, 2012). In addition, the way that data is analysed in order to formulate the findings presented remains unclear. A study which uses a methodology that can be easily replicated and clearly states the epistemological assumptions inherent in the research is required to further elucidate the concept of compassion, particularly from a relational perspective. Grounded theory would permit researchers to focus on social process and may be a more fitting way to gain insight into compassionate care.

In order to gain a deeper understanding of compassion from the perspective of health professionals such as nurses, midwives, and paramedics, Bray et al. (2014) undertook a mixed methodology study. A self-report structured survey was formulated based on literature in the field and following completion participants could volunteer to be included in the second part of the study, a semi-structured interview designed to shed light on the results of the survey data. This included exploring the participants' meaning and experiences in relation to compassion as well as the barriers and facilitators they perceived to giving compassionate care.

Researchers found a high level of consensus between participants' understanding of compassionate care, which denoted little reported differences between qualified health professionals and students. The most commonly selected attributes of compassion that participants deemed to be most important, in ranked order included acting with warmth and empathy, involving patients in care and providing

individualised care, and acting in a way you would like others to act towards you (Bray et al., 2014). The most commonly selected statements in relation to the demonstration of compassionate care included the need to actively listen to patients, respect patients dignity and privacy, and be attentive to patients' needs (Bray et al. 2014). Researchers suggest that these findings indicate that participants had a clear perception of compassion, which challenged Von Dietz and Orb's (2000) view that the concept of compassion lacked clarity (Bray et al., 2014). However, by first using quantitative methodology to explore this perspective using existing literature it is possible that the pre-formulated ideas of compassion may have constrained participants ability to move outside the preconceived frameworks exemplified in the study.

Kret (2011) highlights the complex and often-invisible nature of compassion that is inherent in its relational nature means that compassion is a tacit concept that requires deeper exploration. Therefore, it could be argued that using qualitative methodology to inform quantitative survey creation may have been a more effective way of exploring the concept in order to gain a deeper understanding of the relational nature of compassion. Capturing the experience of participants in relation to compassion may have helped researchers to approach the research question more openly, bracketing where possible their preconceived ideas in order to let themes emerge from the data. Checking theoretical formulations with the population group using survey data following this would then help to triangulate their findings. In this way a mixed methodology approach may have led to a better understanding of the research problem (Creswell & Clark, 2007).

1.5.2. The Facilitation and Inhibition of Compassionate Care

Nursing research also explores factors that facilitate or inhibit the delivery of compassionate care and caring. In a study aimed at exploring participants' understanding of self-compassion as a source of compassionate care, Wiklund Gustin and Wagner (2013) used clinical application research based on Watson's theory of human caring (2008). Four clinical nursing teachers with an interest in learning new theory volunteered to be part of the research and met for a total of twelve hours over the course of the study to explore Watson's theory. Data from the teaching-learning sessions in conjunction with participants' written and oral reflections on compassion throughout the project were analysed using a phenomenological hermeneutical method. Findings identified five themes: being there with self and others; respect for human vulnerability; giving voice to things that need to be seen or heard; being non-judgemental, and being able to accept the gift of compassion from others (Wiklund Gustin & Wagner, 2013). Further, the development of self-compassion and the ability to be non-judgmental, sensitive and respectful towards oneself was indicated to contribute to a compassionate approach towards others (Wiklund Gustin and Wagner, 2013). Therefore, it could be postulated that the level of self-compassion people have for themselves influences and facilitates their ability to give compassionate care. The small sample size and the assumption that participants could put aside their pre-understandings of the topic are limitations of the study. Their research also contributes towards a valuable understanding of the mutual benefits of compassionate care, which would benefit from further study.

Parallels can be drawn between research investigating nurses and research that focuses on physicians and patient care. Carmel and Glick (1996) examined factors that appeared to enhance and inhibit what they termed 'compassionate-empathic physicians' (CEP). A CEP was defined as a physician who exhibited behaviour

reflecting “strong devotion to the welfare of patients on two crucial dimensions of patient care: the scientific-technical and socio-emotional, or as it is often put curing and caring” (Carmel & Glick, 1996, p. 1253). Carmel and Glick argued that due to developments in scientific-technical knowledge and skills, greater investment had been placed on physician’s intellectual ability, which, although easier to evaluate, often has less influence on a patient’s satisfaction than a perception of physicians as being caring and sensitive to their needs. Questionnaire data was used to examine assumed multidimensional influences on CEP.

Findings showed no significant differences between CEPs and non-CEPs with regard to gender, work satisfaction and levels of self-esteem. CEP’s were more likely to be younger with fewer years experience and reported having a heavier workload and more emotional exhaustion (burnout). In addition CEPs were found to score higher on pro-social, non-stereotypical attitudes and empathy measures. A limitation of this study was that CEPs were determined by physician’s colleagues rather than by patients. It could be argued that witnessing care and experiencing care could be highly distinct and as such might not accurately reflect a patient’s experience of compassionate care. In addition de Zulueta (2013) stated that the use of empathy measures in the study of the concept of compassion is problematic as it fails to recognise a key distinction of compassion, which involves a motivation to help.

Despite empathy being considered by physicians as the most important quality for being a ‘good physician’ it was ranked as the least important factor for gaining promotion within the hospital of study (Carmel & Glick, 1996). Therefore, despite its perceived value, compassionate-empathic behaviour was not rewarded on an organisational level. Although this study is somewhat outmoded it raises a pertinent issue in relation to the selection and rewarding of medical staff on the basis of technical achievement and skills rather than caring qualities and abilities.

Organisations may in fact play a key role in the prevalence of compassion and rewarding staff on the basis of compassionate care may motivate and influence a culture of compassionate patient care.

The role of a caring organisation was explored by Longo (2011) in a qualitative study investigating caring behaviours amongst nurses. Findings indicated that nurses demonstrated caring behaviours toward their colleagues by getting to know them on both a personal and professional level. In addition nurses expressed their caring through helping and supporting each other, acknowledging unappreciated care and appreciating each other which contributed to an environment that supported and embraced caring (Longo, 2011). Caring behaviours between nurses were found to be a foundation for the development of a consistently caring environment, which is pertinent to the facilitation of nurse-patient relationships and patient outcomes (Longo, 2011).

Longo's findings support suppositions by Ballatt and Campling (2011) who argued that a virtuous cycle exists within organisations whereby kindness enables good relationships, which leads to better outcomes and reinforces conditions for kindness. They suggest that kindness also directs attentiveness, attunement and trust, generating stronger therapeutic alliance, which leads to better outcomes (Ballatt & Campling, 2011). Campling (2013) emphasised the emotional needs of healthcare workers due to the work they carry out and suggested supportive staff groups can facilitate the emotional work carried out in NHS care.

George (2014) cites the growing promotion of competition, self-interest, profit/loss, economic performance and efficiency as being in direct contradiction to the values of compassion, and may in turn impact upon how an organisation makes fundamental decisions. As such, structure and workplace culture can often inhibit good team

working, thus inhibiting the facilitation of kind compassionate care (Campling, 2013). Cole-King and Gilbert (2011) supported this notion by highlighting how problematic structures within the workplace can lead to negative work cultures. They suggested that employees tend to adapt to the work conditions they encounter which means that uncompassionate working cultures are further perpetuated (Cole-King & Gilbert, 2011). Therefore, the conditions that facilitate and inhibit the cultivation of compassionate care on an individual and systemic level need to be explored further in order that evidence-based recommendations can be deployed into NHS trust policy and practice.

1.6. Rationale for this Study

The Royal College of Nursing (RCN) emphasised the importance of implementing policy to ensure patient-centred compassionate care is at the top of the agenda for the training and on-going professional development of nurses in the NHS (RCN, 2013). The King's Fund stated, "professional regulators can and should provide significant leadership in relation to compassionate care; talking explicitly about what is not acceptable in terms of conduct, attitudes, and behaviours; and setting standards" (Firth-Cozens & Cornwell, 2009, p. 9). However, a definition of compassionate care remains unclear and without an applied conceptualisation of compassion grounded in research, it is difficult to comprehend how organisations such as the RCN and the NHS would identify and appraise this type of care. This, in turn, has implications for how the effectiveness of interventions implemented to address deficits in compassionate care will be assessed. Therefore, research is needed to support organisations to identify their terms and could allow for exceptional compassionate care to be recognised and praised. In addition, accessing research in this area may help to empower nurses to understand and meet organisational expectations of compassionate care, rather than having to strive toward an undefined, and thus potentially unachievable, task.

There are many concerns about the idea of measuring compassion in care.

Bradshaw (2009) levelled that this type of market-driven approach to health care may lead to artificial care rather than a genuine concern for patients. This sentiment is echoed by Paterson (2011) who stated that “compassion is a gift from the heart of a bystander” and as such warned against legislating compassion due to many difficulties associated with mandating it (pg. 22). Instead Patterson recommended that educators teach trainee health professionals about the value of compassion and the nature of suffering by discussing explicitly what is and is not acceptable. Watson (2008) described the issues researchers face in attempting to capture nursing practices. She suggested “instruments simply serve as indicators along the way, and point back to a deeper dimension of nurses’ human caring relational practices, that still remain elusive and non-measurable, as they should be” (Watson, 2008, p. xiv). Therefore, research that provides descriptive accounts that conceptualise examples of compassionate and uncompassionate practice would also be beneficial and preferable to research that attempts to create a measure for what as yet is articulated to be an elusive and invisible concept (Dewar, 2012; Watson, 2008).

This chapter has identified that despite the importance placed on compassionate care, a conceptualisation of what it means in everyday practice remains unclear, with no empirical model to indicate how it could be achieved or enabled to flourish in practice (Dewar & Nolan, 2013). The literature indicates that there is a lack of qualitative research exploring what compassionate care looks like in day-to-day nursing practice from the perspective of both nurses and patients. The research aims of this study are a focused attempt at capturing the process of compassion by using grounded theory research to create a conceptualisation of the nature of compassion in nursing.

The necessity to explore compassion from the perspectives of patients and nurses is underlined by Kret (2011). "Discernment of compassionate care first needs to be based on a clear understanding of the concept of compassion expressed by nurses and perceived by patients. In addition, understanding the perceptions of patients provides insight concerning their care expectations" (p. 30). This is also highlighted by the King's Fund in relation to the need for the emotional side of compassionate care, as experienced by both carer and patient, to be measured "through reports of their experience" (Firth-Cozens & Cornwell, 2009, p. 4). The present research also attempts to address the call back to a values-based humanistically orientated approach to research in nursing as stipulated by Eriksson (2002) "We need to regain the hermeneutical approach to penetrate into the core. Caring today needs this knowledge to help the patient in an increasingly complex world" (p. 61).

It is hoped that findings from this research may add to the understanding of the nature of compassion within nursing, which could contribute to useful strategies for supporting the cultivation and appraisal of compassion in healthcare workers. I believe there is an important role for applied psychology in helping to design and deliver such interventions within the NHS. It is hoped this may also help to increase the sensitivity of psychologists and healthcare workers working with clients facing physical health issues and those working with nurses within Multi Disciplinary Teams.

1.7. Personal Reflexivity: My Personal Relationship to the Research

My interest in researching compassion within nursing care developed due to a combination of professional and personal factors, which have made this topic particularly meaningful and interesting to me. Professionally, I gained an interest in this area whilst working for a staff psychological and welfare service (SPWS) within the NHS. Whilst on placement as a trainee counselling psychologist I worked with a number of clients who were receiving psychological intervention as a result of their

struggle to cope with stress at work. At the time, there were a number of systemic issues such as restructuring, redundancies, de-banding and reallocations of job roles and responsibilities that were causing clients to feel overwhelmed. Although they acknowledged the cause of their stress they also exhibited high levels of self-criticism and shame for not being better able to cope with the pressures of work and life.

I began to integrate Compassion Focused Therapy (CFT) (Gilbert, 2000, 2009, 2010a) into my practice, which is a therapy specifically designed for people with high shame and self-criticism. In CFT, an integrative, multi-modal treatment approach is utilised whereby compassion, kindness to the self and the development of self-soothing skills are placed at the centre of the client's therapeutic experience (Gilbert, 2010b, 2010c). The staff members I worked with often had the desire to give compassionate care to their patients but often struggled to distribute a compassionate level of care alongside their other duties and responsibilities, leaving them feeling anxious and exhausted.

At this time the findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013) were being widely discussed in the media and by politicians and I found the response to the inquiry compelling. It seemed that the pressure on nurses was arguably greater than ever, despite increasingly difficult working environments due to organisational restructuring. The question of the degree to which nurses could be compassionate towards their patients whilst also taking care of themselves arose for my clients and I.

Personally, I gained an interest in this area when a close friend of mine, diagnosed with a rare sarcoma, battled with cancer. He told me about the impact nurses had on his wellbeing during his treatment. He described on various occasions the nurses

whom he particularly liked, that showed him compassion and the difference it made to how he felt both physically and emotionally. I was interested to hear about the notion of compassion and care from a patient's perspective. I was reminded of the many vulnerable patients who had felt powerless in the care that they had received at Mid Staffordshire hospital and found myself wondering about how I could contribute to this topic area by giving voice to both nurses and patients.

When reflecting on the topic for this doctoral research I decided that it did not feel appropriate to conduct a study that directly mirrored my friend's experience in cancer care. I decided to carry out more general research in order to facilitate my ability to step back from my own experiences and suppositions.

Engaging in personal reflexivity has been an essential part of this research process in order for me to understand how my own experiences, suppositions and relationship with the topic area may affect the emerging data. As such the use of a reflective diary and memos helped me to recognise my subjectivity and record these assumptions as they arose in order to reground myself in the data and emerging themes.

Chapter 2: Methodology

2.1 Overview

This chapter provides a detailed account of the research process of the present study. I begin by charting the development of the research question, elucidating the assumptions that underlie it. I then outline the interpretivist-constructivist paradigm that shaped the information sought and how it was understood. Finally, I provide detailed descriptions of the research procedures, analytic process, and ethical considerations are given.

2.2 Development of the Research Question

In this research, I wanted to explore how compassionate nursing care was conceptualised by nurses and patients. I was curious about their understanding of compassionate nursing and what, if any, theoretical frameworks or basic social process could be formulated as way of understanding this topic area. The original research question guiding this study was expressed as follows:

What is the Nature of Compassion in Nursing?

I utilised grounded theory (GT) analysis to explore this research question and question evolved as the research progressed. Willig (2013) points out that due to the nature of GT, it is possible that a research question may change substantially by the time theoretical saturation is reached because the researcher is better able to focus it. In this study the question remained the same but an adjunct question was added which addressed research findings that related to moderating constructs of compassion in nursing:

What is the Nature of Compassion in Nursing and What Makes it Possible?

Some of the assumptions underlying this research question are listed below:

- Compassion exists within the context of nursing
- Compassion in nursing may include some real psychological or social processes
- Compassion exists as a phenomenon that can be described and represented in language
- It is possible for me as the researcher to construct an understanding or interpretation of participants' narrative accounts
- Compassion is something that is of importance to nurses and patients
- There may be differences between the way patients and nurses understand compassion
- Some patients and nurses may be interested and willing to share their experiences as part of this research study.

2.3 My Position Towards the Study Target

Within the context of qualitative research there has been much debate regarding whether a researcher should be a member of the population they are studying or not. A comprehensive overview of this discussion is given by Dwyer and Buckle (2009) who explore the 'insider' versus 'outsider' status of the researcher and its implications. They surmised that there are strengths and challenges related to holding either status but claimed that dichotomous labelling restricts a researcher to be categorised as holding only one or the other of these positions. They argue that there is a 'space between' these statuses, which permit both positions to be held, made possible through the notion that "There is no self-understanding without other-understanding" (Fay, 1996, p. 241, as cited in Dwyer & Buckle, 2009).

I consider myself within the 'space between' the insider/outsider researcher status. Firstly, I identify with being an 'insider' due to my past work as a staff member of the trust wherein the research took place. I therefore have my own experiences in relation to the research's cultural context. I also have my own experiences of nursing care as an in- and outpatient within the NHS in the past. In addition, due to the psychological work I have carried out within the trust's staff services, I have had professional contact with nurses within one of the target populations of the research enquiry. I also identify myself as an 'outsider', someone who is not a trained nurse, nor at present a patient receiving in- or outpatient nursing care. In addition, as a psychologist within the field of counselling psychology, I consider myself as having a non-hierarchical stance in relation to expertise and an appreciation for the uniqueness of all people by which I try to avoid assumptions about individuals based on the notion of universal laws (Cooper, 2009). As such, I also consider myself an 'outsider' due to an awareness that my understanding of another person will never be exact.

In order to help manage the challenges of locating myself in the 'space between', particularly those related to the 'insider' position, I have utilised reflexivity throughout the research process to consider the methodological and ethical challenges that may arise and have planned carefully to address these. Breen (2007) suggested this might include balancing an insider role as a psychologist with being an outsider as a researcher, managing the distance required in order to make sense of data produced, and the risk participants may assume that the researcher already knows the answers. The use of a reflexive diary throughout the study helped me to identify feelings and responses that arose as well as memos, which in turn helped me stand back from the phenomenon in question and reflect on my own process, expectations and assumptions. More information about memos can be found in section 2.9.3.

2.4 Research Paradigms

Before questions of method can be addressed, a study's research paradigm needs to be defined to clarify the belief system that underpins it. The research paradigm sets the context for the study and guides a researcher's choice of method by making clear their philosophical assumptions (Guba & Lincoln, 1994; Ponterotto, 2005).

Broadly speaking research paradigms can be understood within the philosophical anchors of ontology, epistemology and methodology (Guba & Lincoln, 1994). They are defined as follows:

- **Ontology** is concerned with what exists and is a view on the form and nature of reality and being. Ontological questions therefore, tend to address "how things really are" and "how things really work" (Guba and Lincoln, 1994 p. 108).
- **Epistemology** is concerned with the theory of knowledge and the nature of the relationship between what can be known; and the researcher and research participant, such as the "would be knower" and the "knower" (Guba & Lincoln, 1994, p. 108). As such epistemological questions tend to address questions that relate to the "how and what, can we know" (Willig, 2013, p. 4).
- **Methodology** refers to the techniques or procedures used by the researcher to gather and analyse the knowledge that can be known (Crotty, 1998; Guba & Lincoln, 1994).

When addressing one's ontological position, Willig (2012) described the need for researchers to reflect on the extent to which they believe their research aims to shed light on reality as opposed to offering reflections which try to make sense of someone's experiences. These two positions reflect the distinction between realist and relativist ambitions respectively, in relation to the status of the data. These two

positions also exist in relation to the researcher's belief about how they are representing the knowledge the data produces. A researcher in a realist position would hold a belief that they are able to hold up a mirror to accurately represent the internal experience of the other, whereas a relativist researcher holds the data produced as their 'reading' of the data, which says as much about the researcher themselves as it does about the experience the researcher is trying to represent (Willig, 2012).

A researcher's ontological and epistemological positioning is inextricably linked because "to talk about the construction of meaning is to talk of the construction of meaningful reality" (Crotty, 1998, p. 10). With this in mind, I will now outline the research paradigm that informs this study in an attempt to meaningfully clarify my positioning. I will then explore how this informed the choice of methodology.

2.5 Identifying the Research Paradigm for this study

I am interested in gaining a meaningful understanding of the phenomenon of compassion in nursing from the perspective of current nurses and patients.

In order to answer the research question, my ontological position assumes that a world exists and as such any meaning making that takes place occurs within a real reality. I also assume that my presence as a researcher influences what I am trying to measure. In addition I further assume that although there might be many ways of interpreting the phenomenon of compassion, I acknowledge that it exists through the beliefs that individuals hold about it; and, finally, that what individuals enact as a result of their beliefs has real consequences and exists within real constraints such as physical context.

In the context of the present research, this means that while I acknowledge there

may be some reality to the phenomenon of compassion in nursing care, it would be influenced by its existence within contextual parameters. Furthermore, any understanding of compassion will be influenced by participants' 'meaning making' and ability to articulate/represent their meaning during a research interview, as well as my own interpretations of their representation of compassion. Therefore, due to the underlying assumptions of my research question I see this study most closely aligned with an interpretivist-constructivist epistemology and critical realist ontology, located between a realist and relativist position.

Within an interpretivist-constructivist paradigm, Charmaz and Henwood (2008) argue that it is not possible to take an objective stance towards a phenomenon and state that researchers can only construct, not discover grounded theory. Therefore the meaning that a mind makes of the world is subjective as both "the researcher and subject of research are both conscious beings interpreting and acting on the world around them within networks of cultural meaning" (Madill, Jordan & Shirley, 2000, p. 7). Although meaning making is subjective, Crotty argues, "The existence of a world without a mind is conceivable. Meaning without a mind is not" (1998, p. 11). Through this understanding, a compatibility between the interpretivist-constructivist paradigm, which permits different perspectives on reality, and a realist paradigm which acknowledges that a world exists independently of consciousness but, does not mean that meanings exist independently of consciousness.

2.6 Research Design

2.6.1 Rationale For Choosing Qualitative Methodology

Qualitative research was deemed to be the best fit for the research question as "The objective of qualitative research is to describe and possibly explain events and experiences" (Willig, 2013, p. 9). In this case, the nature of compassion in nursing is

to be described and an explanatory framework to explain the concept is to be provided if possible.

Although literature exists regarding the concept of 'compassion fatigue' a dearth exists that can contribute to a general understanding of compassion in the context of nursing. Qualitative research is beneficial for its capacity to facilitate methodology that seeks to answer exploratory research questions as it takes an inductive rather than deductive stance towards data. In addition, a deductive stance and its later formation of hypothetico-deductivism does not provide space for theory generation due to its reliance of existing theories thereby limiting the possibility for new insights into the study area (Willig, 2013).

2.6.2 Grounded Theory – The Chosen Method

Grounded theory was first conceived by sociologists Barney Glaser and Anselm Strauss, as a method concerned with "the discovery of theory from data" (1967, p. 1). Since its conceptualisation the originators of GT disagreed about the nature of GT method and as such a number of versions of GT were subsequently developed.

There are many debates about the methodological directions of GT and despite lengthy justification of the classic GT method, Breckenridge et al., (2012) conceded that a fixation on the epistemological and ontological issues associated with GT may detract from the purpose of GT which was designed to be simple in purpose: "To generate a theory from the data that fits, works and is relevant within the area from which it was derived" (p. 69). For this reason I will not provide a detailed account of these debates and instead point to Charmaz (2014) for a succinct summary of the disagreements surrounding the GT method and an outline of the versions of GT currently dominant in research.

Despite methodological differences it is agreed that there are a set of essential GT methods, which are common features apparent in all versions of GT. These include initial coding and categorisation of data, concurrent data generation, memo writing, theoretical sampling, constant comparative analysis, theoretical sensitivity, intermediate coding, core category identification, advanced coding and theoretical integration with the view to generating integrated and comprehensive grounded theory (Birks & Mills, 2011).

Glaser and Holton (2005) stated, “The goal of grounded theory is to generate a theory that accounts for a pattern of behavior that is relevant and problematic for those involved” (p. 1). For the purposes of this study compassion in nursing or lack thereof, is a concept and pattern of behaviour assumed to be pertinent to the research group. Grounded theory seeks to understand the ways people “negotiate and manage social situations and how their actions contribute to the unfolding social process” (Willig, 2013, p. 80). In this case, compassion in nursing can be thought of as the unfolding social process and I am interested in how it is negotiated and managed by nurses and patients. I hoped using grounded theory would enable me to explore “individual processes, interpersonal relations, and the reciprocal effects between individuals and larger social processes” (Charmaz, 1995, p. 29). For this reason, GT was selected in this study over other qualitative methods such as IPA due to its suitability to understand social processes rather than being simply a descriptive account of individual lived experiences (Willig, 2008).

Furthermore, Fassinger (2005) described GT research as a “methodological exemplar of the scientist–practitioner model” and as such positions GT as a methodology that can offer a great deal to counselling psychology research, in its ability to illuminate the types of problems they might address (p. 165). Henwood and

Pidgeon (1992) also stated that GT is a useful approach for the central role that qualitative methods can be seen to play in the quest for psychological knowledge.

2.6.3 Rationale For Choosing Constructivist Grounded Theory

In response to perceived limitations of other forms of GT, Charmaz developed a social constructivist GT approach (Charmaz, 2006, 2009) which the methodology utilised in this study most closely resembles. Methodologically, social constructivist GT places emphasis on action orientated coding, richer thematic description and acknowledges the researchers role on the co-construction of findings from the data.

Charmaz (2003) stated that her version of GT “takes a middle ground between postmodernism and positivism, and offers accessible methods for taking qualitative research into the 21st century” (p. 250). This interrelates with a constructivist paradigm, which suggests that meaning is created as individuals interact with, and interpret objects rather than lying dormant waiting to be discovered (Crotty, 1998). Charmaz (2006) suggested that data and analysis are created subject to a collaborative process between researcher and participant.

Perceived virtues of the GT method include the way it “encourages a slow-motion reading of texts and transcripts that should avoid the common qualitative research trap of trawling through a set of transcripts for quotes to illustrate preconceived ideas” (Potter, 1998, p. 127). For this reason, Corbin and Strauss’ (2008) interpretivist/pragmatist version of GT was rejected due to its reliance on a detailed, formally structured coding system, including axial coding and conditional matrixes which have been criticised for how it “may limit what and how researchers learn about their studied worlds” (Charmaz, 2006, p. 62) and how it may lead to researchers forcing data onto a pre-defined framework. I was concerned Corbin and Strauss’ (2008) version of GT would be too restrictive and may limit my freedom to engage with emergent data openly; Charmaz’s constructivist GT method was

favoured because of the flexibility it lends researchers to remain open to emerging categories.

In addition, classical GT (Glaser & Strauss, 1967) was rejected due to its realist ambitions which do not recognise the “mutual creation of knowledge by the viewer and viewed” (Charmaz, 2003 p. 250). Therefore, “[b]y adopting a constructivist grounded theory approach, the researcher can move grounded theory methods further into the realm of interpretive social science consistent with a Blumarian emphasis on meaning, without assuming the existence of a unidimensional external reality” (Charmaz, 2000, p. 521).

Crotty (1998) suggested that in reality we create a methodology for ourselves, one that is determined by the focus of our research that enables the researcher to use procedures that achieve the research aims. Therefore, “every research project is unique and in turn requires a unique methodology” (Crotty, 1998, p. 14). In undertaking the challenge to address the philosophical and methodological positioning of this research I am able to justify my methodological decisions in this way. There was no perfect methodology which satisfies all of the assumptions of the research paradigm outlined in section 2.5; however, taking a social-constructivist approach seemed to be the best fit for addressing my research question flexibly whilst aligning with my values as a researcher who cannot deny the subjectivity that is inevitable in the research process.

2.6.4 Rationale For Choosing Abbreviated Grounded Theory

The present study employed an abbreviated version of GT whereby the implementation of theoretical sensitivity, theoretical saturation and negative case analysis only occurs within the texts that are being analysed and no further interview data is collected (Willig, 2013). The reason for the implementation of abbreviated GT

was both pragmatic and ethical. Firstly, time restraints meant that recruitment occurred within a short timeframe meaning that transcribing and open coding could not take place between interviews. In addition due to the restraint of NHS ethics board approval every time an interview schedule is altered it needed to be approved by a standing committee. Due to the limited time available to complete doctoral research I made the pragmatic decision to implement the abbreviated version of the GT method.

Although the full version of GT should be utilised where possible, Willig (2013) suggested ways in which the limitations of the abbreviated version of GT can be addressed. As suggested, line-by-line coding was utilised in order to create a depth of analysis that can compensate for the loss of breadth that occurs due to the researchers reliance on the original data (Willig, 2013).

2.6.5 Evaluating the Quality of this Study

In order to be mindful of quality in qualitative research, I explored a number of sources. There are varying perspectives on the criteria that can be used for evaluating qualitative methodologies. From the literature I drew on the following researchers recommendations. Denscombe (2002) for example, described a number of features that distinguish good social research regardless of the methodology utilised. These include the contribution of new knowledge, the use of precise and valid data, collected and used in a justifiable way, and findings from which generalisations can be made.

Henwood and Pigeon (1992) explicated their criteria for evaluating quality in more detail and their recommendations included, keeping close to the data, creating rich dense integrated theory, using and documenting reflexivity, and highlighting transferability, the extent to which the study findings has a more general significance.

Morrow (2005) suggests various criteria for assessing quality and trustworthiness in counselling psychology research specifically. These include subjectivity and reflexivity, social validity, adequacy of data, and adequacy of interpretation (Morrow, 2005).

In addition, I have drawn on guidance from Charmaz (2014) who suggested that the credibility and quality of qualitative research is dependent on the depth and scope, as well as suitability and sufficiency, for depicting empirical events. I will be returning to these criteria in more detail in the discussion section in order to illuminate how this study took steps to ensure the quality of research data.

2.7 Ethical Considerations

Throughout this research ethical considerations were made in order to ensure the study complied with the core principles of human research ethics as outlined by the British Psychological Society (2010) and the Health and Care Professions Council's guidance on conduct for students (HCPC, 2012). Central to completion of ethical research is a researchers duty "to make sure that the human beings they study—fellow citizens they probe, query, prod, and palpate—are treated with dignity and respect" (Shea, 2000, p. 28).

City University Ethics Committee and the London – City and East Health Research Committee granted ethical approval for this research details of which can be found in Appendices J and K. A procedural summary of ethical considerations is outlined below.

2.8 Participants

All participants were working for, or receiving treatment from, within the hospital trust. Participants were recruited from the trust from three different specialisms, which

were chosen to represent the different contexts of patient care. A critical care unit was selected for its treatment of patients with acute physical health problems who were more likely to remain for a short stay within the department. A rheumatology service was chosen to represent patients who had chronic long standing physical health problems who were more likely to have a long history of treatment within the department. Finally, an elderly medicine service was selected in order to represent patients indicated in the literature search as being more vulnerable to non-compassion in nursing.

Working out how many participant interviews are sufficient for qualitative research is a dilemma that is contested among qualitative researchers, as is whether it is an epistemologically appropriate question. In a discussion paper Baker and Edwards (2012) provided reflections on the many possible responses from the perspectives of social scientists and student researchers. They argued there is no straightforward riposte and as such they concluded, “it depends” on a multitude of factors. As well as epistemological debates, they pointed to outside determinants such as time to complete the project, practicalities of recruitment and satisfying ethics committee boards.

The number of participants sampled in this study reflects a pragmatic attempt at providing diversity that is reflective of different contexts of patient care, as well as meeting practical requirements and restraints. I found guidance by Jensen (2012) helpful in this regard, as she suggested that it is not the quantity of interviews that was important but rather the quality, time, and care taken to analyse the interviews that is what is valued in qualitative research. She described the importance of researchers ‘taking their time’ to do the analysis justice and in so doing highlighted that ‘more’ does not necessarily mean ‘better’ in quality qualitative research (Jensen, 2012).

2.8.1 Sample

Only a small amount of demographic information was recorded. In order to protect the confidentiality of participants who could be identifiable if a demographics table was utilised I have provide pertinent sample details in the summary paragraphs below.

The sample consisted of twelve participants, six nurses and six patients. All participants were UK residents and represented a broad socioeconomic range. All six nurse participants were female and their length of employment as a nurse ranged from two to twenty-five years. Nurses were from varied ethnic backgrounds and four spoke English as a second language. Two nurses were from within a rheumatology department, three from within elderly medicine and one from within critical care.

Of the six patient participants, four were male and two were female. Ages ranged from approximately thirty to ninety years of age. Patients were from varied ethnic backgrounds and two spoke English as a second language. One participant was from within rheumatology, one from within elderly medicine and four from within critical care. The inclusion and exclusion criteria for the sample were as follows:

Inclusion criteria

- Aged 18 or above
- Ability to give informed consent
- Capable to participate in a semi-structured interview
- Current employment as a nurse in the NHS OR present or recent patient (within the past 3 months) of the NHS

Exclusion criteria

- Participants under the age of 18
- Participants known to the researcher in a personal or professional capacity
- Participants deemed actively distressed
- Participants deemed inappropriate or unsuitable to participate by ward staff for ethical reasons such as heavy medication, distress or cognitive capacity

2.8.2 Recruitment

Recruitment for the study was carried out in two phases, first nurses and second, patients. Several meetings were carried out with the head nurses for elderly medicine, rheumatology and critical care in which they were informed of the study. Once the head nurses were satisfied with the remit of the research and had negotiated how it could be carried out with least disruption to staff and patients, they were provided with advertising posters to pin up in common areas (Appendix A), and participant information sheets (Appendix B).

The first phase of recruitment targeted potential nurse participants. Head nurses informed their nursing staff about the study verbally within staff team meetings and via email, and gave nurses who were interested in taking part were given a participant information sheet and relevant contact details. Recruitment stopped once I had interviewed six nurse participants with a minimum of one nurse from each department.

The second phase of recruitment targeted potential patient participants. During designated rheumatology and critical care outpatient clinics agreed in conjunction with the head nurses, patients who met the research criteria for the study were informed about it at the end of their outpatient appointment. If patients were interested in taking part they were given a participant information sheet and were

asked if they would like to speak to the researcher right away or make contact at a later date. I was situated in a separate clinic office nearby for convenience and participants who requested to speak to the researcher were introduced to me and I answered any questions they had about the study.

Recruitment within inpatient elderly medicine occurred on designated days agreed in conjunction with the head nurses when I could be in attendance. On these days nurses identified patients who had been assessed as having cognitive capacity and gave them information about the research. If they expressed an interest in taking part I was informed and answered any questions they had. Recruitment stopped once I had interviewed six patient participants with a minimum of one patient from each department.

2.8.3 Procedure

Nurses interested in taking part in the study from elderly medicine and critical care departments informed their nurse managers who organised for interviews to take place during their working day and personally provided cover for their duties to enable them to take part. Interviews took place within private clinic rooms within the department.

I am aware that the involvement of nurse managers in the recruitment process meant that participants were not completely anonymous at the point at which they showed an interest in taking part. The knowledge that a nurse manager would be aware of their involvement may have deterred some potential participants from volunteering. I also cannot rule out the possibility that their involvement may have been due to a desire to be seen by their manager in a positive light. However, in either case nurse managers were not informed as to whether or not the nurse agreed to take part and thus whether time spent with potential nurse participants was to gather research data

or not. Although this arrangement was not ideal it was the only way to gain access to potential nurse participants in these departments. A key role of the nurse managers is to act as the gatekeepers to their staff, patients and wards and therefore, carrying out the research in a way that was both agreeable to the nurse managers whilst remaining ethical was a priority when negotiating these arrangements. As such nurse managers agreed to keep any knowledge of the involvement of their staff and patients in the study completely confidential.

Nurses interested in taking part in the study from the rheumatology department contacted me directly via email or phone. One interview was arranged in a large staff common area on a private table away from other staff members, a location proposed as convenient by the nurse participant. The other rheumatology nurse participant organised for the interview to take place in a private clinic room during a break in her working day. The difference in procedure for rheumatology nurse participants was due to the agreement made with the relevant nurse manager.

Five patient interviews took place within private clinic rooms. The remaining interview took place at a patient's bedside with the curtains around the bed drawn to offer some measure of privacy.

All participants were fully briefed about the study using information provided in the participant information sheet (Appendix B). Following the consent process (Appendix C), I conducted the interview. Patients were informed that they could change their mind and withdraw from the research at any time without any repercussions, and were provided with a debriefing information sheet tailored to either nurse or patient participant (Appendix D and E). No participants showed any visible signs of distress during the interview or utilised the allotted time to debrief once the interview had been completed. All participants were given the opportunity to receive a summary of

the results once they had been completed. No participants received compensation, financial or otherwise, for taking part.

2.8.4 Consent

Informed consent was thoughtfully considered throughout the recruitment of patient participants due to the potential for patients within these departments to lack cognitive capacity to take part in the research. In order to manage the issue of informed consent the researcher worked carefully with ward nurses. Ward nurses were mindful of a patient's medical history before approaching them with information about the study, for example patients who were experiencing occasional memory loss due to brain injury were not deemed to be appropriate even though they were deemed as having mental capacity. Due to the typical presenting medical problems of inpatient older adults it proved difficult to recruit elderly patients. Many lacked capacity due to delirium, organic brain syndrome or were highly anxious or suspicious of recording devices. Therefore, only one patient participant was interviewed from this sample. Whilst I worked with nurses to ensure that only patients who could give informed consent were approached, I also ensured every potential participant I spoke with appeared to have the ability to understand, retain, use and weigh up the information I gave them.

2.8.5 Interviews

Individual semi-structured interviews were chosen as the preferred method of data collection in order to allow participants time to confidentially and openly discuss the topic area in depth without being influenced by the perceptions of other participants. Semi-structured interviews were conducted with participants lasting between 18 and 43 minutes with an average length of interview being 34 minutes. Interviews were audio recorded on two devices to ensure that data would not be lost. Interviews were

transcribed and fully anonymised and all data was stored in accordance with Data Protection Act (1998) and UK data archive recommendations.

I maintained an awareness throughout all the interviews that patients may be tired or feel unwell during the interview, and nurses may be experiencing time pressures due to the nature of their work. Once participants had answered the questions in as much depth as they could manage they were given the opportunity to add anything they thought was important that had not been covered after which the interview ended. The range of interview lengths therefore represents a pragmatic approach to manage the potential inconvenience of the research on both nurses and patients. The locations of the interviews within hospital departments were selected to be of convenience to nurse and patient participants and with the aim that generating data from within the relevant social context might provide a more 'grounded' study (Wimpenny & Gass, 2000).

Some participants had difficulty at points during the interview such as discussing metaphorical ideas, due to the limitation of speaking English as a second language or for one participant due to a speech impediment associated with his advanced age. They were encouraged to find the words that made most sense to them. At times this meant the participants desired tenses, pronouns and meaning were unclear. I used summaries and reflections in order to clarify meaning where it was unclear and asked participants whether I understood them correctly. Although including participants with some difficulty in providing a rich narrative proved slightly more challenging at the analytic phase of the research it was of importance to include participants that represented the diversity of nurses and patients within the NHS.

As referenced in section 2.3 I remained mindful of the potential for navigating the pitfalls of the 'insider' research position throughout the interviews. One of these pitfalls was a potential for participants to assume that I would already know the

answers (Breen, 2007). It was known to participants that I was a psychologist carrying out research and as required by the trust I wore a staff ID badge at all times. I was aware that this could create a dynamic whereby the participant viewed me as an expert and would be hesitant to explore concepts in depth that they assumed were obvious to me in my role.

In order to overcome any potential power imbalances I maintained a warm, open and inquisitive stance whilst gently probing for more information. Open questions such as 'do you think you could say a bit more about that?', 'what comes to mind when you say that?', 'what would be an example of that?' and 'what would I be seeing if I were you?' proved helpful tools to prompt and encourage participants to take an expert stance and talk more freely about the ideas they were exploring.

Once each interview was completed I wrote a descriptive reflective diary entry with any notable observations, thoughts and ideas. If the participant used any non-verbal cues such as specific physical gestures to punctuate or explicate a point I also noted these and what they referred to in order to aid the analytic process. On occasions that I found myself thinking interpretatively about interview data I tried to capture this in a memo so that I could bracket it as much as possible and return to my ideas at a later stage.

2.9 Analytic Process

2.9.1 Initial Literature Review

The use and timing of the literature review is a contentious issue for grounded theorists (Cutcliffe, 2000; Glaser & Strauss, 1967; McGhee et al., 2007). Bryant and Charmaz (2007) highlighted the debate when they discuss the concerns that have arisen for researchers in how they "should approach and use the existing literature relevant to their research topic" (p. 19). Holton (2008) for example takes a purist view

and argues that grounded theory requires the researcher to begin research without an extensive review of literature. In an article addressing the place of the literature review in grounded theory research Dunne (2011) provided a comprehensive summary of the changing positions and perspectives on this over time. For this reason Dunne stated that researchers must explicate and justify their decision regarding the timing of their literature review and how extant literature will be used.

A brief initial literature review was carried out to elucidate the necessity of the research and create a convincing rationale within the research proposal. However, an extensive literature review was not carried out until after the analysis was completed. The purpose of delaying the review was to help avoid imposing preconceived ideas onto the analysis and articulate my ideas without the restrictions of existing theories (Charmaz, 2006), thus limiting the influence of existing literature on the analysis, formation of theory and writing of the analysis. However, to presuppose the ability of a researcher to bracket all prior knowledge of the research area would be untenable and therefore, a memo diary was used to record emerging ideas and reflections and to identify times when thoughts of the data's connection to existing literature were prompted. I will discuss this in more detail in section 2.9.3.

2.9.2 Initial Open Coding

Initial 'open coding' was carried out line by line and followed an approach consistent with Charmaz (2014) constructivist GT that requires researchers to stay close to the data by using action oriented coding and keeping codes short and precise. This helps researchers to describe what is going on in each line and avoid making loose descriptive codes in which the meaning of the data is lost. Whilst carrying out open coding, I listened to the audio recording of each participant's interview in order to listen to the emphasis made by participants, clarify understanding and check the

accuracy of transcription. An example of line by line coding can be found in Table One.

Table 1. Initial line-by-line coding of participant two's interview (page 2 lines 50-60).

Participant's Quote	Initial Open Coding
For them it's just everything I think because sometimes being in the hospital might be a bit	<i>Having an impact</i>
boring as well. So it helps.	<i>Preventing boredom</i>
If you just pass by and say hello, hello, just keep on saying hello, it makes them feel	<i>Greeting patients regularly</i>
important. Known by other people on the ward, and that makes them feel sometimes	<i>Being known by others</i>
very, very happy. Although the situation is sometimes very difficult, they have a lot of	<i>Feeling happy despite difficult circumstances</i>
problems, but it makes them feel very, very appreciated I think.	<i>Feeling appreciated</i>

2.9.3 Memo Writing

Memo writing forms a crucial method of the data analysis process in GT (Charmaz, 2014). Memo writing was used throughout from open coding to the final stages of forming higher-level categories.

There are two main types of memos as defined by Esterberg (2002), procedural and analytic. Procedural memos focus on the process and progress of the research helping researchers to keep track of connections made and the resulting direction of analysis. Analytic memos aim to capture thoughts, ideas, and questions about the meaning of the data. Memos contribute to the development of ideas and provide a space in which a researcher can engage in critical reflexivity (Charmaz, 2014).

Whilst writing memos, Charmaz (2014) recommended asking the following questions in order to maintain a focus on process and help direct the research process:

- “What process is at issue here? How would you define it? To what extent is it explicit or does it remain implicit?
- Under which conditions does this process develop?
- How do(es) the research participant(s) think, feel and act while involved in this process?
- What slows, impedes, or accelerates the process?
- When, why and how, and under what conditions does the process change?
- What are the consequences of the process?” (Charmaz 2014 p. 169)

I found these questions to be helpful prompts for approaching the data analytically when I felt stuck. The questions helped me to be less thematic and tentative and more focused and interpretative. In addition these questions help to keep analysis grounded and minimised conceptual leaps in the analytic process.

Memos were helpful for clarifying connections and comparisons within the data and added richness to the research process. Memos allowed my ideas and assumptions to be captured as they emerged. This process helped me to refocus on the data, making it easier to remain as close to and as grounded in the data as possible.

Memos seemed particularly important in this research due to the use of the abbreviated GT method. I used memos to form questions that, had I been conducting the full version of GT, I would have used to reformulate the interview schedule and test emerging theories (theoretical sampling). As this was not possible I went back to the data collected and asked these questions of the data at hand contributing to theoretical sensitivity (Willig, 2013). For an example of a memo please see Box One.

Memo 22/4/15 – You can talk the talk but can you walk the walk: The difference between *saying* the right thing and *doing/being* compassionate.

Patient five talks about her experience of interviewing teachers who ‘say’ the right things but don’t turn out to make good teachers. She is reminded of this when we discuss how one might assess or interview for compassion in nurses.

“I have interviewed teachers for jobs and I wouldn't say we've made the right appointment. That's not just down to me, but they said all the right things, but in the classroom it was a little bit different. So you can't always go on gut instinct, well yes, everything [in] writing, and talking to a - this particular girl. But work was left unmarked, classroom was messy, all those things that you can't pick up. You can't pick up everything, can you, from an interview.” [P5, 238-244].

There seems to be a gap between what people say and what they do. Suggesting that it is possible to ‘know’ what compassion is without necessarily enacting or ‘being’ compassionate. This is highlighted also other interviews.

Question: How much of compassion in care is purposeful and to what extent if any is it an embodied way of being?

Action: Look up other transcripts to find all the cases of this and look for negative case examples.

Box 1. Example of a memo whilst analysing P5

2.9.4 Focused Coding

The second major phase of analysis in GT is focused coding in which codes that appeared more frequently during initial coding and those that are more pertinent in answering the research question are used to “sift, sort, synthesize and analyse large amounts of data” (Charmaz, 2014, p. 138). Line by line coding involved a process of zooming in to the data at a micro level, whereas focused coding was a way of putting the data back together by zooming out and viewing the wider picture through larger segments of data at a macro level. It helped to highlight the emerging concepts and interpretative ideas without losing the detail that had been obtained during the open coding analysis phase (Charmaz, 2014). Focused coding continued until the construction of hypothetical categories were created which lead to the construction of

major categories and eventually the emerging core category. This process was tentative and remained hypothetical, involving testing through constant comparative analysis. An example of category development from raw transcript data to focused coding is shown below in Figure One.

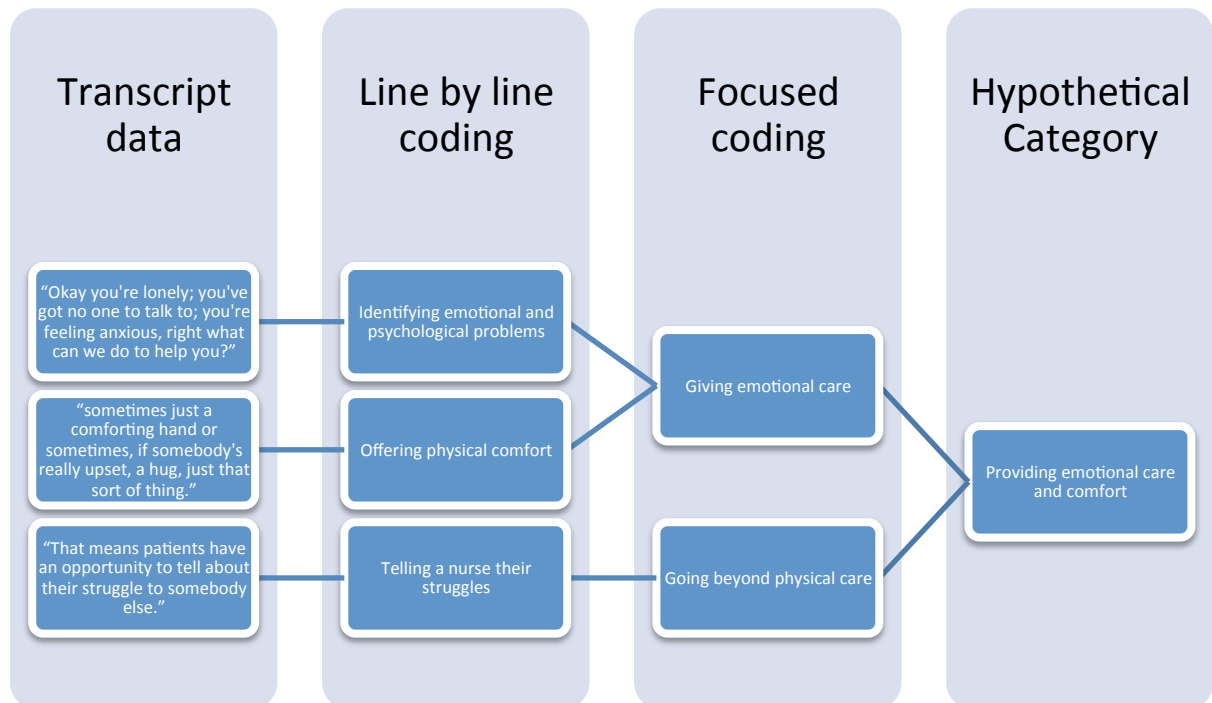


Figure 1. The process of developing of a hypothetical category from raw transcript data.

2.9.5 Constant Comparative Analysis and Negative Case Analysis

Constant comparative analysis was undertaken and requires the researcher to move back and forth between the identification of similarities and differences within emerging categories (Willig, 2013) in order to construct categories that are grounded in the data. This process facilitates the identification of any emerging subcategories and ensures categories are broken down into smaller meaning units so that the complexity of the data is retained and all instances of variation are captured by the emerging theory (Willig, 2013).

As well as engaging in comparative analysis, negative case analysis was utilised in order to develop emerging theory in light of data by looking for 'negative cases' (i.e. instances that do not fit) (Willig, 2013). Once negative cases were identified the category was adjusted or elaborated in order to capture the diversity of the data or where appropriate an explanation was proposed which qualified the existence of the negative case permitting it to remain in the existing category. The occasions when this occurred are elucidated in the findings chapter.

2.9.6 Theoretical Saturation and Integration Toward Theory Development

Traditionally data collection and analysis ceases once theoretical saturation has been achieved. Theoretical categories are therefore, 'saturated' with data and no new patterns or categories can be identified (Charmaz, 2014; Willig, 2013). However, Dey (1999) stated that the term 'saturation' is imprecise and instead suggested using the term 'theoretical sufficiency' as a way of moving away from a prescriptive GT and instead acknowledges the researchers subjective role in deciding when categories are saturated. In this research rigorous constant comparative analysis was utilised for the twelve interviews until it seemed unlikely that new categories would emerge and inconsistencies in the data were accommodated or accounted for.

One of the aims of the study was to develop an explanatory theory of compassion in nursing and as such, through a process of constant comparative analysis, I sorted categories in order to identify a core-connecting category, main categories and sub themes. Research supervision was utilised to assess the quality of initial analysis, the formation of emergent categories, the synthesis of integrated categories and theory development. The results of the study are presented in narrative and diagrammatic form in the following findings chapter.

Chapter 3: Findings

3.1 Presentation of the Findings

I intended to explore compassion in nursing care by interviewing those involved in both sides of the experience, the one who is giving compassion and the one who is receiving it. Traditionally these roles are ascribed to nurses and patients respectively. However, participants varied in the degree to which they identified with their experiences of caring for others or being cared for themselves irrespective of their ascribed role. Some participants used both perspectives to formulate ideas relating to compassionate care and most described their imagined ideas about others in these roles. Therefore, participants often shifted between their genuine lived experiences and hypothetical scenarios and postulations. This variability presented a challenge in how to present the findings from the two groups.

One of the principle aims of this study was to develop an explanatory theory of compassion in nursing, valuing equally the position of nurse and patient. Thus, the aim of this chapter is to present the data in a way that values participants' experience in both these roles and integrates them into a coherent structure. To achieve this the accounts of nurses and patients are presented alongside each other throughout. For ease of reference I have numbered participants one to twelve, and refer to them using their number, for example 'participant one'. Participants one to six are nurses and participants seven to twelve are patients. An abbreviated reference, for example 'P1', is used to identify each participant's transcribed interview extracts.

Due to the extensive nature of the data it was not possible to present an exhaustive account of all the categories and themes present in the analysis. As such, categories that were most saturated in the participants' accounts and most closely parallel the aims of the research were prioritised and presented here. It is important to draw the

reader's attention to the fact that the main categories are not necessarily distinct and therefore, do overlap in places.

The findings are presented as answers to a series of research questions I asked myself following the analysis of the data in order to structure the research findings and each of the main categories and their sub-categories will be presented in turn. The findings are illustrated with extracts from participants' accounts, which are underlined in places to highlight salient words. To promote transparency, examples of research process memos and reflective notes are included to highlight reflections and questions raised during the analysis of the data. Finally, a tentative model of the process of compassionate nursing care is presented at the end of the chapter.

3.2 Introduction and Overview of Findings

Five main categories emerged from the analysis of participants' accounts and were identified as key dimensions representing compassionate nursing care. A core-connecting category of 'Caring For and Caring About' was identified which applied to the five main categories as illustrated in Figure Two.



Figure 2. The five main categories and the core-connecting category ‘Caring For and Caring About’.

3.3 Core Category: Caring For and About the Patient

Findings suggest that compassion in nursing care is a complex and highly personal experience. All participants described how compassion was expressed through practical nursing tasks when ‘caring for’ a patient, as well as a felt sense of genuine ‘caring about’ a patient. There was a shared sense that compassionate nursing was about giving patients more than just physical care and required a nurse to tailor his or her approach to individual patients.

The process of compassionate care seemed to be twofold and bidirectional. In order for care to be perceived as compassionate nurses needed to genuinely care about the patient’s wellbeing. However, compassionate intention in isolation would be insufficient to meet the patient’s needs, therefore, the way the nurse actively cared

for the patient was crucial to patient's experience of care. Both patients and nurses appeared to experience beneficial outcomes from compassionate care. This was particularly apparent when patients perceived that the nurse cared about them as an individual and personalised their care. Benefits included reduced emotional distress and a mutual enjoyment of care. The main categories and their relationship to the core-connecting category are introduced in Table Two and a full list of the main categories and sub categories are listed in Table Three on the following page.

Table 2. Relationship between the main categories and the core-connecting category.

Category Title	Category Overview	Link to caring for and caring about
The Development and Motivations of a Compassionate Nurse	Examining participants' understanding of the key motivations and qualities of compassion and how these develop in application to nursing	Initial context: Setting the scene for the compassionate nurse
Genuinely and Authentically Caring for a Patient as an Individual	Exploring the reported necessity for nurses to care about the patient	Illuminating caring about the patient
Applying Compassion in Care	Outlining the facets described as compassion in action, i.e. how compassionate care is applied in practice	Illuminating caring for the patient
Moderating Constructs	Identifying what seems to be essential factors in facilitating the delivery of compassionate care	Providing the context of compassionate care
Enhancing Patient Recovery and Patient Experience	Exploring participants reported benefits of giving and receiving compassionate care	Subsequent perceived benefits to caring in this way

Table 3. Summary findings table of main and sub categories

The Development and Motivations of a Compassionate Nurse.
Having a Natural Disposition and Motivation to Care
Learning to Apply Compassion Through Personal and Professional Experience
Genuinely Caring for a Patient as an Individual
Genuinely and Authentically Caring
Humanising and Viewing Patients as Individuals
Understanding the Relational Connection with Patients
Applying Compassion in Care
Treating Patients with Dignity
Personalising and Tailoring Care
Providing Information and Explanations Carefully
Providing Emotional Care and Comfort
Caring Attentively
Going the Extra Mile
Moderating Constructs
Having Time
Being within a Compassionate Organisation
Enhancing Patient Recovery and Care Experience
Enhancing the Healing Process
Reducing Emotional Distress
Increased Trust and Openness
Mutual Enjoyment of Care

3.4 How does a Compassionate Nurse Develop? The Development and Motivations of a Compassionate Nurse.

Table 4. Sub-categories of the 'Development and Motivations of a Compassionate Nurse'.

The Development and Motivations of a Compassionate Nurse.
Having a Natural Disposition and Motivation to Care
Learning to Apply Compassion Through Personal and Professional Experience

This section presents the study findings that focus upon the development of compassion within the role of a nurse. The two themes highlighted within this category are presented in turn and are outlined in Table Three.

3.4.1 Having a Natural Disposition and Motivation to Care

When asked about the qualities of a compassionate nurse, all participants referred to a nurse's character to some degree. Particularly when asked to imagine what they would look for if recruiting a nurse some participants spoke about looking out for a person's natural disposition.

P1: "...it would just be a judge of personality, so somebody's natural disposition." [197-198]

P10: "I want to see [...] their character, because if they've got a good strong character, whatever you want from them, they're going to know. They don't have to be ever so clever. If it's something natural to the human body, they'll find it. I think so anyway." [301-304]

Participants one and ten seemed to suggest there is a certain type of personality or character type that is particularly suited for the nursing profession. So much so that participant ten placed the internal character of the nurse in higher regard than their

intelligence. This emphasis suggests the importance of a nurse whose natural disposition is suitable for the job. Participant ten also described a natural ability to care for a patient due to this type of “character”. The sense that a person’s suitability for nursing comes from within is echoed by participant six.

P6: *“We have - how will I say that - it's already within you. This is already within you, but this is now like a global [...] expression or notification to others that this is what actually we do.”* [233-235]

Participant six stated that explaining compassionate nursing care to people who are not in the profession is akin to expressing what is already inside a nurse. Participant ten built on this further when she described the need for compassion to be innate.

P10: *“I think that feeling has got to be innate in you, [...] it should be there.”* [397-398]

P3: *“So at the end of the day you are who you are as a nurse. [...] it could be the darkest of circumstances but they [nurses] would still bring a smile to your face.”* [335-338]

The participants appeared to be describing the necessity for nurses to have, on a fundamental level, a natural inbuilt desire to care due to their characterological traits. Participant three described it as though being a compassionate nurse is interchangeable with one’s identity, indicating that it is a preexisting stable construct. She went on to suggest that this identity is experienced as a calling, which is inseparable from compassion whilst participant four indicated that it is not limited to patients.

P3: *"For you to be a nurse, there has to be a calling in you and that calling has to come with compassion. It [...] is not something you force and it is not something you can pretend."* [85-87]

P4: *"Caring and understanding, well not just the patient. Compassion can also mean it can be with anyone."* [392-393]

Due to the sense that nurses are naturally compassionate through their character some participants indicated that the motivations to be a nurse should be mostly about wanting to care. Ideas about nurses being motivated by other factors were expressed by some with scepticism, in relation to such a nurse's suitability or capacity for compassion. Participant one for example stated that she would not want to hear nurses talking purely about career based motivations in a job interview.

P1: *"I think in an interview you could ask something like what's the reasons that they applied for the job or applied for nursing and you'd want to hear maybe if any words like compassion or caring or anything like that came into it or is it all just career-based etcetera."* [194-197]

P5: *"It's hard to get nurses these days [...] because there's not really any incentives to keep us here. [...] You're doing it because it's your - it's almost for the love of it."* [449-452]

P3: *"It's about who you are, it's about what you really want. Is it something you really wanted to do or are you just doing it because it's where you'll get a job and that's it? So that makes a big, big difference."* [346-348]

Participant three described a person's identity as a nurse and the impact of wanting to be a nurse versus wanting a career. This idea parallels participant two's description of her experience of giving compassionate care, not because she saw it as part of her role, but it was important to her that her patient liked her which in turn affected how she felt.

P2: *"It's not just because it's my job or it's part of my role, it's because I like - it's essential for me to know the person that I'm taking care of, not just because it's important for the medical records or this or that but if I know that that patient likes me, it makes the difference to my day."* [94-97]

Participant twelve echoed this sense of the underlying motivation and intention of a nurse when she said that she would be "picking a nice heart" suggesting a valuing of the kind disposition of a nurse.

P12: *"Whereas if you're picking a well-trained nurse, you're picking a nice heart, I would say. It's more like that."* [392-393]

Participant five described her own experience and expectation that others become nurses because they care for people, suggesting a genuine feeling of care and compassion towards patients, which is part of her basic human instinct.

P5: *"...I like to think most people get into nursing because they want to care for people and things like that. I mean a lot of people do get into work for that reason so you feel like you can fall back on that always as well because that's your basic human instinct."* [137-142]

The sense of having genuine care for individual patients is explored further in Section 3.5.1.

3.4.2 Learning to Apply Compassion Through Personal and Professional Experience

All nurse participants identified ways that their personal or professional experience had influenced the way they cared for patients. Participant five described how showing compassion becomes second nature once one has learnt to carry out clinical tasks effectively. She suggested that once one learns what to do practically with a patient one is able to incorporate compassion into their physical care.

P5: “Once you’ve done your practical things it sort of becomes second nature and in actual fact you can probably make more room for compassion and all those other things when you know what you’re doing practically. You can draw up medication and get things done quickly and put up drips while you’re talking to a patient and giving them that time.” [123-129]

Some patient participants also made links between the experience of the nurse and their ability to give compassionate care effectively. In the following extract participant ten described how experienced nurses were able to perceive what she wanted and highlighted the difficulty trainee nurses face at the start of her training to learn how to care in this way.

P10: “They would know from me. [...] The right and the wrong way. I think if they were experienced. Trainees don’t. It must be a hard job to learn but I think when they’re more experienced it’s second nature.” [347-349]

Participant eleven also referenced indirectly the notion that a nurse's experience has a bearing on their ability to care compassionately. She described how she noticed the young age of two nurses whose care she was critical of.

P11: *"Well one thing I would notice was age. Now whether that should come into it or not I don't know. But they were younger than the night staff, for instance, or appeared to be younger."* [109-111]

Participant four spoke about her experience of struggling with compassion when she was newly qualified, confirming participants ten's supposition about the difficulty of learning how to care compassionately as a trainee. She went on to describe how there was a process of growing through experience.

P4: *"I did struggle quite a little bit on that compassion part of it [...] understanding how to apply it, [...] it can get all muddled up. You don't know what - what do I say? How do I approach that person? So, I would read more or maybe research more on compassion as you're doing now, so I know how to approach it and how do I apply the compassion. Like I said, from the beginning it was a different thing and from the time of being newly qualified, I have grown. You've engaged yourself in so many cases. It really makes you - it grows you a lot."* [425-434]

She also seemed to indicate that the feeling of compassion and the application of it are two distinct processes with the latter developing over time. Participant ten emphasised the idea of the differentiation between the feeling and application of compassion by suggesting that a nurse must learn to move compassion from a felt sense into application within the patient care.

P10: *"The feeling is when you do feel compassion for somebody, but if you've got the character and the learning ability, you move it up here to your head and try to work up for that person. While you're dealing with that person, show them a little tenderness, a bit of caring."* [316-319]

All nurse participants shared the concept of developing skills and growing through experience. Participant one spoke about how her experience of being a patient taught her a great deal about a patient's perspective of care and it appears to have deepened her empathy towards her patients in that she is better able to understand their emotional experiences.

P1: *"I think you never really completely understand what patients are going through until you've been a patient yourself. It's a different experience. You're unwell, you're vulnerable, things feel completely out of your control."* [113-116]

Participant three described the effects of personal experience on the way she cares. She also seemed to draw on her own experiences to deepen her understanding and the empathy she feels towards the patient, which in turn increases her compassion.

P3: *"...a lot of issues nurses are looking after is what we've actually been through ourselves at one point or another, [...] So their [the nurses] parents are elderly as well. So they are able to identify with the patient because it's almost like you're looking at your own parents with the same kind of mentality, so to speak. So you tend to be more compassionate because you understand what it is to have someone who is elderly and maybe on their own and that kind of thing. It rings a bell with what you yourself have got going on in your life."* [36-44]

Participant two described her enjoyment of the elderly patient group that she cares for and how her personal experiences contribute toward this.

P2: *"Well I grew up with my grandparents around me so I do feel like being around elderly people, it's not just because I wanted to be a nurse or anything, it's just because I like - I really like it. So for me, knowing them, it's just from my personal experience."* [92-94]

Some participants drew a distinction between what skills they felt could be learnt and what had to be authentic. For example, participant two spoke about communication in relation to compassion in care stating that it needs to come from within the person.

P2: *"Communication especially because skills, you can learn them. [...] Communication is really difficult to learn. It has to be authentic. It has to come from you. So communication is the first - it's definitely the priority."* [298-301]

Participant two's extract introduces the concept of authenticity in nursing care highlighting its importance as a priority for nurses. Cross-comparing this data with data from other interviews, led to this early memo in Box Two.

Memo 12/3/15 – Perceiving Genuine Compassion

"you can tell, you can look at and you can tell that the nurse is compassionate." [P3 135-136] *"It has to be authentic. It has to come from you."* [P2 300-301]
P2 and P3 seem to be talking about something within a nurse and indicate that you can pick up on whether or not a nurse is compassionate through observation or ones your experience of them.

Reflection: What it is people perceive when they can "tell" if someone is compassionate?

Question: How important is the perceived authenticity or genuineness of the compassionate care for patients?

Box 2. One of the memos that helped form the development of the sub category ‘Genuinely and Authentically Caring’.

Subsequent analysis indicated that all twelve participants referenced the idea of authenticity, either directly or indirectly, as an important factor within compassionate care. I go on to explore this category in the next section.

3.5 What is the Nature of Compassion? Genuinely Caring for a Patient as an Individual

Table 5. Sub-categories of ‘Genuinely Caring for a Patient as an Individual’.

Genuinely Caring for a Patient as an Individual
Genuinely and Authentically Caring
Humanising and Viewing Patients as Individuals
Understanding the Relational Connection with Patients

This section presents study findings that focus upon emergent themes that related to the need for nurses to engage in care genuinely in order for it to be compassionate. The three themes highlighted within this category are presented in turn and are outlined in Table Four.

3.5.1 Genuinely and Authentically Caring

In addition to ideas represented in section 3.4.1 regarding the need to have a general “natural disposition” towards care, participants also described the necessity for nurses to have a perceivable, genuine care for each of their patients. This concept of nurses genuinely caring about their patients was represented in all twelve participant narratives.

When asked to describe the attributes of a nurse who had been memorably compassionate participant seven responded with an assertion about the nurse’s genuine interest in him.

P7: “She was genuinely interested in me as a patient. She was very caring and a few of them were like that.” [48-49]

Participant seven appeared to instantly associate genuineness with compassion and this response seemed to indicate its importance to him and its role in his perception of the nurse in question as having compassion. Participant three also highlighted the way that she helped patient to know that she cared about them.

P3: “It makes them realise that you actually care. You care because you are talking to them.” [260]

The emphasis placed in this statement “actually care” by participant three denotes a possible patient perception that nurses should genuinely care. In this example spending time talking to patients therefore indicates a genuine interest in them, much like the experience of participant seven. This is emphasised by participant eight when he described enjoying the “interest that they took” in him and which is reiterated by participant nine.

P8: “They care. The interest that they took in me which I did like, I was quite happy about that.” [64-65]

P9: “Well take interest in what they are doing for me. Seeing if you feel alright.” [63]

Participant four described compassion as “actually feeling” for the patient, thus engaging her emotions in the care of her patients. She also stated that compassion

is essential for giving care. Participant eight also affirmed this concept of the inseparable nature of care and compassion.

P4: *"How you deliver the care, it's all what you have, what the compassion that you're actually feeling for that person. Yeah, and the high standard of care will fall into that. So, you must have the compassion to give the care."*
[198-201]

P8: *"That I could say it's like one heart, you know. The caring you get from these people and the compassion they give to you, they go together. You couldn't separate them."* [220-222]

In the extract below participant ten described the "real feeling" from a nurse which appeared to relate to nurse participant four's experience of "actually feeling". The participant also described genuine compassion as something that is perceivable in a number of ways, such as through their body language.

P10: *"I think it's something you can see in them. [...] You can see in the expression in their face, the expression in their eyes, the way they gesture, whatever. I think there is always something in that whole person. [...] the way they turn to somebody when they open a door, things like that. [...] mount up and it's in the feeling from them, the real feeling from them."* [307-312]

Many participants referenced a similar experience of being able to tell whether someone is genuine or not and describe how this is evident to them. For participant seven this was through his perception of what they were saying and for participant eight it was through his perception that they "miss" him when they leave.

P7: *"It doesn't matter what people say, it's what you read that they're saying."*
[273-274]

P8: *"The way they say bye to you, you can tell they're going away for a few hours and they're going to miss you. You get that to and from them. You can tell."* [234-236]

In contrast to the findings above participant five suggested that it is possible for a nurse to "act" compassionately without feeling it. In this extract she described the difficulties she encounters showing compassion when she is unhappy at work.

P5: *"...if you're unhappy and you're stressed, I think it's more the stress and things like that, it's very difficult to shed all that and step outside your own issues to provide that for other people. You can act it to a certain extent. You do, you do sometimes you don't feel like smiling and being nice and doing all that but you do do it. But they're the times that you won't really remember." [252-258]*

It is unclear from the participant's account whether or not her patients are able to perceive when she is acting versus "actually" caring about them. However, irrespective of whether the compassionate care perceived by patients is genuinely felt by the nurse the positive effect it had on their experience was evident in the findings from many participants.

P10: *"I said, yes, you're smiling and how are you, I said you made me feel better. Yes, and he said then, well I'll never forget - it's good to see you looking so well. Really nice doc-cy."* [160-163]

Participant ten recalled an experience of care that she will “never forget” because the doctor said that it was “good” to see her looking well which indicated to her he was genuinely pleased to see her recovering. In this extract she referred to him as “doc-cy” which denotes a familiarity, or a connection with him, as one might have as a pet name within a family or close friendship. The link between compassion and the relational nature of care is discussed in more detail in section 3.5.3.

Finally, participant three emphasised her genuine care for patients in this extract when she corrected my reflection in the interview “they feel like they matter.” She stated, “they matter”. In her interactions with the patient described below she reveals how she relates to the patient as a person helping them to realise that she “actually” cares about them. In so doing she appears to be humanising them because “they are not just a statistic”.

P3: *“You are taking your time to know more about them. [...] I've got a lady who always asks me, how is that footballer of yours? Every morning she always asks me. I say, he was very naughty, he didn't do his homework yesterday and we'll have a big laugh about it. [...] It just makes them feel they are not just a statistic. They're not just there. They matter.”*

Researcher: *“They feel like they matter.”*

P3: *“They matter.” [260-269]*

The subcategory that addresses the idea of humanising patients is explored further in the next section.

3.5.2 Humanising and Viewing Patients as Individuals

The majority of participants discussed ideas relating to viewing patients as an individual. The sub-theme label uses the word ‘humanising’ due to an assertion

made by participant seven that when he was treated without compassion he felt “dehumanised” and “like a number”.

P7: *“Very much like a number I suppose, like an object where they had to treat you in various procedures. It dehumanised you.” [440-441]*

P7: *“Well they would just see me as somebody else on the conveyer belt. I don't think it would help them either. It can't be good for them. It must be much better for them when they can interact with the patient.” [444-446]*

Participant seven built on this further when he described the experience of dehumanisation as being “somebody else on a conveyor belt”. He described the imagined negative impact of seeing patients in this way both for patients and nurses. Participant four articulated a similar idea likening it to being “items in a factory” which gives the impression of being a commodity, a part of production line, where the patients and nurses are objectified in terms of function rather than viewed as individual human beings.

P1: *“It's like this isn't just an item in a factory, these are people. Nurses are people, patients are people. You can't just see them as numbers. You can't quantify it like that because we're humans. We have a lot of emotions, consciousness, a lot of things going on, sick humans, very vulnerable.” [326-329]*

Like participant seven, participant one warned against seeing patients as “numbers” and instead emphasised the vulnerability of patients. In this section of the interview she wanted managers to remember that nurses and patients are people who have feelings. The need to acknowledge the personhood of patients is paralleled by

participant three when she described an uncompassionate nurse as one who gives care that is “ticking boxes”.

P3: *“If she walks in and finds that there is no interaction with the patients, people just ignore - basically just ticking the boxes, coming in, giving medication, doing what you need to do and going home, to me there is no compassion in that. There is no compassion in that at all. Anybody can do that.” [80-83]*

P11: *“Thoughtfulness - the thoughtfulness provided for the patient as well. Not just medical care. Giving a bit more to making the patient feel an individual. Maybe that's the best way of describing it. Rather than one of a ward.” [363-367]*

Participant eleven also stressed the need for thoughtfulness in order to help patients feel like an individual, rather than one of many. This extract implies that what defines nursing with compassion, as opposed nursing that “anybody can do”, is in the care that goes beyond basic medical tasks.

Participant three compared compassionate nursing and standard nursing using an analogy of private care. In this extract she illustrated the need to go beyond medical care so that a patient feels like they matter.

P3: *“It's almost like being treated privately. [...] You can't complain but do they really know you as a person, are you just a statistic to them? So you can get a high standard of care but as a statistic, yes. I will look after you really well, I'll give you your medications on time, I will never be late with your medications. If there are any changes, I will let the doctor know on time. If*

there is any operation, I will take you in on time. Then we'll send you home."

[316-321]

Overall, findings showed that most participants placed a strong emphasis on the idea of seeing patients as "people" and not "just patients".

P1: *"So I try to always think about how it would be for me and I also try to incorporate that everybody processes things differently and everybody deals with things differently. There's no right or wrong way to any of this. So I always try to think holistically about the person. So they're not obviously just a disease or a treatment, they're a whole person."* [10-14]

P4: *"Are you taking into consideration that they actually are people? They're not just patients; they're somebody. That is somebody."* [186-187]

P5: *"Ask people nicely, don't just order people around, they're not your cattle to order this way and that. Communication is a really big key."* [362-363]

P6: *"As a person. Treat them as a person and not just as a patient or a sick patient, but something else; more than that. Even if they are unwell or they are not unwell, you still treat them the way you want them to be treated."*
[306-308]

P7: *"Well the compassionate side is relating to the patient, letting them know that they see you as a person not as simply a patient."* [358-359]

Despite the need to genuinely care for patients and see them as individuals, findings indicated this did not necessarily equate to a high standard of care. In order to be

effective nurses need to meet appropriate nursing competencies and apply the compassion they feel to be suitable to each patient in order to be effective. This is exemplified in the extracts below from participant four.

P4: *“If I say politeness, care, competency as well, because that would be one of them. Because if you're not competent it means you're not going to be able to look after patients. You won't be able to pick up on patients' requirements, or needs shall I say. So, you need to have that competency. The skills that come within the job as well.”* [158-165]

P4: *“Some, they might have the compassion. The compassion is there, they care, but how they apply that care, it really does matter a lot. Yeah, it really does matter a lot. Because I could care about you, but then how I come to you as a caring person, that will have an impact.”* [400-404]

Ideas relating to how compassion is applied in care as highlighted by the extract above are addressed in section 3.6.

3.5.3 Understanding the Relational Connection with Patients

Almost all participants described the relational nature of care to varying degrees. For participants four and five the relational connection with patients was characterised as becoming a friend for patients.

P4: *“The relationship, you become more that it's not nurse and a patient anymore; [...] It becomes more like a friend. So, that really does help a lot.”*
[240-242]

P5: *"Just being that friend to that patient - because they were long term patients."* [48-49]

Participants one and six outlined trust as the benefit of a relational connection with patients.

P1: *"Can you see some kind of connection between the people, between the patient and the nurse because you want to see that there's some kind of trust there."* [245-246]

P6: *"So yes, compassion is actually a very important thing, because that's the first thing where you can gain your rapport and the trust in you."* [70-71]

Participant two described her experience that building relationship helps give elderly patients a sense of belonging.

P2: *"Rather than just saying hello, say hello [patient name], how are you? Call them by their name. That makes the difference so they feel that they belong. They've got this kind of feeling, I belong here. [...] There's no - what's the point of living if I'm not doing anything now. My children have been raised, they're grown up, they've got their own lives and I'm here doing nothing. So they just feel the - they've lost their sense of belonging."* [63-68]

The sense of belonging described seemed pertinent in the context of the lack of identity elderly patients may feel due to the absence of a sense of connection with their family. Nursing was likened to having familial qualities by a number of participants.

Participant eight described being treated by nurses as though he were a member of their family. This reminded him of care he received from his family and he contemplated the significance of this in relation to this care being given by a stranger.

P8: *"It means taking great care. Taking great care. It's when you really start in a view to look after somebody. I was treated as though I was theirs. Very good treatment."* [160-161]

P8: *"Well in some cases it makes you think, because this now is a stranger. This is a stranger who is distributing this same thing to you that you had from your family. It takes you back; it takes you all the way back."* [184-186]

When describing her experience of compassionate care participant one also associated the care she received as having a familial quality to it when she described her nurse as having a motherly energy. For participant twelve this was showing compassion how a mother might to a child, including using kind words.

P1: *"She had almost a motherly kind of energy but I've always remembered that moment."* [120-121]

P12: *"You can use some kind words to them. There's no harm in using a word like dear or something like that, so it makes them feel at home. Every time a child is hurt, the first thing the mother does is to be compassionate. That's what is making the child get that confidence and recover from whatever illness or whatever pain he has got. I mean, it's the same thing for grown-up people as well."* [375-380]

The notion of the familial nature of care also extended to dealing with boundaries or ruptures in relationships. In this extract participant six described being badly treated by patients and how she deals with them like she would if she were relating to a family member.

P6: *"Sometimes, silence is actually a good response, because if you just keep silent, that means that you don't throw back bad things to that patient, even if they treat you badly. So, [...] it's like when you, your sister or your family have an argument and you keep quiet. That makes one understand that it's enough."* [87-91]

Findings indicated that the extent to which a nurse created a close relationship with a patient, in terms of how he or she feels about them, also needed to have boundaries. Participant two spoke about the sadness she feels when a patient dies due to her genuine care but also described the necessity for this response to be kept at an appropriate level.

P2: *"It's really difficult because if you are taking care of a patient for two months, three months, it's almost impossible not feeling really connected to them. Sometimes the family as well, it's not just the patient but the family. [...] I think we can separate things. The family does understand that but sometimes it just - you just can't. If you want to cry, why not? A patient just passed away in your hands, why not cry? You are allowed to, but it has to be something in the moment and not three, four or five months thinking about the same patient."* [125-133]

Participant ten addressed her own need for boundaries with nurses when she talks about not wanting them to be "over-coddly" with her. In addition she stated that she

did not think of them as “anything but nurses”. This suggests that the relational connection with patients needs to be tailored to the preferences of each patient as outlined in section 3.6.2.

P10: “Well in a way. I mean, I don't want them being too over-coddly with me but I don't think these nurses would have been. I really don't. I really don't. At no time would I have thought of them as anything but nurses.” [230-232]

This statement indicates the need for nurses to be careful in how they apply compassion. The next section of the results will explore the concept of how nurses apply compassion in care in more detail by attempting to answer the question ‘what does compassion in care look like?’

3.6 What Does Compassionate Care Look Like? Applying Compassion in Care.

Table 6. Sub-categories of ‘Applying Compassion in Care’.

Applying Compassion in Care
Treating Patients with Dignity
Personalising and Tailoring Care
Providing Information and Explanations Carefully
Providing Emotional Care and Comfort
Caring Attentively
Going the Extra Mile

This section presents study findings that focus upon how nurses apply compassion in nursing care. The six key themes highlighted within this category are presented in turn and are outlined in Table Five.

3.6.1 Treating Patients with Dignity

Findings indicated that as a part of the process of humanising patients and respecting their individuality there was an essential need to protect their dignity and

privacy. Participant eleven described her experience of being temporarily incontinent and the impression her nurses made through their care.

P11: *"Other than when I was incontinent and they had to keep changing the beds without any [laughs] - looking as though, oh not again. That stands out as being - because it's an unpleasant job to do, but they just got on with it, made me comfortable. I expect I was quite impressed with that really, that stood out, yeah."* [206-210]

Participant eleven referenced this experience a few times during the interview indicating that it represented a significant experience for her. Her description signifies the nurses' repeatedly responsive care, carried out without negative judgment, helped to normalise her situation. Although she did not mention the concept of shame directly it is possible that the nurses' care helped to prevent or take away feelings of shame or embarrassment at a time of vulnerability.

Participant eight referenced feelings of embarrassment in his description of care directly. He indicated that nurses acted to normalise his experience when he would unintentionally expose his body during his sleep.

P8: *"...when strangers see me it was kind of embarrassing for me at first. They put my mind at ease about that. They did put my mind at ease because I was there half the time, I fell asleep, I remove my garments and I would wake up when they're trying to tidy me up, trying to fix it for me. Thank you very much and they said things like, that's what we're here for. It was good; it was very good. Very appreciative of that."* [87-93]

The nurses seemed to reduce his embarrassment “it was kind of embarrassing for me at first” by protecting his physical and emotional dignity. This appears to have happened in two ways, firstly, by covering him up when he exposed himself and secondly by telling him “that’s what we’re here for”, denoting a non-judgemental stance which put him “at ease”.

Many nurse participants also highlighted their perception of the link between compassion, dignity and privacy. Here participant three described assisting a patient with their personal hygiene. She used the word “invaded” which connotes the negative emotionally invasive experience of a patient if a nurse does not protect their privacy.

P3: “Even just assisting them with their personal hygiene. You're talking to them with dignity. Talking to a patient with dignity. Keeping their privacy. Making sure that their privacy is not invaded and is protected all time. It's little things but it means a whole lot to patients.” [68-71]

When asked to describe an example of a nurse providing care that was not compassionate, participant five recalled observing a health care assistant (HCA) bed bath a patient.

P5: “He was completely naked, not even covered with a towel like in sections or anything. The poor man ended up in this massive puddle on the bed. The water would have been freezing. He couldn't communicate either. He had a stroke I think so he couldn't communicate. You could tell he was starting to get cold and I sort of walked in. [...] I think I just mopped up all this water with these towels and just covered him up. I was like the poor man. Imagine being exposed like that and just dumped in lukewarm water all over him, that sort of

thing. So it is hard, it is really hard as somebody comes and takes over from you that you - or you take over from a nurse and you're like what happened that shift? Patients are not happy. I'm not saying that they weren't stressed out or they weren't doing their job. I'm sure they were doing their job but obviously something was missing." [295-313]

In this extract the participant seemed to suggest that what was missing was compassion and as such the HCA was doing her job but without regard for the physical sensations and emotional feelings of the patient.

Participant four built on the concept of respecting the dignity of patients by taking into account the patients preferences and indicated the need for care to be tailored to the individual.

P4: "If a patient says I don't really want to eat [...] now, I'm going to eat later and you come and say it's lunchtime, you have to eat now [...] you're taking away their dignity. You're not understanding. Maybe that's how they do it at home. [...] Some people have preferences. So, yeah, in that way, I say not taking people's feelings into consideration." [140-147]

3.6.2 Personalising and Tailoring Care

Ten out of twelve participants referenced the idea of nurses personalising their care to tailor to each individual's needs. Participant one highlighted an understanding of the individual differences between people's perception of their illness, their experience of it and the way they cope.

P1: "...so trying not to make judgments about people; understanding that we all deal with things differently; understanding that people's perception of pain

and what they're going through it's different for every single person. We have to remember this. Just because one patient deals with it in one way and another patient deals with it in a completely different way, it doesn't mean that either way is right or wrong. It's their disease, their pain, their problem. We're all different." [143-149]

Participant five also acknowledged the individual differences of patients but added the need to think creatively in order to show patients compassion in a way that they would like.

P5: "...you can't have good nursing care without compassion, you can't, because at the end of the day patients will walk away in one piece but they're not going to have felt like they've had good care, even if they're had no hiccups or anything like that. It's very individual because every patient needs something different and it's the attention to detail. Well not attention to detail but thinking outside the square sometimes. You can't just treat every single person as the same. Something that will be really compassionate towards some person somebody else might not like that. So you would have to show it in a different way." [472-481]

In response to the differing needs, perceptions and preferences of individuals many participants gave examples of how they tailor their care accordingly. Participant two described making a note of patient preferences in order to adapt to the individual and give personalised care.

P2: "If that patient likes music and you know they like music, why not? If he likes jelly, why not bring him jelly rather than ice cream? [...] if he doesn't like

water, why not choose other things rather than just keep on pushing water if they don't like to drink water. Just personalise it for you care.” [78-82]

P2: “...if you record at that time that patient normally likes to - at that particular time they like to - or maybe some of them, they don't like to be woken up to go to the toilet but you know them so you just don't do it to that particular patient. So you adapt to the patient that you are taking care of.” [73-76]

Participant ten explained that nurses cared for her in a way that she enjoyed because it fitted with her preferences. She seemed to express a dislike of people feeling sorry for her or being treated in a way that made her feel weak.

P10: “They treated me like me. I never felt specially treated or delicately or anything like that. I never - I felt like me. When you're weak and a bit sick and everything, you don't want to be made - going, I can't stand anymore and [points fingers at head and makes explosion noise]”. [207-210]

Participant seven described his desire to be communicated and empathised with despite being critically ill in intensive care. His extract indicated the importance of not making assumptions about the needs of patients in relation to their medical presentation.

P7: “...when I was in intensive care to say there was nothing wrong with me is a fairytale because I wouldn't have been there, but [...] I wasn't on goodness knows what equipment. So I was quite able to speak to people. So there was no reason not to be able to relate to me. But I think in intensive care it's terribly important for all nursing that nurses understand the value of empathising.” [149-155]

Participant eleven described a similar disparity between her desire to be known by the nurses caring for her and the reality of the care she was given. She described her satisfaction with the medical care that she received but this did not appear to negate her desire for a nurse to understand her individual needs beyond this.

P11: *"It's not the medicals. I couldn't fault that. That was all done. But it's knowing people. I mean I was there for, what; possibly four days [...] So I wasn't just in and out. They see you, don't they? Your own personality comes through a little bit. I think it's being able to read maybe a person and understanding, maybe. It's understanding of what they need as well." [347-352]*

A patient's experience and satisfaction with care therefore, seems dependent on a nurse's ability to perceive the needs and preferences of individual patients and tailor the care accordingly. The necessity of an ability to "read" a person in order to have an "understanding of what they need" is a premise referenced or represented in the narratives of almost all the participants.

Participant one also described the ability of "being able to read people" as being integral to being a good nurse so that a nurse can tailor the care that it given.

P1: *"I would say that would be another important factor on being a good nurse is being able to read people; read the situation; read what you think they can understand and making sure that you tailor your approach to suit each person." [229-231]*

Participant four described an example of a negative outcome of the expression of compassion if it is not tailored to a patient's preference.

P4: *"We have had quite a few cases where patients complained so-and-so touched me, so-and-so did this and that. Not in an uncaring way. They probably did it because they know that they're nurses and they show that they care and they're just being very affectionate. Some people might not see it as like that." [367-372]*

She appears to differentiate between the compassionate intention of a nurse and compassionate action, which needs to take into account the feelings of the patient "some people might not see it as like that". In order to do this participant eleven suggested paying attention to feedback from patients and reiterates the idea that nurses "read a person's feelings" which denotes an emotional intelligence on behalf of the nurse.

P11: *"It depends what feedback you get from the patient really. You might get the feeling from a patient, well they want to be left alone. It's being able to read a person's feelings really. I don't know how you do that other than through experience and your own personality as well." [393-397]*

Participant eleven highlighted the differing needs of patients and varying care according to feedback. Findings showed that the same ability to assess a patient's needs and reactions was required when providing patients with information related to their care. This is discussed in more detail in the following section.

3.6.3 Providing Information and Explanations Carefully

Approximately two thirds of the participants spoke about the importance of a nurse's approach in relation to providing information and explanations to patients carefully. Participant four stated the need to be "careful" in trying to find the right "balance" with how much detail you give to patients.

P4: "So, when I say be careful, it's more of your approach, how you speak to them and what you're telling them as well. That has to be taken into account. You don't want to go into too much detail of what's going on. You have to balance." [251-254]

Participant one highlighted the need to assess each situation so that nurses tailor their explanation to each individual patient compatible with his or her needs.

P1: "So judging the situation; judging what the patient might understand or not understand; and tailoring the way you are with the patient and/or their family to a level of their understanding, rather than speaking a whole lot of medical jargon that they don't understand; being able to judge a situation and I think tailoring how you are so that you are on a reasonably compatible level with them." [217-221]

Participant seven evidenced the importance of finding the right balance and tailoring information to individual patients when he described his experience of receiving a medical prognosis.

P7: "Then when she did come to see me there was no empathy whatsoever and then said things to me that were really bloody distressing actually."
Researcher: "In terms of your condition?"

P7: "Yeah, so unnecessary. They said I had to go home with a - might have to go with a catheter and God knows what, it just completely freaked me out. The point is I didn't - luckily everything was alright but don't say that sort of thing."

Researcher: "I mean how could they have communicated that to you if ...?"

P7: "Well they shouldn't have said it".

Researcher: "Shouldn't have said it, no."

P7: "They should have just been more caring and taken it on a day-by-day basis." [198-208]

The distress participant seven felt when he was given what he considered to be "unnecessary" information seemed to be heightened by the lack of empathy shown towards him at the time.

Findings also indicated that tailoring the explanation given to patients might involve giving them more rather than less information according to their preferences. Participant eleven for example spoke about her desire for more detailed information when she was waiting to be transferred to another ward.

P11: "Giving you sufficient information I think. Because I felt quite frustrated that I was still there." [529-530]

The concept of being thoughtful and "more caring" about the patient's feelings is emphasised by nurse participant three when she explained a recent encounter with an elderly patient suffering with memory loss. She described withholding unnecessary information from him to avoid upsetting him whilst he was dying.

P3: *"I've just been to him and he was asking me for his keys. [...] I said, where you live, that gentleman who looks after you has got your keys so your flat is safe, [...] you've got nothing to worry about. It's just [...] you don't want to tell him; you're from a nursing home. [...] because what he's remembering is how he used to live in his flat. It's just, why do you want to spoil it for him at the last stage?" [281-286]*

The nurse appears to be mindful of the emotional experience of the patient and wants to avoid causing him distress. The premise of providing emotional care and comfort was a prominent research finding and is outlined in the next section.

3.6.4 Providing Emotional Care and Comfort

Findings indicated that giving emotional care and comfort was an essential part of compassionate care and was cited by almost all participants.

The majority of participants used the word 'empathy' in relation to compassion. For participants one and three, empathy seemed to be a way for them to gain an understanding of the emotional experience of the patient.

P1: *"I try to be quite empathetic in my approach. So obviously putting yourself in someone else's position; how you might feel if this was going on for you. So you've been newly-diagnosed with the disease; you're now being spoken to about going on long term treatment. A lot of this is quite scary for people. So we see quite a range of emotion in the clinic. Some patients can be very angry, very emotional, sad, a lot of questions, scared." [4-9]*

P3: *"So as we got chatting, you feel very, very - it touches you and you almost put yourself in that situation, so to speak. I don't know how I can put it.*

[...] I feel like I'm able to empathise and show her compassion whereas probably before I would just look at her like any other patient who has got MS. When you know the patient, you sort of delve deeper, so to speak. A little bit just beneath the skin." [15-21]

The understanding that is fostered in participant three's account increases the compassion she is able to give the patient due to an improved ability to see the patient as an individual. This reflects findings indicated in section 3.5.2 in which participants described the need for humanising and viewing patients as individuals. The necessity to gain an understanding of a patient's emotional experience was also described by patients and nurses.

P4: "Compassion is caring. Caring and understanding, well not just the patient. Compassion can also mean it can be with anyone." [392-393]

P6: "So, everyone seems to be more compassionate and be kind to them, because you have to understand how they feel." [172-173]

P7: "There was one particular nurse who was exceptionally charming actually because I think she understood." [370-327]

For many participants providing the emotional care encompassed in compassion involved enquiring about a patient's wellbeing and spending time listening to them. Participant eleven described her desire for interaction with nurses that went beyond medical care.

P11: "I need some interaction, and especially if you're feeling quite well, as I was. Just someone to say to you, oh how are you feeling today, [patients

name]? Or, you look well, or whatever. Just a little bit more than the medical care." [40-44]

This corresponds with explanations given by participant five that described being "an ear" for patients and participant one who described the need to let patients speak and hear how they feel.

P5: "A lot of patients here sometimes just need an ear as well. [...] It won't necessarily be about their condition necessarily, it could be something else. I find when you have the long-term patients that you're very fond of and you're used to and you know about their lives and things, you get that continuity. They do rely on you for that extra bit of care." [68-73]

P1: "I think a lot of patients don't feel very listened to. You have to let the patient speak; you have to hear what they're feeling." [162-163]

Participant twelve formulated the role of a nurse as being one that gives patients an opportunity to talk about the struggles they are experiencing in order to help to enhance the healing process.

P12: "That means patients have an opportunity to tell about their struggle to somebody else. I mean, you can understand in developed countries, we don't live in a large family. People are more individualistic people." [203-206]

P12: "I mean, nurses or something can give you a psychological care which sometimes doctors can't give because they are too busy." [165-167]

The supposition that compassionate nurses provide both medical and emotional care is supported by a number of participants, for example participant eleven.

P11: *"...good care is not just about the medical side. It's got to include the care, the mental care, if you like, psychological care as well."* [50-52]

Participant one described providing a safe place for patients to be able to express their emotions and nurse participant three described how she cares psychologically for a patient who is confused and in distress.

P1: *"So I think at least they know it's a safe place here, you're not going to be judged. They can, if they want to be upset, they can be upset and we'll still be here for them."* [107-108]

P3: *"Maybe a patient is shouting, is a little bit delirious, confused. Taking time to talk to that patient. Trying to look for ways to calm them down, sitting with them until they actually calm down without thinking, oh I've got to do my notes, I can't spare another 10 minutes or so."* [130-134]

In both accounts participants make it clear they prioritise being available to patients in this way. Participant seven described the effect of having a nurse who could help reduce his emotional distress.

P7: *"It's the nurses that had a very special ability to relate to patients that made you feel much better. I think that was the thing that shone out, the nurses that related to you as a person, could talk the trauma away."* [8-11]

P7: *"I was going through a couple of procedures that weren't very pleasant and I think the nurse was exceptional and was able to remove fear from me, whereas of course others didn't have that touch, that wasn't too good."* [42-44]

More findings relating to the beneficial outcomes of compassionate care are outlined in section 3.8.

Findings also showed that compassion was expressed through physical touch in order to comfort patients in half of the participant accounts.

P1: *"So she had a really kind persona. She was quite softly spoken, very gentle, but her touch was really, really gentle as well. I remember that because I had blood on me and that and she had to clean me. She was just really so gentle and kind, both in her manner and physically the way she touched me."* [127- 130]

P3: *"...when they are feeling a little bit down, sit down, just hold their hand, talk to them, tell them it's going to be okay, I'm here if you want to have a chat."* [201-203]

P5: *"You know asking questions, eye contact, sometimes just a comforting hand or sometimes, if somebody's really upset, a hug, just that sort of thing."* [79-81]

Participants also referenced indirect ways that nurses helped patients to feel more comfortable such as using humour to help to support patients' emotional wellbeing. Participant seven described humour as what helped to carry him through his

recovery in hospital and patient participant ten described it as “vital” suggesting that it was also a vital part of her experience with nurses.

P7: *“I think humour carried me through hospital because I think I am generally very jovial and I would do that every day. I think that was very important for me.”* [60-62]

P10: *“...it gave me something to laugh about. At some point - somewhere along the line I'd make them laugh [...] that sort of thing, but just relax and - no, laughing I think is vital. Really vital in life.”* [116-118]

Whether emotional care and comfort is delivered through touch, listening, humour or psychological care participants outlined the necessity for it to be carried out within appropriate boundaries. For participant four this included an awareness of not overstepping a patients boundaries and ensuring that patients do not overstep a nurses boundaries. Participant ten also referred to boundaries that are needed in relation to emotional care by warning that a patient should not feel imposed upon by a nurses emotions.

P4: *“So, it's like you're opening doors in somebody's life where they don't want to know that. They don't want to know that, so you have to have that boundary.”* [291-293]

P10: *“I would never, never, never, no matter what I knew about them, I would never approach anybody full of sympathy. Never. You can be gentle and acceptable with somebody who's just lost a love of their life or anything like that, without imposing. Without even getting too close.”* [358-361]

In a similar vein participant eight described his sense that a nurses emotions, in this case “seriousness” should not be evident to the patient.

P8: *“the seriousness is there in what you do but that face you don't carry it with you all day. You cannot carry it with you all day. This is what did give people like matrons a bad name.”* [264-266]

These accounts suggest that in order for nurses to deliver compassionate care that is emotionally comforting, there is a need for nurses to boundary their own emotional experience. Participant three described her experience that patients need to associate a nurse with happiness in order to be able to open up to them.

P3: *“They can only open up if you always - they identify your face with happiness and things like that. These patients come in and they say, you've always got a smile on your face and they are able to - as any normal human being would. I mean, I wouldn't like to go somewhere where people are always miserable. You gravitate towards somebody who is much friendlier, much more talkative.”* [115-119]

Giving emotional care necessitates an attentive approach to patient care in which a nurse has an awareness of the needs of patients and acts responsively towards them. The notion of attentive care is addressed in the next section.

3.6.5 Caring Attentively

Most participants cited a preference for giving care that was attentive and responsive to the needs of the patient.

Participant eight described his appreciation for nurses who made sure that they helped him with tasks he was unable to do. He stated his experience of there being “always someone with me” to make sure that he did not fall over. This seems to indicate attentiveness from his nurses who ensured they were with him whenever he needed them.

P8: *“I wanted to go to the toilet, I couldn't manage it. I couldn't stand up, I couldn't walk. [...] So I started using the Zimmer frame and there was always someone with me to make sure I didn't fall. I did appreciate all of that I thought it was very good.”* [74-78]

To some degree it is possible that his positive experience was due to nurses being able to predict his needs which enabled them to be present for him at the right times. Participant five supports this supposition in her ability to be able to anticipate the needs of her patients.

P5: *“...she's only little, it's quite easy to help her move up the bed and then she's comfortable, she's happy, and you've anticipated without her actually having to say.”* [182-185]

P5: *“The patients that I had that couldn't speak, sometimes you would have gotten what they were going to ask - if they were writing on a board and you've already got it and they're like oh okay. You know that even if they can't smile they're quite happy.”* [331-334]

P10: *“They were very, very good. Every so often I'd be lying in bed wide-awake, [...] just lying there, oh dear I wish I could just look out the window but I wasn't well enough to get up. Suddenly this head's here beside me, are you*

alright? You can't get out of bed yet [laughs]. I was still laughing, saying I know." [47-50]

Participant ten laughed as she recalled nurses who would come to her as if they knew what she was thinking. She emphasised the impact their attentiveness had on her. Although she was not able to move and seemed to be feeling low, as implied by her comment "oh dear", the attentive nature of these nurses in anticipating her desire seems to have provided her with a positive experience.

Participant three described a compassionate nurse as someone who is checking on a patient often, and thinking about their presenting symptoms without making assumptions.

P3: *"Looking after the patient, [...] checking on the patient all the time, have they passed urine, what's going on? They haven't passed urine, you look in the charts. It's three hours, okay I'll wait for another two hours and see if they pass it. A proper nurse will always say, do you know what? I'll get the bladder scan, have a look, check that she's alright, reposition them."* [126-130]

In this extract she described reacting quickly rather than waiting to make sure that the patient is well. This idea of acting quickly was also emphasised by a number of patient participants. For example participant nine talked about the rapid response he received when he pressed his call button and the willingness of the nurses who responded.

P9: *"And they come rapidly. And they want to help you, if you to want to go to pass water and things like that. They give me a bottle and they're very willing, very nice people."* [17-19]

P12: *"You have to be passionate, compassionate and able to communicate clearly, understand, give a good listening ear to the patient and able to answer their questions if you can or consult your doctor and get back to your patient quickly." [247-250]*

Participant twelve stated the need to get back to patients "quickly" and a desire for immediate care was a theme throughout his narrative. However, the need for immediacy expressed by some patient participants seemed to be moderated if a nurse provided them with an explanation.

Participant seven recalled asking and waiting for a nurse to remove his eye patches each morning. He described the feeling of worry he would have when he was not given an explanation or a timeframe for responding to his request.

P7: *"They're seriously understaffed at times [...] but if they just said look I'm so sorry I'll be another 10 minutes that's all I needed. The fact that they couldn't do it for half an hour, that didn't worry me. What worried me is they didn't." [241-244]*

Participant two's account concurs with this idea that patients accept having to wait for care if a nurse communicates her desire to help and gives the patient a timeframe within which the requested care will take place.

P2: *"Sometimes if you explain to them, they really accept but they just want you to explain to them, well I can't do this now because I'm taking care of the patient in the next bed, but if you give me a minute, me or one of my colleagues will go and help you." [145-147]*

The ability to anticipate a patient's needs seemed to be linked to a nurses ability to think about the individual needs of a patient in order to tailor the care accordingly. Participant two described the needs of an elderly patient in comparison to a young patient.

P2: *"...especially if it's an elderly patient, of course their needs are different from a young person so we have to keep on asking them, keep being on top of their needs. Even if they don't talk, you have to be able to identify or - and act towards that [...] to keep reminding them that they have to drink. As we grow older we forget these things. So we just keep on reminding them and I think they appreciate the way you treat them because it seems like you're caring for them."*

[23-30]

Participant two described the appreciation of the patient when you anticipate and keep "on top of" their needs as it helps them to feel like a nurse cares for them. In addition to caring for a patient's physical and emotions needs participants also described compassionate nursing as giving "that bit extra" to patients. This is discussed in more detail in the following section.

3.6.6 Going the Extra Mile

Half the participants referenced the concept of compassionate nurse caring in relation to giving patients more than the basic care and in some cases going out of their way, in order to enhance the patient's experience of care. Participant three described this action as "going that extra mile" and defined it as the difference between empathy and compassion, thereby putting into action the empathy a person may feel for someone in order to help him or her. She cited an example of a patient

who has no family to visit them and how she thought about the patient's needs as a result and acted upon them.

P3: *"...compassion is where somebody is passionate about what they're doing, passionate about looking after their patients, going that extra mile, but with empathy - I do sympathise, but I need to go home now. You shut the door, you think of other things. [...] With compassion you can go and think, oh dear well I did this but did I do it right? I wonder if tomorrow maybe I can... The other day - we have a patient nobody visits. She really likes orange juice and we didn't have it. We had apple. I thought, I wonder if I get the juice, orange juice, [...] and I brought it in and she loved it. To me, that is what it's about. Just little things, just thinking about somebody rather than sympathising with them, gosh if she had had a child now, the child would have brought her this. You're empathising but you're not helping the person."*
[351-361]

Being actively compassionate in this example is therefore not just thinking about the patient and their experience but having a desire to help them. This mirrors a dictionary definition of compassion in which is it stated as "a feeling of a deep sympathy and sorrow for another who is stricken by misfortune, accompanied by a strong desire to alleviate suffering" (The Unabridged Random House Dictionary, 1987).

Acting on compassion is a concept participant five also described throughout her interview. In these examples she stated that compassion is about going out of her way to give a patient a positive experience. She described an example in which she took time and effort in the practical care she gave to a patient. She also remarked upon the time that is needed in order to be able to give patients a good experience.

P5: *"I think it is all part of the experience, that sort of thing - just going out of your way just that little bit or just giving somebody that time."* [65-67]

P5 *"TED [compression] stockings, people just leave them on because they can't be bothered taking them off and putting them back on. But to take them off [...] and really give them a good rub down and put some cream on and letting that dry off before putting TEDs back on it's lovely. Patients are like oh my gosh that just felt amazing. But it's all time isn't it as well and that's the thing."* [194-200]

Patients also described their experiences of nurses making extra effort with them and how they stood out to be the ones who had compassion. Participant seven described nurses coming to speak to him when they were off duty, which perhaps represented a care beyond the remit of their ascribed working hours.

P7: *"Yes also saying hello to me when they weren't on duty. They would pop across, just a few words. It was lovely."* [55-56]

P11: *"That's what makes a difference between a really good nurse and one that does the job but not that bit extra."* [356-367]

Participant nine described his perspective that nurses were keeping him in hospital longer than necessary as a way of demonstrating being extra careful with him. He described enjoying the attention he received.

P9: *"I saying the best of attention. [...] They keep me in here maybe a little bit over the time sometimes."* [148-150]

However, at another stage of the interview he described the nurses just doing “their duty”.

P9: “Well they just do their duty more or less. More or less they get me a bottle, get me washed in the morning and they are quite busy to be honest. They’re quite busy. They do their duties alright.” [74-76]

He attributed his nurses’ behaviour to how busy they were which echoes comments by participant five that having enough time facilitates compassion in care. This is explored in more detail in the next section.

3.7 What Helps Make Compassion Possible? Moderating Constructs.

Table 7. Sub-categories of ‘Moderating Constructs’.

Moderating Constructs
Having Time
Being within a Compassionate Organisation

This section presents study findings that focus upon emergent themes that appeared to act as moderators for a nurse’s ability or capacity to carry out effective compassionate care. The two key themes highlighted within this category are presented in turn and are outlined in Table Six.

‘Time’ and a ‘Compassionate Organisation’ are defined conceptually as moderators for the purposes of this research because they are variables that seem to indicate an influential link between a compassionate nurse and the actual or perceived outcome of compassionate care. According to the definition by Baron and Kenny (1986) a moderator is a qualitative or quantitative variable that affects the strength or the direction of relationship between the predictor and the outcome. Information

regarding how I came to this category title is outlined in the reflection note below in Box Three.

Reflexive Note: Is it a Barrier of a Moderator?

Originally this category was called “*Barriers to Compassion.*” However, when cross-comparing data within and between interviews this label did not always seem to be an accurate reflection of what participants were describing. In order to identify the most appropriate label I returned to the data with the question: “Do these factors stop nurses carrying out compassionate care?” Although participants described factors that make giving compassion harder, findings indicated compassionate care could still be present. Therefore, the word “barrier” was perfunctory, as it was an interpretative and conceptual leap away from the participant’s accounts. Instead a category label that captured how these constructs facilitate the compassionate care process seemed more appropriate. I was reminded of a statistical mediation model from a past research project and how a “moderator” influences the strength of a relationship between two variables. In this case the desire to care compassionately, and the ability or capacity to do so.

Box 3. Reflexive Note regarding the development of sub-category label ‘Moderating Constructs’.

3.7.1 Having Time

The concept of a nurse’s limited time was a subject spoken about by all twelve participants in very similar ways. For nurses this appeared to be about having enough time to be able to care compassionately in addition to tasks. Most patient participants indicated a desire for nurses to be able to make time for them beyond completing physical care tasks.

Participant one talked about the time pressure she experiences in trying to cover all perceived aspects of care within a limited timeframe.

P1: “...we are pushed for time in the clinics [...] So it can be quite difficult because not only are you needing to provide all of this emotional support but you've got the clinical side of things as well.” [38-43]

This extract also indicates the difficulty with managing the scope of compassionate care due to the demands that are placed on nurses through the duties they are required to carry out. The findings indicate that these demands mean that finding the time to incorporate compassion into the care can be a struggle despite the intentions or desire of the nurses. Participant two described the tension between what she knows she “should” do and practically what she is able to do in the time she has available.

P2: *“Sometimes you provide the care but you just don't have time to keep on filling the paperwork because they tend to be a lot. So if you've got paperwork and you've got things to do with the patients, you just tend to do everything very quickly. Really, you should have time to talk to them, the things that we were talking about earlier, but sometimes that's not possible if you are in a rush and if things have to be done. So sometimes we see a lot of things that could have been done in a different way, definitely, in terms of communication, especially.” [235-241]*

Participant three described her perception that nurses should be “making extra effort” but did not agree with participant two’s sentiment that a sense of time pressure should get in the way of this.

P3: *“The way they are going about what they are doing, making the extra effort, not thinking that it's going to take too much time if I do it this way. They do it anyway, rather than that it's going to take too much time if I do it this way. They do it anyway, rather than thinking - because some people might think, it's going to take too much time, let me do something else.” [138-141]*

Participant one highlighted a sense of tension, between the desire of a nurse to care compassionately in the way described by participant three above without thinking about it taking “too much time” whilst also acknowledging practical limitations of task demands on their ability to do so. She described this as a struggle for nurses who “do their best” to incorporate compassion.

P1: *“I think the demands are higher and they've got more patients to care for than ever before. It's so task orientated so you have to give this drug at this time, you have to do this at this time [...] I would imagine that sometimes you're so busy with the clinical it must be quite hard to incorporate being compassionate as well. I think probably a lot of them do their best but I would imagine it's a bit of a struggle yeah.”* [272-278]

Participant five compared her experience of nursing in her country of origin and nursing in the NHS in the extract below.

P5: *“In the public hospitals in [another western country] we actually have nurse-patient ratio. So it was one nurse to four patients. So it was really manageable and you actually did feel like you got to know your patients. Whereas here you're just too busy, you're just too busy.”* [91-95]

Participant five repeated being “too busy” to emphasise her point, demonstrating the strength of impact of time on her ability to care. Participant one talked about her “frustration” and being “undervalued” when she had to do too much within varying constraints.

P1: *“I feel frustrated when I feel that I can't perform my job to the best of my ability because of all these other constraints; because of being understaffed;*

because of being asked to see too many patients in the clinic; because of the way management treat the staff. Yeah so you do feel undervalued and frustrated but you do your best really.” [365-369]

Findings appear to demonstrate the difficulty nurses have to contend with the disparity between their desire to give what they deem to be compassionate care, and their capacity to do so, due to demands placed on them by their progressively increasing workload. This suggests an emotional toll or suffering experienced by nurses when they are not able to give the care that they would like. A negative experience of lack of time also seemed to be shared by patients when they perceived that nurses did not have or make time for them.

P11: “Now there were two in the daytime [...] who, as I've just quoted, did their job but nothing more than that. When I asked [...] when am I going on to another ward? ‘Oh there's not a bed yet’. That's it. Finished. Maybe just a little bit more of, I'm sorry but we're waiting for a bed and I'll let you know as soon as we know, something like that.” [59-65]

P11: “I could understand as well, or perhaps I would have been a bit more understanding, if they were rushed off their feet. But they didn't appear terribly busy. So it wasn't that they hadn't got time for the odd word. I would have said they had.” [136-139]

Participant eleven appears to suggest that because the nurses did not look busy they had the time to give her a “little bit more”. During the interview she described these nurses as ones who did not have compassion. She said she would have been more understanding if they had been busy which suggests she differentiates between nurses who did not have time to show compassion but still were inherently

compassionate and those who were not. Participant twelve also demonstrated an understanding of the limitations of nurses due to time pressure but emphasised his sense that the priority of nurses should still be to “listen to the patient first.”

P12: *“First listen to the patient at least to some level. Some patients can be really long and you may not have enough time. That's understandable. To some level, they have to listen to the patient first.”* [184-187]

Participant seven described the impact of being cared for by nurses who gave him the impression they did not have time. His extract seems to highlight the sense that some nurses made time for him despite similar time pressures.

P7: *“So they showed absolutely no empathy, giving the impression they didn't have any time. Nobody has time there but the ones - it's always the way, the ones that don't have time make the time don't they?”* [183-186]

In addition to having enough time to spend with patients nurses highlighted the effect of being within an organisation where all staff act compassionately. The idea of a compassionate organisation is explored in the next section.

3.7.2 Being Within a Compassionate Organisation

Although participants were not directly asked about their experiences related to NHS staff members who were not nurses, all patient participants referenced other members of the healthcare profession. For patients their experience of compassion seemed not just to depend on their nurse's care but also the other staff members they came into contact with during their care.

P8: *"Well the kindness that was bestowed on me is what I'm trying to refer to [...] it didn't end with any one person they all did the same thing. Even the guy who did the catering he made time to come and spend five minutes with you and chat, find out how you are feeling, what was yesterday's dinner like? [...] Everybody, everybody - there are places you meet people I suppose who don't care. I mean I remember meeting people like that in my life but not here, they're all good people."* [163-170]

Participant eight described kindness being "bestowed" on him by all staff members that he encountered and talks about his encounter with non-medical staff. The use of the word "even" suggests his surprise that the catering employee would take an interest in him. It seems that the experience of having a universally compassionate staff team made a significant impact of him and leads him to describe them as "all good people".

The impact of non-medical staff members was also referenced by participants seven and patient eleven, who both used the same adverb "even" to express their surprise at the importance of these encounters to them. Participant seven stated that his encounter made him "feel a lot better" and participant eleven that it made her feel important and that it needs to come from all members of staff regardless of their role.

P7: *"...the lady that came in to do the bed linen they're normally very chirpy and every lovely. Even that was terribly important because you felt you could relate to them and just have a normal conversation with them. That made you feel a lot better as well."* [421-425]

P11: “...even down to the lady who brought me a cup of tea you just felt that - not that you were special, but you just weren't one of 10 in a day that they were doing the same thing with.” [256-259]

P11: “...it's that bedside manner that is very important right from the person who gives you a cup of tea, if you like, right up to a consultant.” [516-517]

When asked to give an example of compassionate care, participant ten described her experience of a doctor who remembered her name. The idea that he remembered her despite all the other patients he saw in his clinic seemed to suggest to her that she was important.

P10: “There was one doctor that I used to like, he used to come by my bed most mornings, [...] hi [patients name], how are you? I'd say, I'm doing well today. He'd say, you look well actually. I might see you later, and go on his way. A young doctor and I remember, I went to this clinic, the after-care [...] I was called in and it was this doctor. So I said, oh, and he said, hello [patient name]. Straight away remembered my name. How many patients does he have?” [152-158]

Participant ten's extract shares a similar feeling to that of participant eleven above who liked not feeling like “one of 10 in a day that they were doing the same thing with.” The idea of patients not wanting to feel like one of many is explored further in section 3.5.2.

For all nurse participants the wider organisation factors were referenced as a factor that influenced their ability to show compassion in some way. Some nurses described the effect of morale on their behaviour at work.

P1: *"So you may have been nursing for say 10 years and you're still only at a band six level. [...] So you just kind of stay at this level getting paid the same amount of money; feeling undervalued; feeling underpaid. Of course this is going to reflect in the way that you behave at work isn't it?"* [339-343]

P5: *"Even pay and morale and things like that as well and that sort of thing. If you can't provide for your workforce then it's got to be a constant cause of unhappiness and issues for people then I don't know."* [446-449]

The effect of feeling "underpaid" and as such as "undervalued" suggests that organisational incentives which are perceived to value staff, such as competitive salary, can make a difference to nurses morale and behaviour at work.

Participants two and four described their experience of how paperwork and "bureaucracy" can get in the way of being able to "give that compassionate care". Participant two emphasised her discontent about the effect it has on patient care by repeating the words "very unfair". The impact bureaucracy on the time nurses have available to spend with patients is described more fully in the previous sub category 'Time'. Participant two stated that it affects nurses' emotions leaving them "unhappy" and participant four experienced it as "challenge."

P2: *"Generally I think people are just unhappy with the lot of paperwork we have to do because sometimes you have to take care of the paper and not the patients. It's very unfair. Very, very unfair."* [352-354]

P4: *"...with the economics, the politics, they're bringing in all this bureaucracy and that's leaving you less time with patients. So, you're not really able to*

give that compassion as a nurse [...] Sometimes, it seems like nurses don't care. They do care, but sometimes that paperwork, like I say, it just puts you in so much pressure, because you're so into it. You have to do it, because if you don't do it, you're going to have to answer to it if anything happens. [...] it's a challenge [...] It really makes things difficult.” [318-328]

Many nurse participants referenced the effect of management and general team support on their capacity to give compassionate care. When participant four was asked for an example of a lack of compassion she described her managers, suggesting that a lack of understanding from managers is perceived as a lack of compassion. An absence of compassion from management and in turn understanding seems to cause difficulties for nurses who may require a greater level of assistance to deliver compassionate care.

P4: “You need support and it's mainly - it's not actually just that, the same level staffing with you, [...] the managers as well, when they haven't got that approach to just understand what you're going through, to understand the level of the assistance that you need being a nurse.” [90-95]

Participant six described her experience of being busy on a ward and her frustration when members of her team did not support her. The outcome of this was that she found it harder to express compassion.

P6: “You still have to look after two and no one is helping you. That kinds of thing and you get annoyed. So, your compassion, your empathy is getting hard to express. It's so hard to express when you are too busy and no one seems to be helping you.” [176-177]

Participant five appeared to agree with this process when she described the benefits of working in a team below, which indicate increased morale and ability to give compassionate care. Participant four also described the benefits of teamwork when enabled to support a patient's family because of support she received from other staff members.

P5: *"It's time efficient and also it's bonding for each other as a team member to do that. Everyone feels good. If you can help people you feel good. [...] if you're finished and everyone else is running around then you feel awful don't you? So it's just nice because then you all can sit down together if you're complete. I think it's good for morale and stuff and therefore people are more likely to then want to get in there with their patients and make a difference."*
[222-230]

P4: *"I had support from my staff as well, the one that was actually already experienced, experienced in that area of nursing. They supported me and that helped me to support the family at the same time."* [25-27]

These extracts describe a positive outcome for nurses and patients when a nurse is working within a compassionate organisation. Further exploration regarding the outcomes of compassionate care are outlined the next section.

3.8 What are the Outcomes of Compassionate Care? Enhancing Patient Recovery and Care Experience.

Table 8. Sub-categories of 'Enhancing Patient Recovery and Care Experience'.

Enhancing Patient Recovery and Care Experience
Enhancing the Healing Process
Reducing Emotional Distress
Increased Trust and Openness
Mutual Enjoyment of Care

This section presents study findings that focus upon the beneficial outcomes of compassionate care highlighted by participants. The four key themes highlighted within this category are presented in turn and are outlined in Table Seven.

3.8.1 Enhancing the Healing Process

All participants talked about the impact of compassion on the health of patients, reporting emotional or physical health benefits.

P10: *"I said to him, you were like a get well pill in the morning sometimes. He said, am I? I said, yes, you're smiling and how are you, I said you made me feel better."* [160-161]

Here, participant ten's description of her doctor like a "get well pill" denotes the powerful effect of compassion on her overall wellbeing through her daily social interactions with him. This powerful effect is reiterated by participant three who talked about the transformation of elderly patients in her care due to compassion.

P3: *"So a lot of elderly are living in isolation. So when they come into hospital, they - you can see it when you are talking to them, when you just take five minutes just to get to know somebody and then you can see they open up. It's like a flower, they just bloom. They open up and once they - you've looked after them, encouraging them to eat and drink, it's almost like a completely different person. Without the compassion, I don't think they would [...] it's almost like being surrounded by people but you are lonely, so to speak. If you show a bit of compassion then it just makes them a whole lot much more better. They recover quickly and it gives them confidence, even maybe like in mobilising, different things which probably they'd given up on before."* [49-59]

Participant three attributed a faster recovery to spending time getting to know patients but also seemed to suggest a recovery beyond what a patient has been admitted into hospital for. She described the confidence that it instils in patients to try different things and the subsequent hope that this fosters within them “probably they’d given up on before”. Participant four described a similar process of enhancing recovery through compassion by helping to build a person “up”.

P4: *“You’re getting them into that step of recovery. Compassion helps recovery as well, because if you haven’t got that compassion, you’re not helping that person to build up.” [228-230]*

P11: *“You need a bit of encouragement I expect to get better as well.” [114-115]*

Participant eleven also described the recovery process and considers the role of encouragement in supporting a patient to “get better”. These extracts denote a sense of hope, confidence and positivity that can be gained by patients from a compassionate nurse that aids recovery, one that appears to go beyond their physical healing. During the analysis I was interested in nurse three’s suggestion that compassion can help patients try things they had previously given up on. I have included analytic memo in Box Four regarding formation of subcategory ‘Providing Emotional Care’ and its link with ‘Enhancing the Healing Process’. More information about findings related to emotional care and compassion can be found in section 3.6.4.

MEMO 12/3/15 - Amelioration

P3 *"If you show a bit of compassion then it just makes them a whole lot much more better. They recover quickly and it gives them confidence, even maybe like in mobilising, different things which probably they'd given up on before."*

Reflection: Participant three talks about the transformation of a patient that goes beyond the mending of physical ailments. She describes patients blooming like flowers, opening up, and trying what they had given up on in the past. This caused me to think about the therapeutic alleviation of pain both emotional and physical i.e. amelioration, an improvement for the patient perhaps beyond what their admission diagnosis requires. To what extent is providing emotional or psychological care a part of what nurses and patients deem to be 'compassionate care'?

Action: Go back through transcripts to explore this question and try to find some negative case examples in order to throw further light on the process.

Box 4. A memo that helped form the development of the subcategory 'Providing Emotional Care and Comfort'.

Participant eight associated being "liked" by his nurses as an important part of his healing process. He suggested that he would have become more ill if had not been the case.

P8: *"It was important for me because that completes part of the healing. I mean they can sense it would - if it was the other way round you will make yourself sick. I was sick so you make yourself worse. No it was good, very good."* [117-119]

In addition to compassion having a healing effect, participant eight also appeared to be referencing its affect on his levels distress "make yourself worse". This supposition is explored further in the next section.

3.8.2 Reducing Emotional Distress

Many participants referenced distress of either themselves or a patient they had treated. Participant one described her personal experience of emotional vulnerability

as a patient when she was “really scared” and emphasised the strength of the impact that a compassionate nurse had on her.

P1: *“It was just really, really caring and it’s a moment that really struck with me. I was in a really bad way emotionally and really scared and it just helped me to calm down and things like that. Yeah no it had quite a big impact actually.”* [130-133]

Participant one articulated the reduction of fear and the sense of calm that compassion fostered in her due to compassionate care. Participant eight described a similar experience in which he “couldn’t be worried” despite the severity of his situation, due to being well taken care of.

P8: *“Whether when you recall the severity that you’re in that has you there it doesn’t matter, it doesn’t really matter because you’re being well taken care of. You feel happy about that part of it. You couldn’t be worried.”* [196-198]

P7: *“...[uncompassionate care] heightens one’s distress. Whereas if somebody’s the opposite you automatically feel more relaxed.”* [127-128]

Participant seven described his experience of care with a nurse who did not communicate with him. Therefore, compassion nursing care appears to have the effect of calming and reducing distress whilst uncompassionate care has the inverse effect, both of which tangible for patients. Some nurses also observed a similar effect, such as participants three and four who commented on the happiness and change in the patient’s presentation due to compassion.

P3: *"By the time they are being discharged you think you can tell they're really happy and they're a different person. Yes, to me, all that passes into compassion. It's little, little things but it makes a big difference."* [228-231]

P4: *"The smile. You see them as a happy patient. You really do see the happiness that comes out of them. They're able to tell you more. They're able to engage you into how they feel. So, that's a big thing."* [233-235]

As well as reducing emotional distress and increasing happiness and confidence, participants indicated that it helped patients feel socially comfortable to speak more freely, to "tell you more" and ask for what they needed. This indicated the effects of increased trust and openness.

3.8.3 Increased Trust and Openness

Participant two described caring for older adult patients and the potential impact of a lack of compassion on their ability to be able to ask for help.

P2: *"Sometimes, that patient just likes your company or just likes having you around, or it makes them feel more comfortable, or they are scared of being alone. So if you're then to be like, I've just been with you seven times, they're going to be scared to ask to go to the toilet again."* [108-111]

It could be argued that a patient's ability to ask for help or tell a nurse how they are feeling could directly contribute to treatment outcomes. Participant twelve described not having this ability as a potential barrier to recovery.

P12: *"Yeah. If a patient is not able to tell completely about his illness, you don't get a thorough diagnosis, which means you don't get good treatment, which means he's not going to recover."* [361-363]

Participant six's account agrees with the above extract, as she is able to get patients better help as a result of their subsequent ability to better express themselves. It is possible that this may also have implications for providing more efficient care.

P6: *"...if they feel that you are concerned about their situation, they might be able to express themselves to you in a way how you can help them to get better."* [39-40]

Participant six suggested that a patient's ability to express themselves is facilitated by compassion, empathy and kindness. Participant accounts five and six agreed that this produces feelings of comfort, safety and trust in a nurse.

P6: *"But, because you are kind and compassionate to them, because you empathise how they feel and you explain to them to what you are doing to them [...] They have that feeling of safe. They are safe to you and somehow they trust you [...] they feel better afterwards then they would trust you even more."* [58-64]

P5: *"...they're not afraid to then ask for things as well if they know you [...] they feel more at ease and more comfortable and safer I suppose knowing that they can rely on a certain nurse rather than always switching nurses."* [105-108]

From multiple accounts, it was possible to understand patient participants' ability to be open and honest with nurses and its reciprocal benefit through constructing a cyclical model of care as seen in Figure Three.

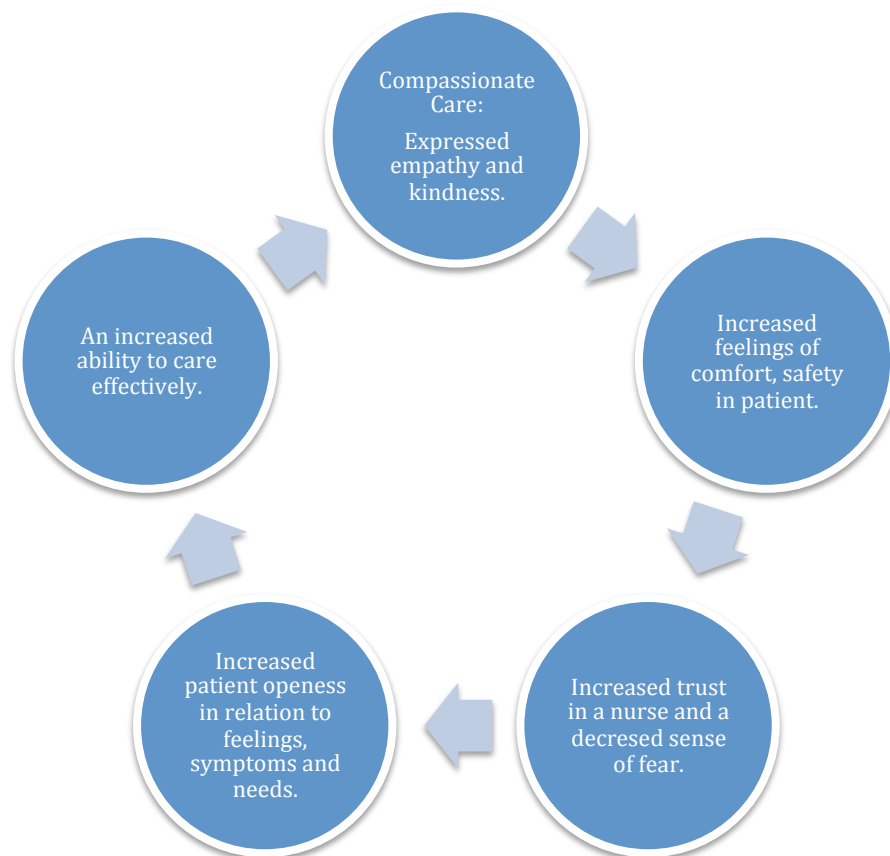


Figure 3. Reciprocating cycle of compassion on care and patient recovery.

As demonstrated in Figure Three there is a benefit for both patient and nurse when the patient is able to be open about how they are feeling as it can lead to an increased ability to care effectively. The concept of compassion having mutual benefit was demonstrated in findings in relation to nurses and patients enjoyment of care.

3.8.4 Mutual Enjoyment of Care

Almost all participants spoke about an increased sense of enjoyment of care when the care given or received was compassionate. So much so that one participant stated that he “really enjoyed” his stay in hospital and that he cherished the care he was given by nurses which seemed to denote the gratitude he felt.

P8: “It’s funny [...] maybe before I would say I would not enjoy a stay in hospital. [But] I did, I really enjoyed it - as much as I wanted to go home I did enjoy the stay I had there because I was well looked after.” [136-139]

P8: “You’re taking care of me. I cherish that.” [204-205]

Participant nine seemed to build on this idea of having a pleasurable care experience when he says that he will miss being there.

P9: “Well I’ll miss this place alright. The hospitals, I get such good care and [...] whether it’s here or [the hospital trust] they are well, they looked after me well.” [131-132]

Participant two echoed the sense of a patient’s appreciation when she described her sense of their experience in hospital and what it is like to have a nurse sit with them.

P2: “I think they really, really appreciate what you do for them. If you just sit down with them and talk about weather or whatever or television, for them it’s just everything I think because sometimes being in the hospital might be a bit boring as well. So it helps.” [48-51]

Participant five stated that when patients are happy with the care they have received they are happy to tell their nurse that this is the case.

P5: *"If the patient's happy with your nursing care they will tell you. I never ask or anything. They will say oh thanks I've had a great day with you; or that was great; or no other nurse has done that for me before; or that was really good; or I hope I have you tomorrow, that sort of thing. Patients are quite good because it is a vulnerable position. So I think when they do have a good day they're quite happy to say that."* [322-328]

Receiving positive feedback or appreciation from patients was highlighted by participant one as a factor that affected her sense of wellbeing. She described "seeing patients get well" and "being thankful" as ways that she gets "back" from the giving of herself in the profession and the absence of this can leave her feeling "hollow and exhausted". Her account suggests her sense of enjoyment of giving compassionate care is dependent on receiving positive feedback from patients.

P1: *"You're constantly helping others; you're constantly being kind; you're constantly giving a lot of yourself really. Quite often it may feel that you're not getting a lot back. So obviously seeing patients get well, patients being thankful, all of that, it's great but you don't always see that much of that. So sometimes it's like you're giving a lot of giving and caring and then you're not getting a lot back. So that can sometimes leave you feeling a little bit hollow and exhausted and then not to mention you've got all these pressures on you as well."* [310-314]

A general sense of enjoyment resulting from giving compassionate care was evident in five out of the six nurses interviewed. Here participant two described her

happiness due to a patient appreciating her care and participant four her sense of satisfaction when she gives compassionate care.

P2: *"You go home but you're still going home happy because you've done what you're supposed to do and that patient really appreciated your care."*
[98-99]

P4: *"Satisfaction. I feel good. I really do feel good that you're helping somebody. You're getting them into that step of recovery."* [227-228]

Participants five and six described the sense of positivity and achievement they gained from seeing the result of their compassionate care respectively.

P5: *"It's times that you remember making a difference and the times that you're happy and you're going about your job the way you like it and getting a lot of positivity from it"* [258-260]

P6: *"Deserving. Yeah, that's an achievement for me, especially when they see that I was compassionate and they trust you. [...] that's something for me, because, [...] it's just like you are one of the family and they trusted you and they want your opinion and if they trust you, they say okay, let's go for this one and then you can see the result. If they become happy, good."* [311-315]

The sense of pleasure that both nurses and patients gain from the delivery of compassionate care is evident in the majority of participant accounts. It is possible that a reciprocal relationship can go some way to explain this process. A nurse who gives compassionate care experiences a patient who demonstrates pleasure upon receiving care and responds in a number of ways which are beneficial to the nurse.

These responses include positive feedback, trust, and openness. As well as an expedited recovery as suggested in Figure Three, a sense of job satisfaction, achievement, happiness and positivity may energise a nurse, enabling her to continue to give patients compassionate care. This reciprocal benefit may in turn nourish on-going compassionate care. A diagrammatic representation of this second reciprocal process can be found in Figure Four.

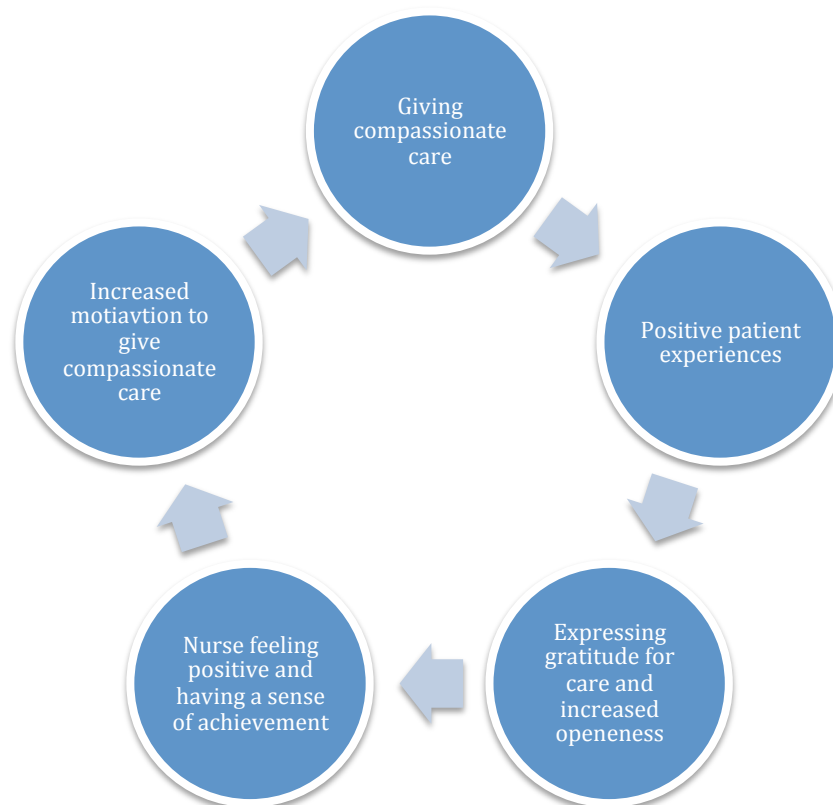


Figure 4. Reciprocating cycle facilitating on-going compassionate care.

These findings indicate how compassion is beneficial for patients and for nurses and may also influence the effectiveness and facilitation of continued compassionate care due to the increased amount of information disclosed by patients. Further information about the implications of these findings for professional practice can be found in the discussion chapter. A proposed schematic overall model of compassionate nursing care encompassing the findings from this research is outlined in the next section.

3.9 A Proposed Schematic Model of Compassionate Nursing Care

The proposed relationship between the seventeen categories that are connected by the core category “Caring For and Caring About” the patient can be seen below in Figure Five.

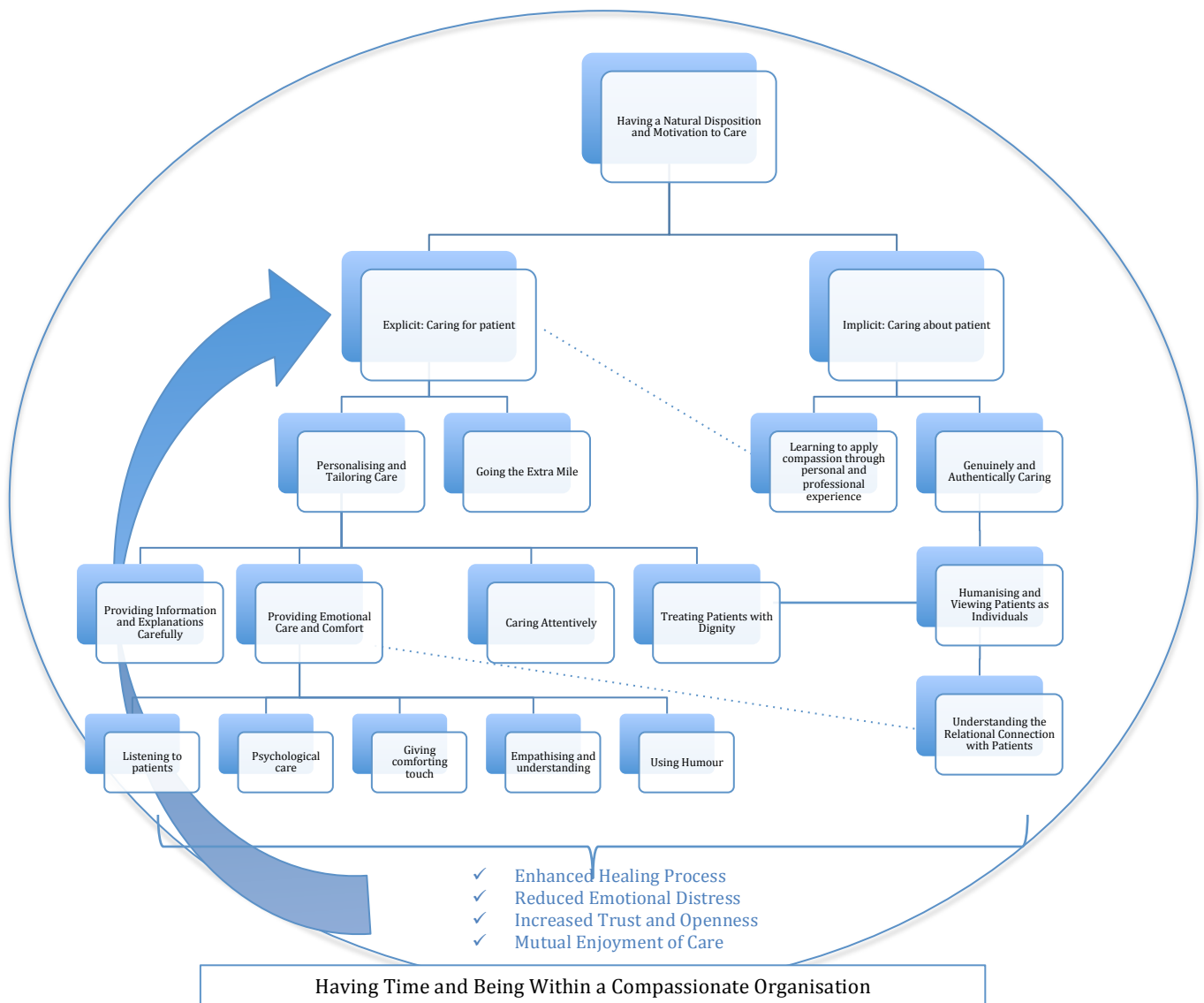


Figure 5. A proposed schematic model of the process of compassion in nursing care.

The schematic model in Figure Five highlights two broad processes underpinning the emergence of compassion in nursing care indicative of a dual process model. The first process is an implicit process, exemplifying the internal experience of the nurse and the second in explicit controlled process of applying felt compassion in care.

The categories are situated within the moderating constructs of having time and being within a compassionate organisation as these factors were found to influence the ability of nurses to apply compassion in care.

The categories are shown to feed into the outcomes of compassion, which include an enhanced healing process, reduced emotional distress, increased trust and openness and a mutual enjoyment of care. These in turn link back into a nurse's explicit ability to care effectively for the patient.

In summary this quote from participant twelve seemed to encompass a great deal of the research findings articulated in this chapter.

P12 "So just like - when it comes for cooking, like when you say somebody cooked a nice meal, it's just not the taste of the meal. It's about the love and passion, how they make it and present to you, yeah, so that is what is making you tasty. It's the same thing with the care. It's just not medicines and drugs."

[178-182]

I will now go on to discuss the findings in the light of relevant literature and explore the implications of the findings in relation to professional practice.

Chapter 4 Discussion

4.1 Overview

The aim of the present study was to contribute towards an understanding of the nature of compassion in nursing and what makes it possible. The introductory rationale and a review of the literature concluded there is little empirical research defining the concept of compassion within the context of nursing and therefore, this study had the potential to generate new knowledge.

GT was selected as the best method to produce an account to describe and explain compassion from the perspective of both patient and nurse participants. Following the GT analysis of twelve qualitative interviews five main theoretical categories and one core category emerged, which applied to all the theoretical dimensions. A schematic model proposing a relationship between the categories was also presented.

In this chapter I will further develop the presented findings in light of existing research and highlight areas where new understandings or questions for future research have emerged. Next I will evaluate the strengths and limitations of this study and discuss how the research meets the standards of credibility and quality outlined in chapter two, section 2.6.5. This will be followed by a consideration of the implications for clinical practice.

4.2 Discussion and Interpretations of the Research Data

The core research category 'Caring For and Caring About' was generated and abstracted from the research data and forms a basis from which the main categories can be understood. Participants described compassionate nursing as encompassing

genuinely caring ‘about’ patients in addition to caring ‘for’ them and their physical needs.

A distinction between caring ‘for’ and ‘about’ patients is also delineated in healthcare literature that examines the separation of care and cure in the context of modern and historical conceptualisations of nursing and medicine (Jecker & Self, 1991). Jecker and Self exemplified the difference between the sense of caring about another as a feeling or attitude state whilst caring for as denoting an applied skill or ability. Whilst neither is mutually exclusive, the separation of the concepts makes it clear that caring ‘about’ a patient does not necessarily imply caring ‘for’ them just as caring ‘for’ does not imply caring ‘about’. In addition concern ‘about’ the other may vary in felt depth, just as the skill with which one cares ‘for’ another can also vary in ability (Jecker & Self, 1991).

Finally, the difficulty inherent in exploring and explicating concepts relating to care and compassion is highlighted when reflecting on the ease with which one can perceive “who cares *for* a patient, [whilst] it can be exceedingly difficult to construe who cares *about* a patient” (Jecker & Self, 1991, p. 296). An attempt to illuminate these processes is a challenge undertaken in part by this research.

4.2.1 Category 1: The Development and Motivations of a Compassionate Nurse

Research findings from the present study indicate that the process by which nurses become effective compassionate carers is dependent on having a natural disposition and motivation to care. This is then used as a platform from which to learn to apply compassion on the basis of both their personal and professional experiences. This finding has some similarities to nursing theorist Patricia Benner’s (1984) conceptualisation of nurses learning through experience. Benner suggested that over

time nurses advance from a novice position, through to an advanced beginner, competent, proficient, and then some become experts. Her theory places utmost importance on the expedition of skills through experience, whereby theory provides only a foundation and is therefore not central to the traditional role of caring (Benner, 1984). She suggested that over time nurses become more confident and comfortable in their nursing practice, allowing theoretical formulations to emerge from their own practice and observation (Benner, 1984; Meleis, 2012).

Findings from the present study also suggested that nurses gain greater proficiency in compassionate care over time. This is contrary to research conducted by Kret (2011) wherein a nurse's level of experience was negatively associated with levels of compassion, suggesting that as nurses progress their passion decreases and they become increasingly cold. Kret's (2011) findings imply an increase of skills and experience over time does not relate to an increase in compassionate care.

However, some nurse participants in the present study indicated that an increase in skill and proficiency allowed them greater time to give compassion to patients whilst a number of patient participants indicated that more experienced nurses seemed to be more compassionate. The findings of the present study raises doubts over the assertion that a nurse's level of compassion decreases over a time. An alternative explanation for the findings is that the impact of external factors that moderate a nurse's capacity for compassionate practice become more influential over time.

A study by Maben, Latter and Clark (2006) examining the theory-practice gap in nursing in the United Kingdom supports the assertion that the influence of external factors on compassionate practice is a significant determinant of values-based practice. Maben et al.'s (2006) findings suggest that nurses hold strong ideals and values upon leaving nursing training programmes but professional and organisational factors mean that these are effectively sabotaged from being implemented (Maben et

al., 2006). These factors were said to include a lack of support, poor role models, time pressure, staff shortages and work overload (Maben et al., 2006). Findings from the present study add to Maben et al.'s (2006) study findings by suggesting that nurses do not lose their strong ideals but instead struggle with the mismatch between their motivation, intent and ideals to give compassionate care and the constraints they experience of a day to day basis within their workplace.

A possible explanation for the disparity between Kret (2011), Maben et al. (2006) and the present study findings is that over time experienced nurses gain greater knowledge and ability in how to apply compassion and a greater attunement to the needs of patients. However, the demands of external organisational and professional factors impact upon the ability to actualise and apply compassionate practice ideals. Therefore, this may be a struggle shared by newly qualified and more experienced nurses. The increasing coldness Kret (2011) describes could be a coping strategy for managing the theory-practice gap highlighted by Maben et al., (2006) or the result or an indication of caregiver burnout. Future longitudinal research that controls for the occurrence of burnout may be beneficial for shedding further light on the phenomenon of decreasing compassionate care over time.

4.2.2 Category 2: Genuinely Caring for a Patient as an Individual

Research participants in the present study described compassionate nursing as care that encompassed a relationship and connection that was genuine. Developing a relationship, emotional connection and knowledge of a patient have all been indicated to enable compassion in practice, however, studies have yet to clarify the processes involved (Dewar, 2013). Participant's request for a real relationship with nurses was a research finding shared by Jackson and Stevenson (2000), who explored the role of nurses in mental health services. They found patients expected nurses to share their lives, in addition to providing professional services (Jackson &

Stevenson, 2000). Sharing personal information and admitting mistakes have been found to be key ways of finding common ground with patients, which can help facilitate a compassionate patient-caregiver relationship (Sanghavi, 2006).

Fricchione (2011) described the power of relationships with patients as “the medicine of friendship” whereby a loving friendship between physician and patient can allow a doctor to continue to heal a patient even when medications have lost their efficacy (p. 17). However, the importance of this mode of caring is often lost due to a tendency of health care professionals to decentralise “the power of caring in deference to the magic of medical science” (Pearson, 2006, p. 22).

Although the need for a genuine relational connection with patients was a prominent research finding in the present study, it is highlighted as a problematic concept by nursing standards literature that suggests close relationships with patients can decrease appropriate professional boundaries (Nursing Standard, 1997). Despite this, it is clear the desire for a genuine connection or relationship with nurses is something that both nurse and patient participants valued. The focus on the centrality of the interpersonal relationship with patients seems to be an additional way that nursing values are returning to traditional nursing origins, as defined by Peplau who emphasised the significance of the interpersonal and at times therapeutic process of nursing care (Peplau, 1952). Dewar (2013) offered guidance on how to engage patients and family members in relational care whilst minimising a professional’s vulnerability. Question examples include: “How do you feel about your experience?”, “What helps you to feel positive and well?” and “Tell me something that will help us to care for you here?” (Dewar, 2013, p. 51).

The genuineness of a nurse’s approach to the patient was also a key research finding in the present study. Nurse and patient participants alike valued the sense of

genuine authentic care and connection, with most referencing the sense of 'knowing' whether care was genuine or not. In addition, participant five described her experience of acting compassionately when she did not feel it and compared this to times when she was genuinely compassionate, finding the latter brought her greater positivity: "*It's times that you remember making a difference and the times that you're happy and [...] getting a lot of positivity from it*" [258-260]. This supports suggestions by de Zulueta (2013) that when compassionate care is 'ersatz' (artificial) it leads to emotional exhaustion, burnout and is detectable by patients.

Prominent twentieth century philosopher Martin Buber (Buber, 1923/58) described the need for genuine relational contact as engaging in an I-Thou mode of existence, which is needed to fully engage in a complete openness to the other. This is as an alternative to a detached objectification of the other in an I-It fashion (Buber, 1923/58). Paterson (2011) illuminated the experience of I-It relating and objectification of a patient by citing essayist Anatole Broyard who when suffering from prostatic cancer wrote: "I'd like my doctor to scan me, to grope for my spirit as well as my prostate. Without some recognition, I am nothing but my illness" (Paterson, 2011, p. 22). In addition he wished that his doctor would "give me his whole mind just once, be bonded with me for a brief space, survey my soul as well as my flesh" (Paterson, 2011, p. 22).

Carl Rogers a highly influential psychologist, considered one of the founders of humanistic psychology, highlighted the significance of the I-Thou relationship for therapeutic work (Rogers, 1974 as cited in Van Deurzen & Kenward, 2005). He observed that "[the] recognition of the significance of what Buber terms the I-Thou relationship is the reason why, in client-centered therapy, there has come to be a greater use of the self of the therapist, of the therapist's feelings, a greater stress on genuineness" (Rogers, 1974 as cited in Van Deurzen & Kenward, 2005, p. 29). The

emphasis on genuineness and caring about and for the other in a way that does not objectify but instead humanises them are findings that mirror those of the present study. It also indicates a commonality between the therapeutic task of a nurse and that of a therapist.

The need for I-Thou relating is extended further by Yalom (2011) when he described the need to relate to patients or clients as fellow travellers. Yalom (2011) suggested the distinction between the therapist “us” as the healer and “them” the patient as the afflicted, should be abolished. Participants described their desire for normal relationships with nurses, often comparing nursing care to care within a family, doing as you would for a loved one. Yalom (2011) situated the therapist, or in this case the carer, on an equal level with the recipient of care, using the knowledge that we have all suffered, are suffering and will suffer. It could be surmised that the more disconnected and detached the nurse becomes (I-It relating) the less the patient engages in the relationship and experiences the healing benefits of relational care as outlined in section 4.2.5. Connecting genuinely in relational care through inherent mutuality (I-Thou relating) with a patient may help them to feel more than the sum of their symptoms and in turn a nurse more than the administrator of medicine within a didactic health care system.

The present study findings highlight the need to humanise patients by viewing them as individuals rather than objects. This finding is echoed by Jacobson (2009) in a study exploring the social process of dignity violation in healthcare. Jacobson’s (2009) findings indicated patients felt their dignity was violated when they heard themselves being spoken about or were treated like a ‘thing’ rather than a person within the healthcare system. Both nurse and patient participants in this study shared the sentiment of abhorrence to being subjected to objectification and compared this to being seen as “numbers” like “someone else on the conveyor belt” which resulted

in feeling “dehumanised”. A number of nurse participants reported objectification in their perceived treatment by managers who related their value to their efficiency. This was reminiscent of suppositions by Karl Marx, a philosopher and prominent socialist who stated that this is the inevitable outcome of the capitalist political economy. He wrote, “In manufacture the workmen are parts of a living mechanism. In the factory we have a lifeless mechanism independent of the workman, who becomes a mere living appendage” (Marx, 1894, p. 461). Campling (2013) suggested that in order to create a kind and compassionate healthcare system the marketisation of care needs to be eliminated.

The objectification of patients within the healthcare system is also evident in the literature, which cites the occurrence of referring to patients as numbers or as their illness rather than using their names. Carey (2005) suggested this results in a loss of identity as a person experiences a shift from being a person to being a patient following inpatient hospital admission. One patient highlighted her experience when one ceases “being a person and become[s] ‘the carcinoma in Room B-2,’ like I was” (Carey, 2005, para 65). However, research by Woolhead et al. (2006) exploring communication between older adult patients and their healthcare providers found that the opposite of this impersonal form of address could also cause problems. Researchers found that for some patients the use of their first name and pet names without their prior consent was disrespectful, patronising and humiliating (Woolhead et al., 2006).

It is clear from the present findings and literature outlined above that both patients and nurses dislike being objectified as a ‘nurse’ or ‘patient’ and value being treated as an individual. This is consistent with research that states compassionate care requires the healthcare worker to treat the patient as an individual by striking a balance between providing guidance and allowing the patient autonomy (Sanghavi,

2006). Therefore, compassionate care is personal, treats the patients with dignity and is tailored to the desires of each individual. This undermines previous suggestions that etiquette-based healthcare practice is all that is required and that feelings-based care, such as empathic approaches, should be abandoned (Kahn, 1988; Smajdor, Stockle & Salter, 2011 as cited in de Zulueta, 2013).

Participant three described the experience of receiving uncompassionate care whereby all her physical care needs were met but she was left feeling uncared for: *"basically just ticking the boxes"* [80]. The problem of 'tick-box' care has been highlighted previously in response to a review of the Liverpool Care Pathway, which was originally designed to ensure that palliative care patients had a dignified and comfortable death (Neuberger, 2013). However, a review found that because care procedures were mandated patients and family members' individual needs and preferences were often not taken into account and as such care was delivered and experienced as a tick-box exercise. The review highlighted the need to communicate clearly the nature and prognosis of a patient's physical health concerns (Neuberger, 2013). Recently updated guidelines proposed: "People need to have meaningful choice and be involved in decisions about their end-of-life care, allowing them to maintain comfort and dignity until they die" (Henry, 2015 as cited in Mundasad, 2015). Therefore, highly prescriptive guidelines cannot adequately guide healthcare professionals in values-based interpersonal care, particularly when patients are distressed or confused (de Zulueta, 2013). Instead, findings from the present research suggest a flexible approach is required that humanises the patient as an individual, takes into account their needs and preferences and goes beyond basic physical care to ensure care needs are met holistically and competently.

4.2.3 Category 3: Applying Compassion in Care

Present study findings suggest a number of ways that nurses apply compassion in nursing care. One application participants described was the provision of “psychological care” which placed nurses in a therapeutic role requiring them to listen, calm and comfort patients.

Within nursing literature there is a particular focus on the psychological care that nurses give patients within mental health care settings through a therapeutic relationship (Gilburt, Rose & Slade, 2008; Rydon, 2005). Nursing literature focusing on the therapeutic relationship in physical healthcare settings is not as common, but it does highlight the need for nursing work of an interpersonal and emotional nature to be recognised within clinical practice, education and research (McQueen, 2000; Pearson, 2006). Pearson (2006) suggested it is within the relationship between nurse and patient that the core therapeutic content of nursing lies but also highlighted that little attention is paid to the therapeutic intention of nursing people. Pearson (2006) recommended that caring for and about patients in nursing should be thought of as therapy in itself and its power should not be minimised in deference to the rituals of ‘real therapists’.

Future research could further explore the present research findings regarding the significant role of psychological nursing care for recovery within non-mental health care settings. In addition, research could explore the extent to which and the reasons why patients deem it to be integral to good care. This could prove beneficial for establishing an evidence base for the integration of emotional and psychological care into nursing practice guidelines, allowing for greater clinical time to be dedicated to this undertaking.

Many participants cited the use of humour as being integral to the emotional care they received. For example participant seven states: *“I think humour carried me*

through” [60]. The use of humour within the nurse-patient relationship is thought to be valuable in nursing practice and has been associated with many beneficial outcomes, including physiological and psychological wellbeing and the reduction of stress and anxiety (Tremayne, 2014). Findings from the present study suggest compassion has a similar impact upon patient well-being. With humour being cited by a number of participants it is possible that this is one of the mechanisms that contributes towards the beneficial outcomes of a compassionate approach to patient care. Further research is required to explore this supposition in more detail.

An additional way participants described the application of compassionate nursing care was in the careful provision of information and explanations. Many participants described the need for nurses to strike the right balance between giving patients enough information without too much unnecessary detail. The importance of communicating patients’ medical information in a clear and useful manner was a finding that was also apparent in research by Sanghavi (2006), which explored what makes for a compassionate patient-caregiver relationship.

Findings from the present research also suggest that applying compassion in nursing care requires health professionals to go the extra mile for their patients. Many participants described this as giving patients a “little bit extra”, leaving patients feeling cared for and appreciated. Graber, Johnson and Hornberger (2001) and Pearson (2006) described the importance of spontaneous acts of kindness and generosity by healthcare staff and the impact it has on patients who rarely forget these moments. Participants from the present study gave examples such as: saying hello to patients whilst off duty, getting patients their favourite food or drinks and going out of their way to adapt their care. This linked with research findings that showed care needed to be personalised and tailored to patients’ individual needs. It is likely that the ways in which nurses “go the extra mile” would be specific to the patient and context.

Further research eliciting examples of when patients felt nurses went the extra mile for them might be helpful to illuminate this concept further.

Finally, research findings from the present study indicated that applied compassionate care requires nurses care attentively, to such an extent that they are sometimes able to anticipate patient needs. GT research by Jackson and Stevenson (2000) exploring the role of mental health nurses similarly suggested that patients wanted nurses to anticipate their needs even when they were unable to express themselves verbally. Dewar (2013) stated this component of compassionate care requires emotional attunement in order to act in a way that feels compassionate for both the caregiver and the patient. Attunement has been described within healthcare as “the delicate and precise art of reading another person’s emotions and responding sensitively and appropriately” (de Zulueta, 2013, p. 88). McQueen (2004) described the attunement skill as emotional intelligence, which requires more research within the nursing context. Future research exploring similarities and differences between compassion and emotional intelligence may be helpful to further clarify terms within a nursing context and explore whether emotional intelligence is indeed a facet of compassion. Measures of emotional intelligence have been developed (Goleman, 2001) and as such may be a helpful construct to develop a way for compassion to be integrated within evidence-based practice. Georges (2011, as cited in Flynn & Mercer, 2013) suggested that at present evidence-based practice masks a depersonalisation of care, a move away from the values at the core of nursing which is the reason for the compassion deficit in healthcare. This controversial stance indicates the necessity for the value of compassionate care to be highlighted by researchers in order that adaptations can be made to evidence-based practice healthcare culture in nursing.

4.2.4 Category 4: Moderating Constructs in Compassion

Moderating factors that inhibit or facilitate the perception of, and ability to give, compassionate care were a prominent research finding within the present study. Although compassionate practice is influenced to an extent by training and development, it is the culture and organisation within which nurses work that seems to be the main influence on the development of compassion in nursing care (Flynn & Mercer, 2013). A systematic review by researchers Flynn and Mercer (2013) in response to the Francis Report (Francis, 2013) suggested that any failure in compassion is likely due to NHS organisational culture and government health policy and ideology rather than deficiencies of nurses or nursing practice. It highlighted the impact of the organisational and social context; they recommended nurses make a record of each time organisational pressures hindered them from delivering compassionate care (Flynn & Mercer, 2013).

Jacobson's GT research findings support the supposition that health care settings can contribute to uncompassionate care, particularly when there are "multiple tensions between needs and resources, crisis and routine, experience and expertise, and rhetoric and reality; and in the embeddedness of health care in a broader social order of inequality" (Jacobson, 2009, p. 1536). Furthermore, organisational settings that are characterised by stress and urgency, distraction, rigid and hierarchical structures and a lack of resources are more likely to see a violation of dignity in care (Jacobson, 2009). However, Jacobson (2009) also identified two groups that are particularly at risk of a violation of dignity and thus uncompassionate care, which included institutionalised elderly patients, and individuals whose lifestyles or health conditions are particularly stigmatised, such as sex workers or drugs addicts. These findings suggested there are social processes that increase the likelihood of uncompassionate care for particular social groups. This raises questions about Flynn and Mercer's (2013) assertion that compassion deficits are purely organisational and cultural. Therefore, an understanding of the impact of organisational cultures or

structures on uncompassionate, undignified care for specific patient groups remains unclear.

Research by Woolhead et al. (2006) further contributes to knowledge of barriers to high quality care whilst exploring the concepts of dignity and communication within elderly healthcare setting. Cited barriers included: “lack of time, staff, resource scarcity, regulation and bureaucracy”, as was “a lack of awareness and effort” (Woolhead, et al., 2006, p. 370). It is suggested that dignified compassionate care is not actively valued by healthcare organisations who typically prioritise obvious care outcomes, such as a measureable tasks and activities. Therefore, more pressure is placed on nurses to complete non-clinical tasks, leaving less time available for the invisible acts of compassion such as talking to patients (Pearson, 2006; Woolhead et al., 2006). Although compassionate acts are theoretically considered to be important they hold little currency for those managing, developing and funding services (Dewar, 2012) and as such compassion may be implicitly or unintentionally quashed.

Flynn and Mercer (2013) highlighted the inevitable tensions that can arise between the task-focused culture of evidence-based practice in the NHS and the nurses who seek to deliver compassionate care. Many nurse participants in the present study highlighted their struggle to give patients compassionate care within the expectations and constraints of their managers and non-clinical tasks. Maben et al. (2006) described the incongruity between nursing as it is taught and how it is practiced as having profound implications for job satisfaction, morale and retention rates. They suggested that the conflict caused by professional–bureaucratic work can be reduced by providing adequate supervision and mentoring, and by addressing resource and skill mixes (Maben et al., 2006). However, they warned that without an acknowledgement of the overstretched nursing workforce in the UK there could be

detrimental implications for individual nurses and the nursing profession as a whole (Maben et al., 2006).

Present study findings indicate that patients as well as nurses needed to experience all members of staff as compassionate “*from the person who gives you a cup of tea [...] right up to a consultant*”. The majority of participants cited the importance of patient interactions with the members of staff (clinical and non-clinical) and how these interactions made them feel. This finding aligns with research suggesting that if compassion is evident throughout the organisation people feel seen, known, valued, listened to and less alone (Kanov et al., 2004).

Nurses in the present study said working within a compassionate organisation helped them to care compassionately when they received support from their team and managers. A systematic literature review by Hopkins, Loeb and Fick (2009) suggested that a compassionate health service enables its nurses to be responsive to non-medical expectations of patients. The present findings echoed research by Woolhead et al., (2006) which identified spending time with, listening to and acknowledging patients as individuals as non-medical expectations of nursing care that helped older adults patients feel valued and care for.

The importance of a compassionate organisation can also be illuminated through an understanding of Gilbert's (2009) psychological model of compassion, which proposes humans evolved to have three types of emotional regulation systems which interact with each other: threat and protection system (linked to the autonomic fight or flight response), the drive or incentive system, and the contentment and soothing safeness. The last system has an affiliative focus that helps to regulate threat by seeking kindness and support, thereby restoring a sense of safeness, soothing the threat system and enabling compassion. A sense of safeness is not activated merely

by the reduction or absence of threat (Bueno, 2011) and as such the soothing and safeness system is crucial for the regulation of the other systems. Therefore, fear shuts down a person's capacity for compassion, which is inherently problematic in a caring environment, particularly if there is a heightened threat focus due to under resourcing. Creating a safe, supportive environment for healthcare professionals is key for the promotion of an organisational culture that supports compassionate care.

Gilbert's (2009) psychological model of compassion also helps to build an understanding of how an individual's capacity to give compassionate care may also be moderated by internal factors. Gilbert posits that a 'compassionate mind' is developed through a series of specific skills and abilities, which go beyond simple emotions or motivations, and instead encompass a complex combination of attributes and qualities (Cole-King & Gilbert, 2011; Gilbert, 2009). Gilbert's theory suggests that there are six key attributes of compassion, which include: sensitivity, motivation, sympathy, distress tolerance, empathy and non-judgement (Gilbert, 2009). In a healthcare setting it has been suggested that if any one of these key attributes is missing a nurse may experience compassion fatigue or compassion deficit, as, for example, a nurse could feel motivated to give compassion but lacks empathy (Cole-King & Gilbert, 2011).

The six compassion attributes posited by Gilbert have some similarities to the findings of the present research broadly in five areas. 'Sensitivity' maps on to the subcategory 'caring attentively', 'motivation' maps on to the subcategory 'having a natural disposition and motivation to care', 'sympathy' maps on to the subcategory 'providing emotional care and comfort', 'empathy' maps on to the subcategory 'genuinely and authentically caring' and finally 'non-judgement' with the subcategory 'treating patients with dignity'.

Charmaz reminds researchers “what participants don’t say can be just as telling as what they do say” (Charmaz, 2014, p. 91). Notable in its absence from the findings from the present research was a discussion relating to nurses’ own level of distress tolerance, as a key attribute of compassion outlined in Gilbert’s (2009) conceptualisation of compassion attributes. Participants also did not reference a nurse’s level of self-compassion, self-care skills or emotional ability to give compassionate care. Instead all factors highlighted by participants that appeared to moderate a nurse’s ability to give compassion were external.

The lack of discussion about the internal experience of nurses in relation to their ability to give compassion was surprising, particularly in light of the large amount of nursing research explicating the compassion fatigue and burnout that can result from the stress and burden of caring (Joinson, 1992). In addition, in order to offer compassionate care to patients whilst also managing the distress or disgust that can arise during care, nurses need the ability to tolerate and regulate difficult thoughts, feelings and emotions (Cole-King & Gilbert, 2011; Dewar, 2013).

A possible explanation for the absence of findings relating to internal factors such as affect regulation is that participants assumed or implicitly suggested that all nurses are able to give compassionate care effectively if it were not for external moderating factors. However, it is also possible that the lack of findings elicited in this area may have been due to the social desirability of being compassionate, a potentially stigmatised understanding of compassion fatigue and burnout and a lack of time available within the interview to explore on a deeper level internal factors associated with compassionate care.

Kristin Neff (2003, 2011) pioneered research in the field of self-compassion and conceptualised it as a healthy attitude toward the self that incorporates three main

components: self-kindness, common humanity and mindfulness. Research indicates that one of these components, mindfulness, has been linked with decreased anxiety and burnout and increased empathy and coping skills (Beddoe & Murphy, 2004; Cohen-Katz et al., 2005; Cohen-Katz, Wiley, Capuano, Baker & Shapiro, 2005). Therefore, self-care that incorporates self-compassion may be essential to the ability to enable one to care for others. As such Richards (2013) argued that practicing self-care should be an inherent professional expectation within the role of nursing. This has implications for nursing teaching, supervision and professional practice recommendations and guidelines. Future research may be helpful to explore the link between a nurse's level of self-compassion and the ability to give effective compassionate care to patients. In addition an exploration of the link between self-compassion and burnout in nursing would also be a valuable way to provide an evidence base for introducing and facilitating greater levels of self-care and compassion to support the ongoing professional development and care for nurses and health professionals.

4.2.5 Category 5: Outcomes of Compassionate Care

Findings from the present study suggest a multitude of positive outcomes attributed to the giving and receiving of compassionate nursing care. These included enhancing the healing process, reducing emotional distress, increasing trust and openness and a mutual enjoyment of care.

Findings relating to the enhancement of the healing process share similarities to research by Mok and Chi Chiu (2004), who found that a good nurse-patient relationship in palliative care settings improved patients' physical and emotional states, eased the pain they experienced and led to better care experiences. Similarly kindness and increased social interaction has been found to contribute to faster healing and recovery from physical health conditions (Hamilton, 2010). The notion

that the relationship between caregiver and recipient can be healing is an ancient one with Hippocrates stating “The patient, though conscious that his condition is perilous, may recover his health simply through his contentment with the goodness of the physician” (Novack, Epstein & Paulsen, 1999, p. 516). Similarly Fricchione (2011) suggested that demonstrating loving care for patients contributes to the healing process by creating an atmosphere in which patients’ confidence in their carer and their treatments is increased, resulting in an increased compliance with the treatment regime as well as the healing power of optimism. Stoter (1995) extended the power of the relationship with a patient by stating when a nurse develops a relationship of trust and confidence with a patient, not only will healing occur, but a patient’s other needs can also be more effectively addressed.

Participants in the present study also reported increased trust and openness as a result of compassionate care. For example participant six describes patients being better able to express themselves when a nurse is compassionate. This is consistent with research findings collated by Halpern (2001, as cited by Larson & Yao, 2005) who wrote that empathy (a reported component of compassion) helps patients to become more forthcoming with their concerns and symptoms which facilitates more accurate diagnosis and more effective care. This beneficial process is also represented in the schematic model of the findings proposed in Figure Four section 5.4. Furthermore, research has found empathic care helps patients increase self-efficacy and regain autonomy as well as leading to therapeutic interactions that directly affected patient recovery (Halpern, 2001).

In addition to the stated benefits of compassionate care in relation to the patient experience of care and patient recovery, the present study exemplified the positivity that nurses experienced when they were able to give compassionate care. These included feeling happy, positive, satisfied and having a sense of achievement.

Participant two exemplifies this in her statement *“You go home but you're still going home happy”*. Research supports this finding by indicating that nurses derive satisfaction from their relationships with patients and healthcare workers who engage in the process of empathy enjoy more professional satisfaction (Larson & Yao, 2005; Mok & Chi Chiu, 2004). Research by Gallup (2013) demonstrated that workforces who are highly engaged and motivated in their work benefit workplaces in a number of ways. Results suggested 41% fewer quality defects, 48% fewer safety incidents, 25% less turnover (for high turnover organisations) and 37% less absenteeism (Gallup, 2013). Therefore, if, as the results from the present study and research suggest, being able to care compassionately for patients increases employee satisfaction this may have positive economic and financial implications for healthcare organisations.

Findings from the present study and future research applying Gallup's methods to compassion in healthcare could help to reframe or challenge conventional wisdom that the best cost-effective measures are achieved through driving for efficiencies. This sentiment is shared by Ballatt and Camping who stated that “putting a fraction of the effort that has gone into processes of organising, regulating and industrialising the NHS into developing our understanding of what helps and hinders kindness in its staff would have enormous ramifications for effectiveness and efficiency, as well as for the experience of the patient” (2011, p. 4). It is hoped that this study is seen as taking a meaningful and active step in this direction.

Although the direct benefits of compassionate care are hard to quantify the implications of a compassionate healthcare organisation have been explored by Ballatt and Campling (2011). Their conceptualisation of healthcare reform promotes kind compassionate care behaviour that is nurtured by the wider system. They envisage a virtuous circle where kindness enables good relationships, leads to better

outcomes and reinforces conditions for kindness (Ballatt & Campling, 2011). The virtuous circle as illustrated in Figure Six supports the present study findings as illustrated in Figure Three and Figure Four which exemplify the impact of compassion on care and patient recovery and facilitation on-going compassionate care. The enabling of trust, therapeutic alliance, better outcomes, and kinship which promotes more effective caring and healing are conceptualisations shared by the findings of the present study. However, present findings extend the section in the virtuous circle model relating to kinship by explicating the mutual enjoyment of care that nurses and patients experience which helps to facilitate on-going compassion. The findings from the present study could help lend empirical support to the theoretical formulation of Ballatt and Campling's (2011) virtuous circle model.

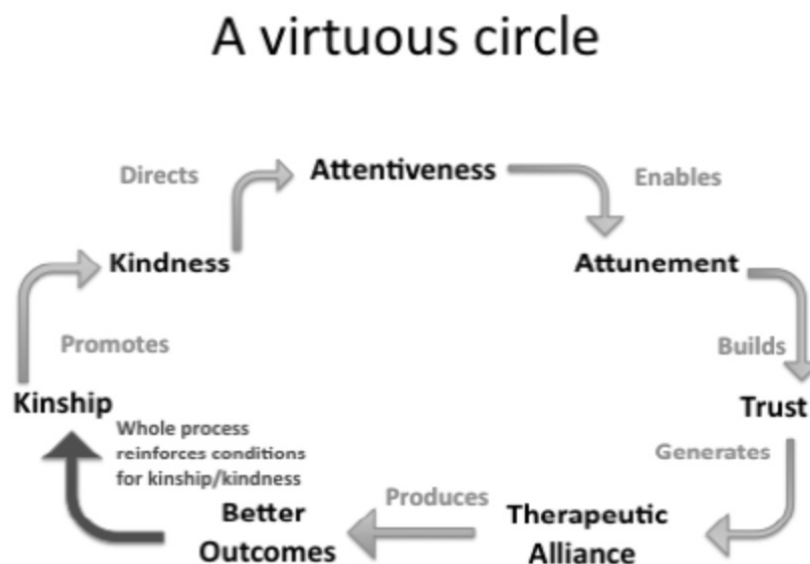


Figure 6: A virtuous circle (Ballatt & Campling, 2011; Campling, 2013).

4.3 Evaluation of the Study

The aim of this study was to contribute toward an understanding of the nature of compassion in nursing care and what makes it possible. Through the use of Charmaz's (2006, 2009) social constructivist GT approach to investigate this question, it was hoped that a rich detailed account could be developed, in addition to

the provision of a conceptual theory of the nature of compassion which could be of use to healthcare professionals, healthcare managers and the nursing profession.

I was aware that exploring this phenomenon from the perspectives of nurses and patients was an ambitious undertaking but it felt necessary to gain an understanding of compassionate care from participants involved in both sides of the process. However, it is possible that the ambition and scope of the study may also be considered one of its limitations. Although it has been possible to sketch broad processes outlined by participants, an in-depth examination of the social processes of compassionate care has not been possible. Unfortunately there was not sufficient time within participant interviews to explore the concept at the depth required to gain a greater insight into the processes at play. In addition, the decision not to use the full version of the GT method meant that I was not able to engage in theoretical sampling to explore some of the questions about the concept of compassionate care that arose during the analysis phase of the research and was instead limited to revisiting extant data. The use of abbreviated GT was necessitated due to the timescales involved in the completion of the study and the complex procedures encumbered within the process of resubmitting to NHS ethical committees for approval each time the interview schedule was significantly altered. The same limitations led to an inability to return to participants to carry out focus groups or interviews to invite feedback on the findings and explanatory models. This is regrettable, as an additional level of participant involvement may have served to supplement the procedural measures utilised to ensure credibility of the findings. Therefore, the study findings were able to explore the concept of compassion in care broadly but the process of theory development has been tentative.

In order to address design limitations and to do justice to the phenomenon of compassionate care, the analytic process aimed to reach a balance between an

explanatory account of the nature, development and links to social processes in compassionate care whilst also espousing an experiential account of the meaning of receiving and giving compassionate care. I hope that the depth of analysis and the breadth of the analytic process undertaken enables the reader to obtain a sense of the nature and experience of compassionate care from the perspective of nurses and patients.

A number of limitations could be identified in terms of the sample size of the present study. In an analysis of over five hundred PhD qualitative studies Mason (2010) found that the mean sample size utilised was thirty-one. The present study is decidedly smaller with twelve participants, which although reasonable for a GT study, means that a greater number may have led to a more diverse sample. For example, regrettably no male nurses volunteered to be interviewed. Although the predominance of female nurses in the present study is consistent with research data demonstrating the majority of nurses (approximately 89 percent) are female (Yar, Dix & Bajekal, 2006); it represents an area for future research to explore compassion from the perspective of male nurses and caregivers.

In addition the recruitment of participants from only one source (an NHS hospital trust) may have excluded potential participants that could add useful insights. It would be useful for future research therefore, to attempt to explore compassion in different contexts such as private, community, and mental health care settings. In addition a number of participants mention their family members in relation to the care they received. Although this was not a substantial finding including significant others, such as family members and partners, in similar research this could be an interesting area to explore.

A further limitation of the present study relates to the sampling and recruitment method. As outlined in the methodology Section 2.8.3 I was reliant on nurse managers to gain access to patients and staff members. This meant that it was not possible to ensure complete anonymity to participants in every case. In addition as a researcher I was required to have and wear a staff identity card at all times. This meant that I was unable to portray myself in a fully 'outsider' role and as such participants may have made assumptions about my knowledge or were influenced by what they considered I wanted to achieve from the research. Both patient and nurse participants alike appeared to be frank during interviews about their experiences and views but it is not possible to rule out the potential power imbalance or sense of purpose that wearing a staff identity card may have engendered.

I believe the use of the GT methodology was well justified for use in the present study, however the total reliance on the interview method may be another limitation of the study. Within an interpretivist-constructivist paradigm it is argued that researchers construct, not discover grounded theory (Charmaz & Henwood, 2008). As such the findings presented represent one of a number of possible constructions, theories and models of compassion. As such it is highly probable the inclusion of alternative methods would likely have led to differing constructions of theory. The use of ethnographic methods such as participant observation and the use of diaries may have been beneficial. An alternative methodology that could be utilised in future research exploring compassion in nursing is narrative psychology. Narrative psychology explores the way that participants make sense of events and actions in their lives (Silver, 2013). Narratives are often told at times of conflict and illness, and have been found to be a crucial part of the construction and maintenance of self-identity and can promote social change (Silver, 2013).

One of the most difficult aspects of this project was deciding upon what should be included in the analytic account and how to structure the findings. There was a great deal of data that needed to be sifted and sorted in relation the methodological procedure and the research question. Referring myself back to the research question throughout the process helped to focus the direction of the research. The use of in-depth line-by-line action oriented coding meant I was able to navigate the process by oscillating between zooming in and out of the data creating themes and eventually the theoretical categories much like the skeleton upon which the flesh of the data could be arranged.

Many of the participants described factors that did not answer the original research question directly but seemed invaluable to an understanding of compassion. For example I did not enquire into what participants felt made compassion possible nor did I ask participants about the impact of other health and non health professionals on their experience or conceptualisation of compassionate care and yet these were prominent research findings. The research question was adjusted accordingly to allow space for the crucial elements highlighted by participants of what makes compassionate care possible. However, the focus on this part of the research has moved the spotlight of the research to give it a far more sociopolitical and organisational culture focus that I had originally expected.

4.3.1 Procedural Measures to Ensure Standards of Quality, Trustworthiness and Rigour

Throughout all stages of this study I have engaged a variety of methods to ensure the credibility of the research findings by meeting standards that demonstrate quality, trustworthiness and rigour. As previously stated there are varying perspectives on the criteria that can be used for evaluating qualitative methodologies. However, my perspective has been informed by guidance from social researchers (Denscombe,

2002; Henwood & Pigeon, 1992), a grounded theorist (Charmaz, 2014) and counselling psychologist (Morrow, 2005). Throughout the various stages of this study I have engaged thoughtfully with the guidelines recommended by these researchers to ensure these standards were adhered to. I have grouped and briefly summarised their recommendations in Table eight and outlined how I strove to meet them.

Table 9: Procedural measures adopted to ensure quality, trustworthiness and rigour

Guidelines for ensuring quality research	Methodological response
Credibility - Charmaz (2014) suggests that the credibility and quality of qualitative research is dependent on its depth and scope, as well as suitability and sufficiency, for depicting empirical events. In addition Denscombe (2002) highlights the need for using precise and valid data.	Analysis was carried out at depth in order to provide a rich and detailed account. Data from both patients and nurses was sought in order to provide a conceptualisation that encompassed both sides of compassionate care process. Participant quotes are provided throughout the analysis chapter. A research supervisor checked and provided feedback on all stages of the study, including coding, synthesizing the analysis, findings and analytic models. Limitations of the study are explored in section 4.3.
Proximity to the data - Henwood and Pigeon (1992) and Charmaz (2014) state the need for researchers to keep close to the data in order to create rich dense integrated theory.	Action oriented coding was utilised to keep codes precise and to describe what is going on in each line. Thereby avoiding making loose descriptive codes in which the meaning of the data is lost. Constant comparative analysis was undertaken, identifying similarities and differences within emerging categories in order to construct categories that are grounded in the data. Negative case analysis was utilised in order to develop emerging theory by looking for 'negative cases' in the data.
Reflexivity - Morrow (2005) emphasises the need for counselling psychology researchers to acknowledge their subjectivity and reflexivity. Henwood and Pigeon (1992) state that reflexivity needs to be used and recorded.	Personal, methodological and epistemological reflexivity was engaged with and documented throughout the process. A memo diary with a procedural and analytic focus kept track of connections made and the resulting direction of analysis. Excerpts are included in the

	methodology and findings chapters.
Clarity and usefulness Descombe (2002) highlight the need for new knowledge to be contributed from which generalisations can be made. In addition Henwood and Pigeon (1992) state that research is required to have transferability, the extent to which the study findings have a more general significance.	The original contribution of the study in light of existing literature is outlined in section 4.2. Implications and potential applications of the findings are explored in section 4.4. Tentative explanatory models of compassionate care are presented in sections 3.8.3, 3.8.4 and 3.9.

4.4 Implications of the Study Findings

Literature outlined in the present study has demonstrated that in order for compassionate care to move from rhetoric to reality, empirical research is needed to promote and support its emergence in healthcare. The present study has contributed to a greater understanding of compassion in the context of nursing, which may help to guide a new approach to evidence-based practice to challenge the prevailing focus on efficiency and quantitative measuring of care which are said to undermine traditional care values (de Zulueta, 2013). In addition, the present research has contributed to an increased understanding of what helps and hinders compassion in nursing, an objective that is necessary due to its ramifications for effectiveness and efficiency, as well as for the experience of the patient (Ballatt & Campling, 2011; Kleinman, 2008).

The involvement of NHS patients as participants in this study alongside nurses was crucial in light of Dewar et al.'s (2011) assertion that compassion is defined by the people who give and receive it. As such the description of interpersonal processes that capture what compassion means to patients and nurses is an important element in the promotion of compassion. For this reason the present study is uniquely placed to add knowledge and understanding to the definition of compassion in nursing care, a necessity for contemporary nursing research outlined by the Kings Fund (Firth-Cozens & Cornwell, 2009).

I see counselling psychology as a fitting home for the present research even though in its subject it is situated within the field of physical healthcare. Compassionate care is a complex concept which literature demonstrates is challenging to define due to its inter and intrapersonal nature. Counselling psychology as a discipline embraces working with such complexities and does so with the awareness that although “we cannot get rid of the trees we can mindfully and deliberately clear a space in the forest so that light can shine down on others’ experiences” (Kasket, 2013, p. 5). My intention has been to shine a light on a construction of compassion in a way that illuminates it for readers but also seeks to apply the values of counselling psychology through ‘ethics in action’ (Cooper, 2009). During my time working in an NHS staff psychology service I witnessed the difficulty faced by a number of exhausted healthcare workers who were motivated to give high quality compassionate care but felt constrained by the pressures they faced in their workplace such as understaffing. This experience motivated me to shine light on this struggle. Creating an understanding of compassion that is socially and culturally embedded in the experiences of those involved, in order to theorise and better support such clients in the future, is an endeavour that closely adhered to the characteristics of counselling psychology practice (Cooper, 2009).

The present research highlights the powerful impact compassionate care has on patients and nurses. Many of the participants described a complex interplay of factors, which together contribute to the experience of compassionate nursing care. These factors raise a number of implications for professional practice in the areas of nursing, counselling psychology, therapeutic practice and healthcare organisations. In order to avoid the development of prescriptive care guidelines, the present research seeks to illuminate the concept of compassion in a manner that avoids the discussion of the specificity of particular skills or approaches. Instead an emphasis has been placed on the complex and delicate interpersonal process of

compassionate care between the nurse and patient. However, it is pertinent to note that value statements in isolation are insufficient to create a compassionate culture, the emphasis on efficiency, and quantitative measuring undermine traditional values of care (de Zulueta, 2013). Instead “deep, authentic and deliberate dialogue” needs to be engaged in to “allow for good sustainable, solutions to emerge” whereby the kind of healthcare the government wants to provide is radically rethought as well as the kind of a moral climate that is needed to support it (de Zulueta, 2013, p. 89). Research findings from the present study and literature outlined in this chapter suggest that attention should be given to empowering and enabling nurses to do this by evidencing the factors that enable it to flourish in practice.

4.4.1 Implications for the NHS and Healthcare Organisations

The findings from the present study indicate that patients desired all members of staff they encounter to be compassionate regardless of their job role. Examples included doctors, HCA's, catering staff and domestic staff members. As such it is not just nurses who can have a profound powerful effect on a patient's experience of care. It is clear that healthcare organisations need to engage with how they provide compassion consistently across staff from multiple disciplines. This may involve thinking carefully about the criteria used for hiring, training and inducting staff members into a healthcare organisation.

Findings from this study could be used to create induction materials that help to conceptualise compassion. Educating staff members in compassion could be a part of mandatory training, regardless of whether they have a clinical or non-clinical role. Holding such multidisciplinary training may help employees reflect upon their role in creating compassion within the wider culture of the healthcare organisation. For example staff members could be asked to provide examples of ways they could complete daily tasks compassionately and think about how they can support staff

across multiple disciplines. Therefore, it is hoped that findings from this research may help to connect healthcare professionals to the deeper values of compassionate care within the NHS (Ballatt & Campling, 2011).

Research findings from the present study indicated that compassion leads to positive outcomes for patients and nurses. This presents a potential opportunity for healthcare organisations to improve patient experience of care and increase employee satisfaction through the promotion and facilitation of compassionate care (Mok & Chi Chiu, 2004). Employee satisfaction has been empirically linked to a variety of outcomes that benefit employers and therefore, may have positive economic and financial implications for healthcare organisations (Gallup, 2013). It is hoped that these findings could be utilised to challenge perceptions of how to create efficiency and effective economic outcomes within healthcare organisations.

Furthermore, there is the potential for the present research alongside future research proposed in this chapter to influence evidence-based practice in the NHS by providing a greater understanding of compassionate nursing so that good work can be recognised and celebrated. Conversely, care practice lacking compassion may be more easily identifiable so that staff can be given appropriate support. It is therefore possible that findings from research such as the present study could help to guide the training and support of nurses in professional practice and guide future research.

4.4.2 Implications for the Nursing Profession

The findings from the present study may prove useful to support for the formation of new nursing theory in relation to compassion. The schematic model of compassionate nursing care proposed in Figure Five may be a useful tool reflection on the various and related facets of compassion. However, the most helpful recommendations for improving and informing compassionate nursing care could be

drawn from the accounts of the participants. The examples of compassion they gave, particularly within challenging circumstances are invaluable and could benefit from being collated into case examples. These could support self-reflection, professional development and promote ideas of how to apply compassion successfully in nursing practice. The study findings may be beneficial for developing compassion training and professional development programmes. The inclusion of theory from therapeutic models such as those stipulated by Rogers (1961) and Buber (1923/58) and self-care skills in training may be a beneficial way to prepare nurses for the task of compassionate care.

Pearson (2006) suggested that the acknowledgment of the therapeutic power of caring is often lost in the quest for health and healing. However, findings from the present study highlight the need to acknowledge that compassionate nurses are engaging in a therapeutic role and relationship with patients. As such nurses and therapists share a similar task, to care for their patients or clients and restore them to physical or mental health. However, it could be said that a nurse's task is greater as they are required to heal both body and mind.

The therapeutic task of compassionate care arguably needs to be supported by a provision similar to that offered to therapists. This concurs with recommendations outlined by Dewar (2013) who suggested that in order for healthcare professionals to develop compassion effectively, space and support is required to allow for reflection on the self in the process of care giving (Dewar, 2013). This space helps healthcare professionals learn to recognise difficult thoughts and feelings as they arise and develop the ability to tolerate difficult emotions, situations and memories (Dewar, 2013). Such space could be provided by psychological supervision. In addition, supervision could help nurses manage the stress caused by factors which moderate their ability to give compassionate care, indicated in the present study as being within

an uncompassionate organisation and not having enough time. Supervision would thereby help nurses navigate the theory-practice gap and professional and organisational sabotage which they may encounter upon leaving training and entering the nursing workforce (Maben et al., 2006).

A further way compassion could be supported is through the implementation of Schwartz Center Rounds. The Schwartz Center Rounds provide opportunities for healthcare staff to engage in reflective practice and create supportive environments in which all can learn from each other (Lown & Manning, 2010). Research has found these to be effective in providing support to health care professionals whilst also enhancing relationships within teams and between health care professionals and patients (Lown & Manning, 2010).

4.4.3 Implications for Counselling Psychology

Counselling and applied psychologists have the potential to implement and develop useful interventions for promoting the emergence of compassion in healthcare, based on research findings such as those outlined in the present study and psychological theories of compassion (Cole-King & Gilbert, 2011).

Many psychologists are now undertaking management and supervisory roles within new NHS structures, which require staff from multiple disciplines to be trained and supervised to deliver psychological interventions. Psychologists are therefore, increasingly line managing and supervising non-psychology trained members of staff. Counselling and applied psychologists can help promote the evidence for the supervision and support needed to promote compassionate care and prevent compassion fatigue and burnout. Findings such as those from the present study could be utilised in the development of supervisory models targeted at non-

psychologists to aid the understanding and facilitate the practice of compassionate care.

The BBC (2015) recently reported that hospital staff absences for mental health reasons have doubled over the past four years. Gaining an understanding of the work of nurses and healthcare professionals through this study may help psychologists gain insight into this potential client group. An increased understanding of the moderators of compassionate care in particular may be helpful in the treatment of compassion fatigue and burnout. In turn psychologists could help to teach, facilitate and promote self-care and reflective practice within healthcare organisations in order to help prevent compassion fatigue and burnout.

The unique role of counselling psychologists as therapists and researchers places them as healthcare professionals who can provide important sources of learning, supervision and narratives regarding compassion in care that is constructive and empowering towards nurses and patients. This may help to challenge narratives that vilify nurses and are punitive towards the profession in the media, in particular by highlighting ways that compassion is externally enabled or disabled. Changing the political and mainstream rhetoric in relation to care may be a way that counselling psychology can help to provide a safe space for open dialogue with nurses who struggle with compassionate practice to come forward and understand more about themselves and their patients.

Cole-King and Gilbert (2011) proposed that there are many ways to improve the ability of healthcare professionals to engage in compassionate care which include teaching self-compassion skills and working through resistance to compassion. CFT (Gilbert, 2009) could be one way to better support NHS nurses to cultivate compassion whilst providing necessary support to help reduce the impact of the

stress of doing so. CFT utilises a skills-based integrative treatment approach whereby compassion, kindness to the self and the development of self-soothing skills are placed at the centre of the client's therapeutic experience (Gilbert, 2010a, 2010b). Gilbert advocates CFT as a way to help clients become attentive to, and "engage with, 'suffering' and the skills associated with the alleviation of suffering" (Cole-King & Gilbert, 2011, p. 29). This acts to enable individuals to cultivate warmth towards others rather than a sense of detachment. CFT could be modified for healthcare professionals to help them imagine the experience of the patient, formulate what they could do support their physical and emotional needs, and the relief the patient may feel when their needs are attended to (Cole-King & Gilbert, 2011). By asking nurses to imagine the benefits of their care they learn not to rely on the gratitude of a patient, which may never be expressed (Cole-King & Gilbert, 2011).

In addition to how the present research findings can be utilised by psychologists to support other healthcare professionals, they may act as a useful encouragement regarding our own therapeutic practice. Findings pointed to the powerful effect of the therapeutic relationship for promoting healing. Although the centrality of the therapeutic relationship is a premise most therapists are taught as foundational to their practice, being reminded of its significance, evident even in the fleeting encounters referenced in the present study could be helpful.

Healthcare professionals and psychological therapists across the NHS have seen increased organisational pressures referenced by the participants in the present study, such as under-staffing, increased workloads and decreasing time to spend with clients and patients. The current cost cutting drive in the NHS is leading to increasingly limited and short-term therapeutic treatment, meaning greater pressure is placed on therapists to achieve significant outcomes faster. The paralleled experiences of nurses and healthcare professionals highlighted in this study are

punctuated by patient's stories of powerful encounters, brief moments of connection that were healing for them. It is possible that as therapists become bogged down in bureaucracy and pressure for efficiency they may feel more inclined to reach for techniques and modalities that attempt to get fast results. Although this is a valid endeavour findings of this research are a helpful reminder that it is in the genuine encounters, the use of the self and the relationship and as such the I-Thou relating that can be most transformative for clients and patients (Buber, 1923/58; Rogers, 1961). Re-grounding in the 'core conditions' of the therapeutic relationship (Rogers, 1961) is a helpful task for both nurses and therapists alike. The need for honesty, unconditional positive regard and empathy are vital for both physical and emotional care and provide an environment conducive to healing (Rogers, 1961). Therefore, present study findings are a helpful reminder to counselling psychologists and therapeutic practitioners not to lose sight of the power and significance of genuine human contact inherent in the therapeutic relationship.

4.5 Personal Reflexivity

As a researcher I have had an undeniable impact on the construction and arrangement of the findings presented (Charmaz & Henwood, 2008). However, the process of research has also had a significant impact upon me as the researcher undertaking it (Hanley, Lennie & West, 2013).

During the present study I have had the sense of oscillating between being an 'insider' and 'outsider' in relation to the subject matter (Dwyer & Buckle, 2009). There were times when nurse participants were discussing the impact of understaffing and other organisational issues within the NHS when I experienced a pull to my own views about the injustice of these issues due to their effects on staff and patients alike. Equally there were times when patient participants described the impact of health professionals on their care when I was reminded of the experiences of a close

friend who sadly passed away before I could share with him the findings of this study. However, on many occasions I felt like an outsider trying to gain access and understanding about something I had not myself experienced. In either case I experienced the knowledge being shared with me much like a student eager to learn, understand and master something just outside of their grasp. I have found GT methods a useful way to navigate the insider and outsider positions, particularly in the earlier stages of analysis when line-by-line coding helped me to step back from my own suppositions and view the data naively. The use of a reflective journal and memo writing has also been a crucial way to document the research process and where I positioned myself in relation to it.

At times I have navigated through the present research with great anxiety and uncertainty, feeling as though I were peering toward the peak of an insurmountable mountain. Having reached the end of the process I find myself feeling humbled, grateful and considerably educated by the experience. Doctoral training and the research process have been personally and professionally transformative and I feel deeply grateful to each of the participants in this study for being willing to take part and contribute their experiences. I hope that their stories will inspire and enable others to further develop personal and organisational compassionate practice.

I hope to use the findings from the present study to support compassionate practice within the NHS. I am committed to disseminating these findings in the hope that it will inspire other researchers to develop further knowledge in this area. Furthermore, I am committed to using the findings of the study to contribute toward positive changes for the participants groups interviewed. This is likely to involve devising workshops and disseminating summarised findings within the hospital trust where the research was carried out. At present research findings are already being used to inform the development of professional development workshop for critical care nurses within the

trust. An area of nursing in which the demands are high and nurse managers are pioneering ways to sufficiently support their staff.

There are challenges ahead to be faced by the NHS due to the changing economic climate and on going governmental reforms. This may represent a trying time for nurses, psychologists and fellow healthcare professionals. However, my experience of speaking to participants in this study about compassion in the NHS has been inspiring and motivating. I hope it provides inspiration for others who may feel heavy laden about the future of Britain's health service.

Despite its difficulties, through the stories and experiences of the employees and patients who generously give, receive and share transformational compassion in their care, the humanity of the NHS is still demonstrated.

Peabody summarises the humanity in care this with the following statement:

“The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed, but the reward is to be found in that personal bond, which forms the greatest satisfaction of all medicine. One of the essential qualities of a clinician is interest in humanity, for the secret of the caring of the patient is in the caring for the patient”. (Peabody 1927, p. 882).

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Appendices

Appendix A: Advertising Poster



CITY UNIVERSITY
LONDON

Emma Hollywell
Department of Psychology
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City University London
Whiskin Street
EC1R 0JD

Email: Emma.Harris.1@city.ac.uk
Tel: 020 7040 8500
Website: <http://www.city.ac.uk/arts-social-sciences/psychology>

Direct line: [REDACTED]
Fax: [REDACTED]
Switchboard: [REDACTED]
Email: [REDACTED]
Website: [REDACTED]

Compassion and the NHS

Would you like to be part of an important study
exploring the Role of a Compassionate Nurse?

- Are you are patient or a nurse within [REDACTED]?
- Do you have an opinion about all the recent investigations into care in the NHS?
- Would you like to be part of a study that informs the definition of compassionate care?

You may be eligible to participate in a new research study.

By taking part in this topical study you will contribute to research that may provide guidance to policy makers and potentially influence future evidence based practice within the NHS.

Please email the researcher Emma Hollywell at [REDACTED] for more details.

Appendix B: Participant Information Sheet



CITY UNIVERSITY
LONDON

Department of Psychology
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Whiskin Street
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Tel: 020 7040 8500
Website:
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Switchboard:

Direct line:

Fax:

Email:

Website:

PARTICIPANT INFORMATION SHEET

Thank you for considering taking part in this research project. My name is Emma Hollywell, and as part of my study for a professional qualification in Counselling Psychology at City University, London I am carrying out research to explore what constitutes compassionate nursing care. I am also on an honorary placement at [REDACTED] as a Trainee Counselling Psychologist.

*Before you decide if you would like to be involved this information sheet provides some details about the project in order to help you understand what it is about, why it is being conducted and what your participation will involve. **The researcher will go through the information sheet with you and answer any questions you have.** We'd suggest this should take about 5 minutes, please ask if there is anything that is not clear. Please feel free to take more time to decide if you would like to participate.*

WHO IS ORGANISING THE STUDY?

I am Emma Hollywell a Trainee Counselling Psychologist, training at City University London. My email address is [REDACTED]. This study is for a professional qualification.

WHAT IS THE PURPOSE OF THIS RESEARCH?

This research aims to operationalize the concept of compassionate nursing care with the hope that it will allow compassion in health care to be better monitored allowing health care staff to access the support they need to provide this kind of care.

WHY HAVE I BEEN INVITED TO TAKE PART?

I am speaking to current patients and nurses about their thoughts on this topic as I am interested in finding out your thoughts and opinions on the subject of compassionate nursing care which is a topical issue at present. You can benefit from the opportunity to share your opinions and experiences of care within the NHS. This may have a wider benefit of the opportunity to indirectly improve care and support for nurses within the NHS on publication of this research.

DO I HAVE TO TAKE PART?

It's up to you to decide to join the study. The researcher will go through the information sheet with you and if you agree to take part you will be asked to sign a consent form. Your participation in this research is completely voluntary, and you may decide to withdraw at any time, without any consequences. Talk to others about the study if you wish. General information about participating in research can be obtained from INVOLVE. INVOLVE is a national advisory group that supports greater public involvement in NHS, public health and social care research. They can be contacted on 023 8065 1088 or via email on admin@invo.org.uk.

WHAT WILL I HAVE TO DO IF I TAKE PART?

You will be asked to sign a Consent Form indicating that your participation is voluntary and that you understand your rights. You will then be interviewed about your experiences which will take approximately 40 minutes. You will then have the opportunity to debrief about the research with the researcher. This will take approximately 5 minutes.

WILL THE INTERVIEW RESULTS BE ANNONYMOUS?

Yes. The interview will be recorded, and listened to only by me, or an examiner if requested. All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you which leaves the hospital will have your name and any identifying information removed so that you cannot be recognised. Short quotes from the interview may be used in the results of the study to illuminate the findings but would not be identifiable in any way to you. The only time I would have to break this confidentiality is if the interview raises ethical concerns regarding the endangerment of yourself or another person, which I will discuss with you before we start.

WHAT WILL HAPPEN TO THE RESULTS OF THIS STUDY?

I will use the results of the study to complete a doctoral research project. It may also be submitted for publication. A summary of the results will also be made available. This can be emailed or sent to you by post. Please contact the researcher if you wish to be informed of the results.

DO I HAVE TO ANSWER ALL THE QUESTIONS IF I DON'T WANT TO?

No. It is up to you whether you wish to answer the questions. Mostly it will be you choosing what you wish to talk about rather than me asking questions.

WHAT IF I FIND THE INTERVIEW UNCOMFORTABLE OR DISTRESSING?

If you find it difficult or uncomfortable to talk about certain things in the interview at any time, please let me know. A list of confidential support services will be given to you after.

WHO REVIEWS THE STUDY?

All research in the NHS is looked after by an independent group of people called a Research Ethics Committee, whose role is to protect participant's safety, rights, wellbeing and dignity. This research has been reviewed and approved by the London – City and East Ethics Committee and complies with the Code of Human Research Ethics as outlined by the BPS (2010).

WHAT IF THERE IS A PROBLEM?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions on 020 3447 9800 or [REDACTED]. If you remain unhappy or wish to complain formally, you can do this by contacting your local Patient Advisory Liaison Service (details below) or by contacting Anna Ramberg on 02070405060 or via email on [REDACTED].

Patient Advice & Liaison Service

[REDACTED]

[REDACTED]

Tel: [REDACTED]

Email: [REDACTED]

If you have any questions or would like any further information about this research, please contact the researcher Emma Hollywell.

Appendix C: Consent Form



**CITY UNIVERSITY
LONDON**

Department of Psychology
Social Sciences Building
City University London
Whiskin Street
EC1R 0JD

Tel: 020 7040 8500
Website: <http://www.city.ac.uk/arts-social-sciences/psychology>

Direct line: [REDACTED]

Fax: [REDACTED]

Switchboard: [REDACTED]

Email: [REDACTED]

Website: [REDACTED]

CONSENT FORM

I have read and understood the PARTICIPANT INFORMATION SHEET which I may keep for my records, and have had the opportunity to ask questions. I understand the nature of the study and my role in it, and I agree to participate in this research. I understand that my participation is completely voluntary, that I am free to withdraw at any time.

I consent to be interviewed by the researcher and to the interview being recorded. I understand that my anonymity will be protected throughout the research, and that if I withdraw from the study the recording of my interview will be destroyed. I understand that this form will at all times be kept separate from all other research documents and at no point will I be identifiable by name in any part of the findings.

I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998. I understand that the researcher conducting this study is abiding by the Ethical Principles of conducting Research with Human Subjects set out by the British Psychological Society (2010).

By signing below I consent to participate in this research:

Signature: _____

Date: _____

Researcher signature: _____

Date: _____

Appendix D: Debriefing Sheet For Patients



CITY UNIVERSITY
LONDON

Department of Psychology
Social Sciences Building
City University London
Whiskin Street
EC1R 0JD

Tel: 020 7040 8500
Website: <http://www.city.ac.uk/arts-social-sciences/psychology>

Direct line:

Fax:

Switchboard:

Email:

Website:

Debriefing Sheet

Thank you for participating in this research.

What is this study hoping to achieve?

This research is in response to the call for the development of measures of care to help us learn, improve and highlight the positive impact on the people we care for (NHS England, 2012). It aims to operationalize the concept of compassion in healthcare using quantitative research to develop a measure that identifies the role of a compassionate nurse. It is hoped that findings from this research may provide further guidance for policy makers to influence evidence based policy and practice within the NHS. This may include interventions such as Compassion Focused Therapy (2009) to support staff that appear to have a deficit in this area of care.

If you have any questions or would like any further information about this research, please contact the researcher at the following address: [REDACTED] or by telephone on [REDACTED]

Emma Hollywell
Trainee Counselling Psychologist
Doctorate Course in Counselling Psychology
City University London

Thank you again for taking part in this research.

If you have felt worried or troubled by any of the questions in this study please see the sheet attached for organisations that may be able to offer useful information, help and support. Your GP is also a useful person to approach and will be able to discuss and offer guidance regarding these and related issues.

Resources

Patient advice and liaison service (PALS)

PALS

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

You can ask a staff member to contact PALS on your behalf. PALS can visit you on the ward, in a clinic or in a department.

- PALS is a patient-friendly, easy to access, confidential service designed to provide a personal contact to assist patients, relatives and carers.
- PALS can offer on the spot advice and information if you have queries or difficulties
- PALS will listen to your concerns and help you find ways of resolving them
- PALS will take note of what you tell us to help to improve the service our hospitals offer to patients

PALS act as a point of contact for all those wishing to get advice and information about [REDACTED] services.

NHS direct

0845 4647

www.nhsdirect.nhs.uk

Provides local information and guidance relating to medical and mental health issues

Samaritans

0845 790 9090

www.samaritans.org

Provides a 24hr confidential telephone service offering emotional support.

MIND

0300 123 3393

www.mind.org.uk

Provides advice and support on all aspects of mental health and offers local counselling services in many areas.

Appendix E: Debriefing Sheet For Nurses



CITY UNIVERSITY
LONDON

Department of Psychology
Social Sciences Building
City University London
Whiskin Street
EC1R 0JD

Tel: 020 7040 8500

Website: <http://www.city.ac.uk/arts-social-sciences/psychology>

Switchboard:

Direct line:

Fax:

Email:

Website:

Debriefing Sheet

Thank you for participating in this research.

What is this study hoping to achieve?

This research is in response to the call for the development of measures of care to help us learn, improve and highlight the positive impact on the people we care for (NHS England, 2012). It aims to operationalize the concept of compassion in healthcare using quantitative research to develop a measure that identifies the role of a compassionate nurse. It is hoped that findings from this research may provide further guidance for policy makers to influence evidence based policy and practice within the NHS. This may include interventions such as Compassion Focused Therapy (2009) to support staff that appear to have a deficit in this area of care.

If you have any questions or would like any further information about this research, please contact the researcher at the following address [REDACTED] or by telephone on [REDACTED].

Emma Hollywell
Trainee Counselling Psychologist
Doctorate Course in Counselling Psychology
City University London

Thank you again for taking part in this research.

If you have felt worried or troubled by any of the questions in this study please see the sheet attached for organisations that may be able to offer useful information, help and support.

Resources

Staff have open access to the [REDACTED] Service, a team of psychologists, counsellors, and a legally trained welfare adviser. This confidential service is here to support staff with their mental wellbeing, emotional and practical needs in order to keep psychologically healthy at work and be supported to provide top quality patient care.

Team support is also available for coping with change and effects of stress, facilitation of supervision support groups, and support following incidents at work. The service offers workshops on managing working relationships and a conciliation and mediation service with accredited mediators.

Telephone: [REDACTED]

Email: [REDACTED]

Address: [REDACTED]

RCN - Royal College of Nursing

0345 772 6100

www.rcn.org.uk

RCN Direct, Copse Walk, Cardiff Gate Business Park, Cardiff CF23 8XG

The Royal College of Nursing represents nurses and nursing, promotes excellence in practice and shapes health policies.

UNISON

0800 0 857 857

www.unison.org.uk

UNISON Centre, 130 Euston Road, London, NW1 2AY

UNISON is Britain and the UK's biggest public service union with more than 1.3 million members.

Unite

020 7611 2500

www.unitetheunion.org

Unite, Unite House, 128 Theobald's Road, Holborn, London, WC1X 8TN

Unite is a public service union dedicated to serving the best interests of its members and will seek to improve their standard of living and the quality of their lives through effective relationships with employers and government.

Samaritans

0845 790 9090

www.samaritans.org

Provides a 24hr confidential telephone service offering emotional support.

MIND

0300 123 3393

www.mind.org.uk

Provides advice and support on all aspects of mental health and offers local counselling services in many areas.

NHS direct

0845 4647

www.nhsdirect.nhs.uk

Provides local information and guidance relating to medical and mental health issues

Whistleblowing - [REDACTED] Policy

Staff may have concerns from time to time. Concerns should normally be raised informally with colleagues or line managers. 'Whistleblowing' is a more formal process to raise concerns with senior management within the Trust where the informal route has not resolved the matter or where the concern is of a serious nature. Concerns may relate to patient safety, patient experience, the use of resources including money, or how we work together. How to raise your concerns:

Initially, you should report your concerns to your line manager/their line manager. If you feel unable to do this or they do not respond to your concerns within a reasonable timeframe then you can report the matter through a number of routes:

Contact the Trust's Employee Relations team;

email: [REDACTED]

call: [REDACTED]

Contact the Workforce Director (who is the designated lead for disclosure):

e-mail: [REDACTED]

call: [REDACTED]

write to: Workforce Director, [REDACTED]

Contact our internal audit team, if the matter involves potential fraud;

call: [REDACTED]

Contact the NHS Whistleblowing Helpline: 08000 724 725

All of these routes will handle the complaint sensitively and in confidence.

Appendix F: Interview Schedule

Preamble:

I'm interested in your opinion on what constitutes compassionate nursing care. I want to emphasise there are no right or wrong answers but simply your opinion or experiences. Your confidentiality will be protected throughout the research and as such I would like you to tell me what you really think. I have a number of questions I would like to ask but what is most important is for me to listen to your experience in as much detail as you feel is relevant and you feel able to share. If you can remember specific examples that may help me to understand your experiences that would also be helpful. Do you have any questions before we begin?

What are your experiences of receiving care (or providing care) in life that you believed to be truly compassionate?

What are your experiences of receiving care that you believed was not compassionate?

If you were selecting nurses/trainees for their compassion what qualities would you look for?

If you were to observe a nurse on a ward what behaviours would you be looking out for which would indicate they were carrying out their work in a compassionate way?

If you could describe the actions and attributes of a compassionate nurse what would they be and look like?

If a nurse was completely uncompassionate what did you imagine that would look like/ be like?

How would I know if I was receiving uncompassionate care? How would I feel?

Is a high standard of care the same thing as a compassionate standard of care? Expand?

Is compassionate care affected by economic circumstances?

What would you like people to know about compassion based on the conclusions you've made about your own care and caring experiences? Is there anything you'd like to add?

How would you define compassion?

If there's one thing I should take away with me today based on what you've said what should it be?

Appendix G: Example of Transcript and Early Coding

Transcript from Participant One (Nurse)	
<i>Then in your own personal experiences, have you got times where you've experienced truly compassionate care and what that was like? So whether that be from a family member or from hospital contacts. Do you have a good sense of what compassion has been like for you?</i>	
Yeah. If I'm thinking about it I would probably think to my own hospital experience. I think you never really completely understand what patients are going through until you've been a patient yourself. It's a different experience. You're unwell, you're vulnerable, things feel completely out of your control. So I had a time when I was very unwell unexpectedly. I remember being in hospital and I remember a very, very kind nurse who - I had bloods on me and things like that and she was just really kind; really warm; really gentle. She gave me a nice wash and spoke to me really softly. She had almost a motherly kind of energy but I've always remembered that moment. She just made me feel safe. She was gentle. She made me feel cared about. I think when you've experienced something like that you realise how much of an impact you as a nurse have on people to because that was years ago and that really stuck with me as well.	<i>Reflecting on personal experience</i> <i>Building understanding of patient through personal experience</i> <i>Feeling vulnerable when ill</i> <i>Feeling out of control when ill</i> <i>Experiencing unexpected illness</i> <i>Remembering nurses kindness</i> <i>Emphasising nurses kindness</i> <i>Experiencing nurses warmth</i> <i>Washing nicely</i> <i>Being gentle</i> <i>Speaking softly</i> <i>Having motherly energy</i> <i>Remembering mothering moment</i> <i>Feeling safe</i> <i>Feeling cared about</i> <i>Having a significant impact as a nurse</i> <i>Remembering compassion after a long time</i> <i>Not forgetting compassion</i>
<i>Do you think that was the - what does that look like? It sounds like her persona was very kind or was it how she was treating you?</i>	
It was both I think. So she had a really kind persona. She was quite softly spoken, very gentle, but her touch was really, really gentle as well. I remember that because I had blood on me and that and she had to clean me. She was just really so gentle and kind, both in her manner and physically the way she touched me. It was just really, really caring and it's a moment that really struck with me. I was in a really	<i>Being kind</i> <i>Speaking softly</i> <i>Being gentle</i> <i>Cleaning patient gently</i> <i>Remembering gentle touch</i> <i>Being gentle</i> <i>Being kind</i> <i>Having a gentle manner</i> <i>Having a gentle touch</i> <i>Really caring for patient</i> <i>Being struck by memory of really caring</i> <i>Feeling badly emotionally</i>

bad way emotionally and really scared and it just helped me to calm down and things like that. Yeah no it had quite a big impact actually.	<i>Feeling scared</i> <i>Calming patient down</i> <i>Having a big impact on patients</i>
<i>It sounds like it, like you said realising quite how much difference one person can make from that experience and actually then in your role thinking about each encounter may be that you have ...</i>	
Yeah I mean I've had another episode recently. I've had a back injury and that's also been interesting though I've been seeing outpatient doctors, a bit like what outpatients go through. It is amazing if you feel that somebody actually listens to you instead of going in and somebody basically just talks at you; one doesn't listen to anything that you have to say or what you're going through. Or you sometimes feel that people can make judgments about you before they actually know what's going on with you. So I try to incorporate a lot of that into my practice as well, so trying not to make judgments about people; understanding that we all deal with things differently; understanding that people's perception of pain and what they're going through it's different for every single person. We have to remember this. Just because one patient deals with it in one way and another patient deals with it in a completely different way, it doesn't mean that either way is right or wrong. It's their disease, their pain, their problem. We're all different.	<i>Reflecting on personal experience of care</i> <i>Seeing care from patients perspective</i> <i>Appreciating feeling heard</i> <i>Listening to patients</i> <i>Talking at patient</i> <i>Not listening</i> <i>Hearing patients experience</i> <i>Making quick judgements</i> <i>Putting own experience into practice</i> <i>Being non-judgemental</i> <i>Understanding individual differences</i> <i>Individuating experience of pain</i> <i>Understanding individual differences</i> <i>Emphasising individual patient differences</i> <i>Adapting care to the individual</i> <i>Not judging reactions as right or wrong</i> <i>Recognising individual differences</i> <i>Emphasising individual humanity of patients and nurses (we're all different)</i>

Appendix H: Excerpts from the reflexive diary

16th June 2014

I did my first participant interview today and found it fascinating. I felt myself both there talking to them and found my self reflecting as a researcher, almost imagining their quotes in an analytic write-up and wondering what it might say next to them.

I found myself oscillating between the here and now of 'being with' and attending to them encouragingly and imagining myself as an external observer trying to ensure I captured the essence of what she was saying. The benefit of my awareness of the audio recorder was that I became acutely aware of when the participant hadn't really answered the question. I noticed that the participant [p1] was often saying things like "you know" and "so obviously". It felt like she was relating to me as a peer and as such assuming that I knew a lot of the information she was giving me. I worked quite hard to make sure that I reframed the question when this happened and tried to portray myself from very curious stance when this happened. But often times there was a sense that we both knew what she was trying to say but I had to remove myself from holding such an expert stance. This feels like the downside of holding a trust staff ID badge that unfortunately I have to wear as a researcher.

I also found myself wanting to step into the therapist role in the interview. The nurse spent a great deal of time wanting to speak about the struggles she faced in her role, how burnt out she felt and her regrets about having a nurse due to how the role has evolved in recent times. It was hard not to explore this struggle in more detail. The pull to being therapist is something I inevitably will need to be aware of in the upcoming interviews.

9th February 2015

I have started analysis but am finding it a real challenge. Having not used qualitative methodology before it feels incredibly overwhelming and as such I feel stuck a lot of the time. I've noticed that my desire to "get it right" keeps resurfacing despite reminding myself that the research process is incredibly personal and such as long as I follow the guidance there's no real right or wrong way to analyse the texts. I've found the most effective method is to do quick coding and then revisit it the next day and see if it makes sense and whether I still agree with the codes. Often I do which has given me confidence that I appear to be being consistent. Using excel to code has definitely helped but I am surprised at the extent to which I have felt paralysed by the analytic process not feeling like I know how to start or continue. I have found myself particularly with the first interview saying to myself, that sounds like x or y in relation to psychological theory. I have been memo-ing along to capture my thoughts and try to bracket them so that I can return to the data unencumbered.

28th May 2015

I have finally finished analysing! I am trying to construct the main categories and the core category and have found that my data is vast! Although it has taken along time to organise the categories through sorting the process has felt worth it because there feels like a clear way that the data needs to be organised. It's hard though as there are some sub categories, which aren't very saturated but do still feel important, so I have to bracket this and just make sure, I return to the data and sort based on what is most present.

I have found myself on a few occasions thinking about my friend Ken and wondering whether he shared the experiences described by the participants. Some of the care described by the participants sounds so loving and tender and it made me feel quite sad somehow. I hope that he, my family and I are lucky enough to receive care like that which I am starting to gain insight into.

Appendix I: London City and East NHS Health Research Committee Application

NHS REC Form

Reference:
14/LO/0162

IRAS Version 3.5

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Compassion and the NHS: The Role of a Compassionate Nurse

1. Is your project research?

☒ Yes ☐ No

2. Select one category from the list below:

- ☐ Clinical trial of an investigational medicinal product
- ☐ Clinical investigation or other study of a medical device
- ☐ Combined trial of an investigational medicinal product and an investigational medical device
- ☐ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
- ☐ Basic science study involving procedures with human participants
- ☒ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
- ☐ Study involving qualitative methods only
- ☐ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
- ☐ Study limited to working with data (specific project only)
- ☐ Research tissue bank
- ☐ Research database

If your work does not fit any of these categories, select the option below:

☐ Other study

2a. Please answer the following question(s):

- a) Does the study involve the use of any ionising radiation? ☐ Yes ☒ No
- b) Will you be taking new human tissue samples (or other human biological samples)? ☐ Yes ☒ No
- c) Will you be using existing human tissue samples (or other human biological samples)? ☐ Yes ☒ No

3. In which countries of the UK will the research sites be located?(Tick all that apply)

- ☒ England
- ☐ Scotland
- ☐ Wales
- ☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

Date: 14/01/2014

1

139139/548409/1/695

- ☒ England
☐ Scotland
☐ Wales
☐ Northern Ireland
☐ This study does not involve the NHS

4. Which review bodies are you applying to?

- ☒ NHS/HSC Research and Development offices
☐ Social Care Research Ethics Committee
☒ Research Ethics Committee
☐ National Information Governance Board for Health and Social Care (NIGB)
☐ National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

- ☒ Yes ☐ No

5a. Are all the research costs and infrastructure costs for this study provided by an NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC) or NIHR Research Centre for Patient Safety & Service Quality in all study sites?

- ☐ Yes ☒ No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) support and inclusion in the NIHR Clinical Research Network (CRN) Portfolio? Please see information button for further details.

- ☐ Yes ☒ No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) and you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form immediately after completing this project filter and before completing and submitting other applications.

6. Do you plan to include any participants who are children?

- ☐ Yes ☒ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

- ☐ Yes ☒ No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

☐ Yes ☒ No

9. Is the study or any part of it being undertaken as an educational project?

☒ Yes ☐ No

Please describe briefly the involvement of the student(s):

This study is my Doctoral Research for completion of the DPsych Counselling Psychology program at City University London. I am the Chief Investigator.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

☒ Yes ☐ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

☐ Yes ☒ No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

☐ Yes ☒ No

Integrated Research Application System**Application Form for Research administering questionnaires/interviews for quantitative analysis or mixed methodology study****Application to NHS/HSC Research Ethics Committee**

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting [Help](#).

Please define any terms or acronyms that might not be familiar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Compassion and the NHS: The Role of a Compassionate Nurse

Please complete these details after you have booked the REC application for review.

REC Name:
London – City and East Ethics Committee

REC Reference Number:
14/LO/0162

Submission date:
14/01/2014

PART A: Core study information**1. ADMINISTRATIVE DETAILS****A1. Full title of the research:**

Compassion and the NHS: The Role of a Compassionate Nurse

A2-1. Educational projects

Name and contact details of student(s):

Student 1

Title	Forename/Initials	Surname
Ms	Emma	Hollywell

Address

Post Code

E-mail

Telephone

Fax

Date: 14/01/2014

4

139139/548409/1/695

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
Professional Doctorate in Counselling Psychology(DPsych)

Name of educational establishment:
City University London

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title	Forename/Initials	Surname
	Dr	Don	Rawson
Address	Social Sciences Building, City University London		
	Whiskin Street		
	London		
Post Code	EC1V 0HB		
E-mail	[REDACTED]		
Telephone	02070408500		
Fax			

Please state which academic supervisor(s) has responsibility for which student(s):

Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Ms Emma Hollywell	☒ Dr Don Rawson

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

- ☒ Student
☐ Academic supervisor
☐ Other

A3-1. Chief Investigator:

	Title	Forename/Initials	Surname
	Ms	Emma	Hollywell
Post	Doctoral Student		
Qualifications	Studying for DPsych Counselling Psychology, City University London Graduate Certificate in Counselling Psychology, City University London BSc Psychology honours degree, Southampton University		
Employer	City University London		
Work Address	Northampton Square London		

Post Code EC1V 0HB

Work E-mail

* Personal E-mail

Work Telephone

* Personal Telephone/Mobile

Fax

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*

A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and R&D reviewers that is sent to the CI.

Title Forename/Initials Surname

Address

Post Code

E-mail

Telephone

Fax

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available): 13/0613

Sponsor's/protocol number:

Protocol Version:

Protocol Date:

Funder's reference number:

Project website:

Additional reference number(s):

Ref. Number	Description	Reference Number
-------------	-------------	------------------

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

☐ Yes ☒ No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of

specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, this summary will be published on the website of the National Research Ethics Service following the ethical review.

Following high profile failings of Stafford Hospital in providing quality care to patients the NHS has identified that some nurses lack fundamental attitudes to care (Care Quality Commission, 2012). Robert Francis QC stated that it was "a story of appalling and unnecessary suffering of hundreds of people" (2013, February 7). These controversial findings have led the wide scale debates within the NHS about how to address these issues.

Despite strong emphasis on compassion by the Prime Ministers Commission on the Future of Nursing and Midwifery in England, a clear definition of compassionate care in the context of nursing care is not stipulated, leaving what constitutes this somewhat ambiguous and open to interpretation. It is therefore, unclear how the NHS will assess their success in delivering compassionate care in future. This research is in response to the request by NHS England (2012) to "develop measures of care to help us learn, improve and highlight the positive impact on the people we care for" and aims to operationalize the concept of compassion in healthcare achieved through a quantitative research study. The first part of the research gathers views on what constitutes compassionate nursing by interviewing up to 30 individuals for approximately 30 minutes who are either nurses or patients within various Hospital departments. This along with research from existing literature about compassion will be developed into a measure that identifies the behaviours of a compassionate nurse. This measure will be validated by surveying a minimum of 250 nurses and 250 patients within

It is hoped that findings from this research may influence evidence based practice within the NHS and guide the development of interventions to promote compassion within healthcare, helping to ensure frontline staff receive the guidance and support they need to achieve these aims.

A6-2. Summary of main issues. Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

Ethical

Consent

All participants in this research will be adults, and those wanting to take part in this research will be required to be able to give their own informed consent. For the first part of the study they will first be given a detailed Participant Information Sheet. If they wish to participate in the study they will be required to sign a consent form which confirms they have read and understood what the research involves and that their participation is voluntary and they can withdraw at any time. As a trainee counselling psychologist I am familiar with the test of capacity and will ensure participants appear able to understand, retain, use and weigh up the information, and decide whether to participate. Once I have received their consent, I will confirm they are suitable participants (in accordance with my original exclusion and inclusion criteria) and arrange the interview. For the second part of the study there will be detailed Participant Information Sheet, the participants will have to check a box on the form either electronically (if completing the questionnaire online) or sign on paper a consent form that confirms that by answering the questions, they are giving their consent to take part in the research. This research will comply with the Code of Human Research Ethics as outlined by the BPS (2010).

Risks, burdens and benefits

In the interview phase of research participants will be asked various questions relating to their perceptions of what constitutes compassionate and conversely un-compassionate care in relation to the role of a nurse. It is unlikely but questions may cause distress to participants, particularly if they have had a particularly negative experience of care. Distress will be managed by ensuring participants understand they do not need to disclose anything they feel uncomfortable with and ensuring they understand they can stop the interview or questionnaire at any time. In addition the researcher is a Trainee Counselling Psychologist and therefore, has skills in the recognition and management symptoms of distress. All interview participants will have the option to debrief with the researcher for between 5 and 10 minutes.

All participants in both phases of research (interview and questionnaire) will be provided with a debriefing sheet which

includes information about various services and organisations that could help to offer them further support and or advice. Please note there are two information sheets which are individually tailored with information for nurses separately to patients, in recognition of their differing needs and the differing sources of support available to them.

The benefits for participants taking part include the opportunity to share their opinions and experiences on care within the NHS (both in interview and in questionnaire) which is a very topical issue at present, and therefore indirectly an opportunity to help improve care. Within interview participation the participant will benefit from the researchers time as she will spend time with the participant in an engaged manner, listen and demonstrate that she is interested in their thoughts and opinions.

Inconvenience of the research will be managed by having short interviews (approximately 20 minutes) and a short questionnaire (approximately 15 minutes). The researcher will be flexible and make themselves available based on the time the participant has available. Participants will be made aware on numerous occasions that they are entitled to withdraw from the research with no consequences to their care or employment. This will be particularly pertinent for staff members participants who are under time pressures due to the nature of their work and for patient participants who are tired and or feeling physically unwell during the course of the interview or completing the questionnaire.

Legal

Confidentiality

In terms of this research it is considered unlikely that any issue requiring consideration of limiting confidentiality would arise, however the principles of the British Psychological Society (BPS) (and legal and professional obligations generally) will be adhered to. The BPS (2010) guidelines are there to address the exceptional cases where there appears sufficient evidence to raise serious concerns about (a) the safety of the participant; (b) the safety of other persons who may be endangered by the client's behaviour; or (c) the health, welfare or safety of children or vulnerable adults.

Participants will be fully informed about the bounds and limits of confidentiality. The researcher will explain that all information will remain confidential and for the purpose of the research only. Participants who take part in the first part of the research (the interviews) will be made aware that the interviews will be recorded and this material will be stored in a secure environment. Transcriptions from the interviews will have any identifiable information removed or changed to protect the participant's anonymity. Participant information will be held under ethical and legal obligations of confidentiality and only basic demographic such as gender and age will be collected. Where participants have provided their email addresses because they have requested to receive the results of the study, these will be stored separately from the signed consent forms and removed from the questionnaire results data set. Participants for part one of the research, will be told that supervisors of the research will look at the anonymised transcriptions.

All participants' right to withdraw from the research will be emphasised as independent to their right to treatment, their treatment experience or their access to their chosen treatment. For nurses participating they will also as above be advised of the confidentiality of the research. The benefit of the research is that it may contribute towards positive changes in culture or care in the NHS which could benefit all participants as future patients as well as friends and family who access the healthcare service in future.

[redacted] d by experienced supervisors, both within City University and the [redacted] and [redacted] Research on site will be overseen by Nicola Gale (Lead Clinician for the [redacted] who is highly experienced in working with staff and organisational issues within the NHS. [redacted] exists to provide support with staff facing difficult issues in both their personal and professional lives and therefore, Nicola Gale is well placed to supervise this project and provide guidance on ethical issues that could potentially arise from disclosures from staff about matters relating to the professional practice of themselves and others during part one of the research.

Whistleblowing and Potential Disclosures regarding issues such as Poor Clinical Practice, Mistakes, Incompetence, Safeguarding and Risk

It is unlikely that any criminal disclosures will occur during the interview process in the first phase of the research. However, it is possible that during the course of the interviews an allegation may be made against an NHS staff member from a patients or another staff member. It is also possible that a member of staff may make a disclosure about themselves or their conduct which may require a breach of confidentiality, or that of another staff member or the organisation. All participants will be made aware prior to the commencement of the interview, of the limitations of confidentiality, verbally and via the participant information sheet. Confidentiality in accordance with the BPS (2010) guidelines will only be breached in exceptional cases where there appears sufficient evidence to raise serious concerns about (a) the safety of the participant; (b) the safety of other persons who may be endangered by the participant's behaviour; or (c) the health, welfare or safety of children or vulnerable adults; or in response to legal obligations.

In the unlikely event that disclosure occurs which requires a breach in confidentiality or further action e.g. re

safeguarding, the researcher will seek the support and supervision of the field supervisor Ms Nicola Gale who is the [REDACTED] an HCPC Registered Psychologist, and experienced manager. The [REDACTED] is a service that is equipped to deal with legal issues, welfare and support needs arising for staff within the NHS, and is experienced in handling such matters. The staff of the service includes a legally qualified adviser and as a whole the service is well versed in the policies of the [REDACTED] Trust which cover for example safeguarding for children, vulnerable adults, how to raise a concern / whistleblowing. As appropriate the researcher would inform the participant concerned directly of their concern and how appropriate advice would be obtained.

If a participant has a concern that they do not raise within the interview they will be able to refer to the debriefing information which includes information for patients and staff that can provide information and support with such concerns or allegations. These include (for patients) contact details for the local PALS services, NHS choices, and (for staff) staff whistle-blowing policies, trade unions and [REDACTED] contact information.

Management

Development of the Research Proposal and Design

The research idea for this proposal developed following the researchers experience assisting the facilitation of a support group for a staff group of nurses within the [REDACTED] trust. These nurses worked within a department which can be stressful due to the demanding and highly skilled critical nature of the work. Work with this group gave the researcher informal feedback about the demands that nurses face and how they manage to care for patients and family members when there are difficult issues present such as staff shortages, patient deaths, challenging patient behaviour, newly qualified staff and issues within their own personal life causing them stress. It was clear that there was generally a strong desire from nurses to provide high quality, compassionate care whilst acknowledging that these everyday difficulties such as those described above often makes this more difficult. Work with this client group along with the researcher's own interests in the field of compassion based psychological therapy (Gilbert, 2009) and in light of recent findings within the NHS such as the Francis Report (Francis QC, 2013) led to the following development of the research purpose.

Compassion as a concept is discussed in nursing publications largely in relation to compassion fatigue (e.g. Sabo, 2006; Maytum et al., 2004; and Meadors & Lamson, 2008). It is suggested that compassion fatigue occurs when, among other things, the burden of caring for suffering patients leads to stressors which can cause burnout and distress among healthcare professionals (Figley, 2002). Badger (2001) suggests that due to their frequent encounters with death and tragedy, nurses are exposed to stressful situations which demand extraordinary coping mechanisms, and therefore, are also at risk of secondary traumatisation. Schantz (2007) further refines the concept and states that compassion in nursing goes beyond caring, sympathy and empathy as "only compassion impels and empowers people to not only acknowledge, but also act toward alleviating or removing another's suffering or pain" (Schantz, 2007, pp.51). Schantz argues that despite compassion being one of nursing's most valuable assets it is often seen as optional and even an idealistic notion. Following the Mid Staffordshire NHS Trust inquiry's findings which highlighted failings which led to the deaths of between 400-1,200 patients between 2005-2009 wide ranging reforms within the NHS were recommended by the Francis Report. The Prime Minister's Commission on the Future of Nursing and Midwifery in England placed a strong emphasis on compassion. However, a clear definition of compassionate care in the context of nursing care is not stipulated, leaving what constitutes this somewhat ambiguous and open to interpretation. It is therefore, unclear how the NHS will assess their success in delivering compassionate care in future.

There is an apparent tension between the intrinsic desire of compassion to be sensitive to the suffering of patients as stated by Schantz (2007) and the compassion fatigue that can occur due to the stress caused by the burden of caring for suffering patients as outlined by Figley, (2002). It is possible that without the personal and professional resources to manage emotions that arise when acknowledging the suffering of others nurses may engage in uncompassionate care as a way to defend against experiencing overwhelming distress at the suffering of others.

Therefore, it is clear the development of a conceptualisation of compassion in healthcare is necessary to improve the deficits of care that have been identified in recent reports. Commentators such as the Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser (2012) have emphasised the importance of implementing policy to ensure patient centred compassionate care is at the top of the agenda for the training and on-going professional development of nurses in the NHS. Therefore, in order for the professional development needs of nurses in relation to compassion to be fairly and accurately identified, the NHS needs to qualify its terms. This would empower nurses to understand and meet organisational expectations of compassionate care. In addition it would facilitate a way in which exceptional compassionate care could begin to be recognised and praised. In addition, an applied operationalized definition of compassion in healthcare may also provide a method to appraise the implementation of interventions to address deficits in compassionate care.

In summary this research is in response to the request for the development of "measures of care to help us learn, improve and highlight the positive impact on the people we care for" (NHS England, 2012). It aims to operationalize the concept of compassion in healthcare using quantitative research to develop a measure that identifies the role of a

compassionate nurse. It is hoped that the findings of this research may contribute toward a body of evidence to support the NHS' determination to deliver its pledge for "high quality compassionate care" (COI, 2010 pp.3) and provide further guidance policy makers to influence evidence based policy and practice within the NHS.

The research has the support of senior nurse leadership [REDACTED] in Trust, and of the Trust's Staff [REDACTED]

Educational Purpose

As a Trainee Counselling Psychologist on a postgraduate doctoral training programme, it is a course requirement to undertake an individual piece of empirical research on a topic relevant to the field of Counselling Psychology. It is the trainee's responsibility to conduct, write up and submit an original piece of research which builds on existing knowledge. The research must include both data collection and analysis, which can either be quantitative, qualitative or mixed methods. While this is very much the trainee's own work, the research will be supervised throughout for additional guidance and support.

Participant distress

In the interview phase of research participants will be asked various questions relating to their perceptions of what constitutes compassionate and conversely un-compassionate care in relation to the role of a nurse. It is unlikely but questions may cause distress to participants, particularly if they have had a particularly negative experience of care. Distress will be managed by ensuring participants understand they do not need to disclose anything they feel uncomfortable with and ensuring they understand they can stop the interview or questionnaire at any time. In addition the researcher is a Trainee Counselling Psychologist and therefore, has skills in the recognition and management symptoms of distress. All interview participants will have the option to debrief with the researcher for between 5 and 10 minutes.

All participants in both phases of research (interview and questionnaire) will be provided with a debriefing sheet which includes information about various services and organisations that could help to offer them further support and advice. Please note there are two information sheets which are individually tailored with information for nurses separately to patients, in recognition of their differing needs and the differing sources of support available to them.

The benefits for participants taking part include the opportunity to share their opinions and experiences on care within the NHS (both in interview and in questionnaire) which is a very topical issue at present, and therefore indirectly an opportunity to help improve care. Within interview participation the participant will benefit from the researcher's time as she will spend time with the participant in an engaged manner, listen and demonstrate that she is interested in their thoughts and opinions.

Inclusion / exclusion

Employment as a nurse or recent experience of being a patient within the NHS is required for participation in the study. In addition, sufficient command of English language, age of 18 or above and ability to give informed consent are all necessary inclusion criteria. (Please note this study does not exclude speakers of English as a second language as long as they have this ability to articulate their perceptions.) It is pertinent to note here that the researcher was previously on clinical placement with [REDACTED] as a Trainee Counselling Psychologist in the [REDACTED] and [REDACTED] and therefore, to avoid role conflict no staff member who has been a therapeutic client of the researcher will be a participant in this research. Issues arising from this change in role are explored below.

Multiple roles

The researcher (chief investigator) has been on clinical placement within the [REDACTED] Trainee Counselling Psychologist from 2012-2013 in the [REDACTED]. This means that there will be members of nursing staff within the Trust that she has had prior contact with in a professional context. Due to the interests of confidentiality and the inappropriateness of stepping into multiple roles, which could lead to a conflict of interest, past therapeutic clients of the researcher will not be permitted to take part in the research. The researcher will be clear that she is not working in her capacity as a therapist but as a researcher. The researcher will use research field supervision to explore any issues that arise from adopting this new role and will be conscious of not stepping into a Counselling Psychologist role when interviewing participants. This will mean that the researcher will have to put aside any interactional habits that are strongly associated with exercising within a therapeutic capacity. Instead, the researcher will listen and demonstrate that she is thoroughly engaged in a sensitive way and then signpost the participant to the debriefing sheet which includes information about various services that could help to offer them further support and advice if required.

A6-3. Proportionate review of REC application *The initial project filter has identified that your study may be suitable for proportionate review by a REC sub-committee. Please consult the current guidance notes from NRES and indicate whether you wish to apply through the proportionate review service or, taking into account your answer to A6-2, you consider there are ethical issues that require consideration at a full REC meeting.*

☐ Yes - proportionate review ☒ No - review by full REC meeting

Further comments (optional):

Note: This question only applies to the REC application.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. Please tick all that apply:

- ☐ Case series/ case note review
- ☐ Case control
- ☐ Cohort observation
- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☐ Qualitative research
- ☒ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

A10. What is the principal research question/objective? Please put this in language comprehensible to a lay person.

To explore what NHS patients and nurses think the role of a compassion nurse is in practical terms thus operationalizing the term role of a compassionate nurse and creating a validated questionnaire which aims to look at the construct of compassion in a health care setting.

A11. What are the secondary research questions/objectives if applicable? Please put this in language comprehensible to a lay person.

To analyse whether there is a quantifiable difference in what nurse and patients rate are important factors related to compassionate health care. A final exploratory research objective is to increase understanding of Compassion in a health care setting and theoretically explore if a Compassion Focused Therapy intervention could help support staff in the NHS give compassionate care to their patients.

A12. What is the scientific justification for the research? Please put this in language comprehensible to a lay person.

Educational Purpose

As a trainee Counselling Psychologist, it is a requirement to undertake an individual piece of empirical research on a topic relevant to the field of Counselling Psychology. It is the trainee's responsibility to conduct, write-up and submit an original piece of research which builds on existing knowledge. The research must include both data collection and analysis, which can either be quantitative, qualitative or mixed methods. While this is very much the trainees own work, the research will be supervised throughout for additional guidance and support.

Research Purpose

Compassion as a concept is discussed in nursing publications largely in relation to compassion fatigue (e.g. Sabo, 2006; Maytum et al., 2004; and Meadors & Lamson, 2008). It is suggested that compassion fatigue occurs when, among other things, the burden of caring for suffering patients leads to stressors which can cause burnout and distress among healthcare professionals (Figley, 2002). Badger (2001) suggests that due to their frequent encounters with death and tragedy, nurses are exposed to stressful situations which demand extraordinary coping mechanisms, and therefore, are also at risk of secondary traumatisation. Schantz (2007) further refines the concept and states that

compassion in nursing goes beyond caring, sympathy and empathy as "only compassion impels and empowers people to not only acknowledge, but also act toward alleviating or removing another's suffering or pain" (Schantz, 2007, pp.51). Schantz argues that despite compassion being one of nursing's most valuable assets it is often seen as optional and even an idealistic notion. Following the Mid Staffordshire NHS Trust inquiry's controversial findings which highlighted failings which led to the deaths of between 400-1,200 deaths between 2005-2009 wide ranging reforms within the NHS were recommended by the Francis Report. The Prime Minister's Commission on the Future of Nursing and Midwifery in England has placed a strong emphasis on compassion, yet a clear definition of compassionate care in the context of nursing care is not stipulated. This has left what this constitutes somewhat ambiguous and open to interpretation, therefore, it is unclear how the NHS will assess their success in delivering compassionate care in future.

There is an apparent tension between the intrinsic desire of compassion to be sensitive to the suffering of patients as stated by Schantz (2007) and the compassion fatigue that can occur due to the stress caused by the burden of caring for suffering patients as outlined by Figley, (2002). It is possible that without the personal and professional resources to manage emotions that arise when acknowledging the suffering of others nurses may engage in dispassionate care as a way to defend against experiencing overwhelming distress at the suffering of others.

It is clear the development of a conceptualisation of compassion in healthcare is necessary to improve the deficits of care that have been identified in recent reports. Commentators have emphasised the importance of implementing policy to ensure patient centred compassionate care is at the top of the agenda for the training and on-going professional development of nurses in the NHS. Therefore, in order for the professional development needs of nurses in relation to compassion to be fairly and accurately identified, the NHS needs to define its terms. This would empower nurses to understand and meet organisational expectations of compassionate care facilitating a way in which exceptional compassionate care could begin to be recognised and praised. In addition, an applied operationalized definition of compassion in healthcare may also provide a method to appraise the implementation of interventions to address deficits in compassionate care.

This research is in response to the request for the development of "measures of care to help us learn, improve and highlight the positive impact on the people we care for" (NHS England, 2012 pp.6). It aims to operationalize the concept of compassion in healthcare using quantitative research to develop a measure that identifies the role of a compassionate nurse. It is hoped that the findings of this research may contribute toward a body of evidence to support the NHS' determination to deliver its pledge for "high quality compassionate care" (COI, 2010 pp.3) and provide further guidance policy makers to influence evidence based policy and practice within the NHS.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

Research Objectives

The main objective of the research is to explore what NHS patients and nurses think the role of a compassionate nurse is, in practical terms, and operationalizing the role in a validated questionnaire. Secondary research objectives are to analyse whether there is a quantifiable difference in what nurses and patients rate are important factors related to a compassionate nurse's role. A final exploratory research objective is to increase the understanding of compassion within a health care setting to underpin a theoretical exploration of what help could be offered to support staff in the NHS give compassionate care to their patients.

Rationale for Design and Methodology

As a Trainee Counselling Psychologist I work within a pluralistic paradigm which recognises that in a research context "divergent research methodologies can be equally valid in exploring important questions" (McAteer, 2010, in Milton, 2010, p. 8). Analysis of material gathered from interviews with patients and nursing staff about their views on compassionate care will inform a quantitative investigation into the role of the compassionate nurse. This combined approach was chosen as it is hoped it will lead to a better understanding of the research problem (Creswell & Clark, 2007). This research is from a quantitative methodological perspective as my main objective is to operationalise the role of a compassionate nurse into a validated measure. It is hoped this research will provide a focus and direction for future research in this area.

Data Collection Stage One - Interviews

The first stage of the research aims to gather information that will be used to create items for a questionnaire about the role of a compassionate nurse. Some existing literature, such as the work of key philosophers, theorists or historical

figures associated with compassion, will be used to generate items for the questionnaire. The majority of questionnaire items will however, be generated through the data collected from short interviews with nurses and patients within [REDACTED]

Recruitment will take place in two stages for the two parts of the research. The first part of the research is a series of short interviews with nurses and patients. The second part of the research is the completion of questionnaires by nurses and patients. I will outline the plan for these phases of research separately below.

Interviews with nurses

The researcher will visit a nurse team manager's meeting and explain what the study entails. Nurse Managers (matrons, ward sisters / charge nurses) will be given information about the study to give to their staff as well as contact details of the researcher. Where appropriate the researcher will also attend nurse team meetings to explain to staff what the study entails. The researcher will provide the managers and staff with the inclusion criteria and a Participant Information Sheet so that they are aware of what participation will involve. Those who are interested will be able to contact the researcher directly. In addition the researcher will make themselves available, in the Outpatients' Department, inpatient wards, and also at the trust occupational health clinic, where she will be available to hand out leaflets to potential participants and carry out interviews on site if convenient for participants. Those who make contact with the researcher via telephone/email will be asked if they require any further information about the study, which will be provided. If they are happy to continue, they will be invited to attend an interview. During this interview, the researcher will confirm that the individual still wishes to take part. All participants will then be required to sign a consent form. The researcher will inform the managers as soon as the required number of participants has been recruited so no more nurses are asked to take part in the first stage, and give them information about how nurses can take part in the second part of the research.

Interviews with patients

The researcher will visit pre agreed inpatient wards and the Outpatients' Department with leaflets about the research project and give potential participants information about the study. Patients who are interested in taking part will be given Participant Information Sheet so that they are aware of what participation will involve. Those who make contact with the researcher via telephone/email having seen posters or other information e.g. leaflets advertising the study will be asked if they require any further information about the study, which will be provided where needed. If they are happy to continue, they will be invited to attend an interview. During the interview, the researcher will confirm that the individual still wishes to take part. All participants will then be required to sign a consent form. If the participant wants to participate in the study at a later date this will be agreed upon with the researcher to take place within the hospital site at a time convenient to the patient. If a patient contacts the researcher after the interviews have been fully recruited they will be given information about how to take part in the second phase of the research.

Once a participant (nurse or patient) has said they would like to take part in the research they will be given an information sheet (if they do not already have one) and a consent form. They will be asked to read the information sheet and give their consent to participate in the research. This will take approximately 5 minutes. The participant will then be asked a series of questions during a semi-structured interview with the researcher. Interviews will take place on site in the Trust. For NHS staff this will take place in a quiet side room or within a room at the [REDACTED] and [REDACTED]. For patients interviews will take place at the bed side or in patient appropriate quiet areas such as family rooms or in the Outpatients' Department, a spare clinic room or other suitable location to be determined with the management of outpatients. This will take approximately 20 minutes.

Participants will then be given debriefing information and the opportunity to debrief about the interview with the researcher if they would like. This will take approximately 10 minutes. They will then be given the opportunity to give the researcher their email address if they want to receive the results of the study which will take approximately 2 minutes.

Stage 2 - Interim Analysis: Creating the role of a compassionate nurse questionnaire*

*Please note this phase of research will be carried out solely within City University London, using a participant pool of University students. Ethical approval is not sought for this phase of this research which has been approved by City University London.

The information gathered from interviews will form the development of a questionnaire similar to the format of the Cohen teacher role definition instrument (Finlayson & Cohen, 1967). Qualitative data collected from participants will be used to identify constructs prior to the deductive testing of the compassionate nurse role under investigation. It is hoped that the diversity of participants and nurses (from various departments) will allow for more comprehensive robust information to be collected.

To achieve this, interview data will be analysed using a basic thematic analysis which will inform the creation of 160 questionnaire items. In the main these will take the format of statements which will address the three aspects of role

as suggested by Fleming (1958). These are as follows: organisation; general aims; motivation and behaviour. In order to minimise researcher bias the researcher will attempt to bracket any assumptions about the data during analysis and keep a reflexivity journal which will be used to reflect on emergent patterns, themes and concepts. Throughout the coding process the researcher will keep detailed records which demonstrate the development of each of the codes and potential themes from the data.

To reduce the number of items, to create the final questionnaire between 11-31 university student participants will be asked individually to select 25 of the 160 statements that they think best define the compassionate nursing role. By obtaining their core agreement, identifying outliers will be identified with the use of the semi-inter quartile range. The items with core agreement will be produced on a hybrid of a Likert-Thurstone scale.

Stage 3 - Questionnaire validation

For the next stage of the research large numbers of participants are required and therefore, a different approach to recruitment will take place. There will be posters advertising the study and leaflets placed around the hospital and wards for the attention of patients. Staff will be made aware of the questionnaire via an advertisement on the trust intranet and if permitted an email sent to staff nursing groups. In addition nurse managers will also be provided questionnaire details to pass on to their nursing staff. Finally, the researcher will also be present in outpatient and inpatient departments to ask patients to complete the survey. If they are interested in taking part once they have read the information sheet, their options for completion will include: immediately on paper, immediately online on the researchers tablet device, at a time of their convenience on paper with a paid for envelope to post the questionnaire to the researcher or to be given a paper link to the access the website link to complete the questionnaire remotely.

Once a participant (nurse or patient) has said they would like to take part in the research they will be given an information sheet (if they do not already have one) and a consent form which they will be asked to sign if they are completing a paper questionnaire or if completing the questionnaire online tick a box to confirm they have read the information. This will confirm that they have given their consent to participate in the research. This will take approximately 5 minutes. The participant will then be asked to complete the questionnaire (either on paper or online) this will take approximately 15 minutes to complete. Participants will then be given debriefing information and the opportunity to give the researcher their email address if they want to receive the results of the study this will take approximately 2 minutes. On the online questionnaire debriefing information will automatically appear once the participant has completed the questionnaire. If a participant is completing the questionnaire of paper remotely they will then need to post the questionnaire using the paid for addressed envelope provided by the researcher. Debriefing information will also be provided within the envelope provided.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

- ☐ Design of the research
- ☐ Management of the research
- ☒ Undertaking the research
- ☐ Analysis of results
- ☐ Dissemination of findings
- ☐ None of the above

Give details of involvement, or if none please justify the absence of involvement.

The research participants will contribute their ideas as it is their perception of the role of the compassionate nurse which will contribute to the development of the The Role of a Compassionate Nurse questionnaire.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

Aged 18 or above
Sufficient command of the English language both verbal and written.
Ability to give informed consent
Capable to participate in a structured interview and/or complete a questionnaire on paper or online for approximately

20 minutes.

Current employment as a Nurse in the NHS or present or recent patient (within the past 3 months) of the NHS.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Non-English speaking participants (This measure is only being validated in the English language).

Participants under the age of 18.

The participant is not a past or present patient or client of the Chief Investigators in their role as Trainee Counselling Psychologist.

The participant must not be actively distressed.

The participant must not be deemed inappropriate or unsuitable to participate by ward staff for ethical reasons such as heavy medication, distress or cognitive capacity.

RESEARCH PROCEDURES, RISKS AND BENEFITS**A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. These include seeking consent, interviews, non-clinical observations and use of questionnaires.**

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Part 1: Researcher to seek consent from interview participant	1	0	5 mins	Emma Hollywe [REDACTED]
Researcher to conduct individual interviews with participants.	1	0	20 mins	Emma Hollywe [REDACTED]
Researcher to debrief to participants following interview.	1	0	5 mins	Emma Hollywe [REDACTED]
Part 2: Researcher to seek consent from questionnaire participant	1	0	5 mins	Emma Hollywe [REDACTED] Or the participant will complete this remotely either on paper or electronically.
Completion of questionnaire	1	0	15 mins	Emma Hollywe [REDACTED] Or the participant will complete this remotely either on paper or electronically.

A21. How long do you expect each participant to be in the study in total?

Stage One participants completing interviews approximately 30 - 40 minutes.

Stage Two participants completing questionnaires approximately 20 minutes.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

Distress:- There is a possibility that participants might become distressed or upset during the interview stage.

Fear: - Of the implications of the individual's opinions. For patients this might be that participation or choosing not to participate may affect their care. For staff this may be that their opinions may become known to their team or manager.

Inconvenience:- The time it takes to participate in the research.

Rejection: - If a participant shows an interest in taking part, after recruitment has ended and they are not selected, they may feel rejected.

Please see below for the steps that will be taken to minimise risks and burdens:

Distress

In the interview phase of research participants will be asked various questions relating to their perceptions of what constitutes compassionate and conversely un-compassionate care in relation to the role of a nurse. It is unlikely but questions may cause distress to participants, particularly if they have had a particularly negative experience of care. Distress will be managed by ensuring participants understand they do not need to disclose anything they feel uncomfortable with and ensuring they understand they can stop the interview or questionnaire at any time. In addition the researcher is a Trainee Counselling Psychologist and therefore, has skills in the recognition and management symptoms of distress. All interview participants will have the option to debrief with the researcher for between 5 and 10 minutes.

All participants in both phases of research (interview and questionnaire) will be provided with a debriefing sheet which includes information about various services and organisations that could help to offer them further support and or advice. Please note there are two information sheets which are individually tailored with information for nurses separately to patients, in recognition of their differing needs and the differing sources of support available to them.

The benefits for participants taking part include the opportunity to share their opinions and experiences on care within the NHS (both in interview and in questionnaire) which is a very topical issue at present, and therefore indirectly an opportunity to help improve care. Within interview participation the participant will benefit from the researchers time as she will spend time with the participant in an engaged manner, listen and demonstrate that she is interested in their thoughts and opinions.

Fear

Fear will be minimised by explaining to participants that interviews will be confidential whilst explaining the bounds of confidentiality. In terms of this research it is considered unlikely that any issue requiring consideration of limiting confidentiality would arise, however the principles of the British Psychological Society (BPS) (and legal and professional obligations generally) will be adhered to. The BPS (2010) guidelines are there to address the exceptional cases where there appears sufficient evidence to raise serious concerns about (a) the safety of the participant; (b) the safety of other persons who may be endangered by the client's behaviour; or (c) the health, welfare or safety of children or vulnerable adults.

In addition the researcher will advise participants that participating in the research will not have an impact on their care or rights to care. All participants' right to withdraw from the research will be emphasised as independent to their right to treatment, their treatment experience or their access to their chosen treatment. For nurses participating they will also as above be advised of the confidentiality of the research. The benefit of the research is that it may contribute towards positive changes in culture or care in the NHS which could benefit all participants as future patients as well as friends and family who access the healthcare service in future.

Inconvenience

Inconvenience of the research will be managed by having short interviews (approximately 20 minutes) and a short questionnaire (approximately 15 minutes). The researcher will be flexible and make themselves available based on the time the participant has available. Participants will be made aware on numerous occasions that they are entitled to withdraw from the research with no consequences to their care or employment. This will be particularly pertinent for staff members participants who are under time pressures due to the nature of their work and for patient participants who are tired and or feeling physically unwell during the course of the interview or completing the questionnaire.

Rejection

To minimise individuals feelings of rejection if the research is fully subscribed the researcher will clearly outline in the participant information sheet that participants will be selected for the study on a 'first come, first served' basis and that a maximum of 30 people will be required for the interviews. The researcher will take down any advertising materials that relate the first and second part of the research as soon as sufficient data is collected. Any potential participants who contact the researcher after this time will be told that the study has now been completed and thanked for their interest. They will be given the opportunity to take part in the second part of the research if this part of the research is ongoing, as appropriate.

Support

The study is well supported by experienced supervisors, both within City University and the

Research will be overseen by Nicola Gale who is highly

experienced in working with staff and organisational issues within the NHS.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

☒ Yes ☐ No

If Yes, please give details of procedures in place to deal with these issues:

Sensitive, embarrassing or upsetting topics

There is a possibility that the content of the interview (regarding compassionate health care) may cause embarrassment for the participant or be a sensitive topic if they recount a personal experience in which they felt embarrassed by care they or another have received. For example, a participant could recount an experience of being examined or of needing personal care. It is possible that the interview could be upsetting for a participant if they have experienced inadequate care that led to a negative outcome for the participant or their close friend or family member.

The interview will be paced and adjusted so that participants feel heard and to help them thoughtfully consider what they want to disclose without pressure. Participants will be reminded that the interview is confidential, they can withdraw at any time and that they do not have to disclose something if they feel uncomfortable to do so. The researcher will use their skills to help manage the level of detail of the interview in line with what is required for the study so that the participant does not feel they have to divulge unnecessary details which could lead them to feel embarrassed or upset. All participants have the option to debrief with the researcher at the end of the interview. If debriefing is not sufficient to manage a participant's distress, the researcher will ensure that the participant can access support from other services where appropriate. All participants will be provided with a debriefing sheet.

The possibility of embarrassment for the participant will be taken into consideration to a greater extent if it is necessary for the researcher interviews participants in a more public area such as at the bedside or in a commonly used area. (Due to the participant's availability, mobility or request). In addition to the above adjustments such as speaking in a quieter or lower tone of voice, drawing the curtains around the bed and being mindful of the location of patients and staff on the ward may all be helpful in reducing embarrassment or distress if a participant recounts a difficult experience.

The researcher is a third year postgraduate trainee counselling psychologist and now experienced in handling these sort of matters. In addition, the researcher can access supervision from one of the qualified psychologists in the Staff Psychological and Welfare Service in the Trust.

Occurrence of criminal or other disclosures requiring action

It is unlikely that any criminal disclosures will occur during the interview process in the first phase of the research. However, it is possible that during the course of the interviews an allegation may be made against an NHS staff member from a patients or another staff member. It is also possible that a member of staff may make a disclosure about themselves or their conduct which may require a breach of confidentiality, or that of another staff member or the organisation. All participants will be made aware prior to the commencement of the interview, of the limitations of confidentiality, verbally and via the participant information sheet. Confidentiality in accordance with the BPS (2010) guidelines will only be breached in exceptional cases where there appears sufficient evidence to raise serious concerns about (a) the safety of the participant; (b) the safety of other persons who may be endangered by the participant's behaviour; or (c) the health, welfare or safety of children or vulnerable adults; or in response to legal obligations. In the unlikely event that disclosure occurs which requires a breach in confidentiality or further action e.g. re safeguarding, the researcher will seek the support and supervision of the field supervisor Ms Nicola Gale who is the Lead Clinician of the [redacted] an HCPC Registered Psychologist, and experienced manager. The [redacted] is a service that is equipped to deal with legal issues, welfare and support needs arising for staff within the NHS, and is experienced in handling such matters. The staff of the service includes a legally qualified adviser and as a whole the service is well versed in the policies of the [redacted] Trust which cover for example safeguarding for children, vulnerable adults, how to raise a concern / whistleblowing. As appropriate the researcher would inform the participant concerned directly of their concern and how appropriate advice would be obtained.

If a participant has a concern that they do not raise within the interview they will be able to refer to the debriefing information which includes information for patients and staff that can provide information and support with such concerns or allegations. These include (for patients) contact details for the local PALS services, NHS choices, and (for staff) staff whistle-blowing policies, trade unions and [redacted] contact information.

A24. What is the potential for benefit to research participants?

The benefits for participants taking part include the opportunity to share their opinions and experiences on care within the NHS (both in interview and in questionnaire) which is a very topical issue at present.

In the longer term the benefit of the research is that it may contribute towards positive changes in culture or care within the NHS which could benefit all participants as future patients as well as friends and family who access the healthcare service in future.

A26. What are the potential risks for the researchers themselves? (if any)

There is no risk (outside of the normal level of risk in all clinical work) of physical harm to the researcher. The research interviews and questionnaires will be carried out in an area accessible to other staff members such as a ward side room, by the bedside, a staff room or a clinical room at the [REDACTED]. The field supervisor will be informed of the location and time of each interview and site visit for questionnaire completions (although no identifying information about participants will be shared).

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used? *For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Recruitment

Recruitment will take place in two stages for the two parts of the research. All recruitment will take place on the [REDACTED] site. The first part of the research is a series of short interviews with nurses and patients. The second is the completion of a questionnaires by nurses and patients. I will outline the recruitment plan for these phases of research separately below.

Stage One

Interviews with nurse participants

The researcher will visit a nurse team manager's meeting and explain what the study entails. Nurse Managers (matrons, ward sisters / charge nurses) will be given information about the study to give to their staff as well as contact details of the researcher.

Where appropriate the researcher will also attend nurse team meetings to explain to staff what the study entails. The researcher will provide the managers and staff with advertisement leaflets and Participant Information Sheets so that they are aware of what participation will involve. Those who are interested will be able to contact the researcher directly. In addition the researcher will make themselves available, in the Outpatients' Department, inpatient wards, and also at the trust occupational health clinic, where she will be available to hand out leaflets to potential participants and carry out interviews on site if convenient for participants.

Those who make contact with the researcher via telephone/email will be asked if they require any further information about the study, which will be provided. If they are happy to continue, and they meet the inclusion/exclusion criteria, they will be invited to attend an interview. All participants will then be required to sign a consent form. The researcher will inform the nurse managers as soon as the required number of participants has been recruited so no more nurses are asked to take part in the first stage, and give them information about how nurses can take part in the second part of the research.

Interviews with patient participants

The researcher will visit pre agreed appropriate inpatient wards (these will be as agreed with [REDACTED] Head of Nursing at [REDACTED] is the senior nurse responsible for research in the Trust and the senior nursing 'sponsor' supporting the research) and the Outpatients' Department with leaflets about the research project and give potential participants information about the study. Patients who are interested in taking part will be given Participant Information Sheet so that they are aware of what participation will involve.

Those who make contact with the researcher via telephone/email having seen posters or other information e.g. leaflets advertising the study will be asked if they require any further information about the study, which will be provided where needed. If they are happy to continue, and they meet the inclusion/exclusion criteria, they will be invited to attend an interview. All participants will then be required to sign a consent form.

Stage Two

Questionnaire Data Collection

For the second stage of the research large numbers of participants are required and therefore, a different approach to recruitment will take place. There will be posters advertising the study and leaflets placed around the hospital and wards for the attention of patients. Staff will be made aware of the questionnaire via an advertisement of the trust intranet and if permitted an email sent to staff nursing groups (via liaison with the Trust communications department). In addition nurse managers will also be provided questionnaire details to pass on to their nursing staff. Finally, the researcher will also be present in outpatient and inpatient departments to ask patients to complete the questionnaire. If they are interested in taking part once they have read the information sheet, their options for completion will include: immediately on paper, immediately online on the researchers tablet device, at a time of their convenience on paper with a paid for envelope to post the questionnaire to the researcher or to be given them a paper link to the access the website link to complete the questionnaire remotely.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

☐ Yes ☒ No

Please give details below:

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

☒ Yes ☐ No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).

Publicity posters will be in common areas of the hospital such as waiting rooms for patients and notice boards. Leaflets will also be available at nursing stations where appropriate. Staff publicity material will be available in staff rooms, staff Intranet and emails.

A29. How and by whom will potential participants first be approached?

Recruitment

Recruitment will take place in two stages for the two parts of the research. All recruitment will take place on the [REDACTED] site by the researcher. The first part of the research is a series of short interviews with nurses and patients. The second is the completion of a questionnaires by nurses and patients. I will outline the recruitment plan for these phases of research separately below. In both stages of research potential participants will either directly advertised to through posters or leaflets or directly approached by the researcher. The reason for the initial approach not being made by the healthcare team is that this could bias the results of the study if the healthcare team selectively approach participants who they believe to share their views or they see as particularly amenable. However, the researcher will, seek the advice of ward managers when attending inpatient facilities to ensure that an inappropriate potential participant is not approached e.g. a participant who does not have capacity through ill health or medication use or who is experiencing distress such as recently having received bad news.

Stage One

Interviews with nurse participants

The researcher will visit a nurse team manager's meeting and explain what the study entails. Managers will be given information about the study to give to their staff as well as contact details of the researcher. Where appropriate the researcher will also attend nurse team meetings to explain to staff what the study entails. The researcher will provide the managers and staff with advertisement leaflets and Participant Information Sheets so that they are aware of what participation will involve. Those who are interested will be able to contact the researcher directly.

In addition the researcher will make themselves available at the trust occupational health clinic, outpatients and inpatient wards where she will be available to hand out leaflets to potential participants and carry out interviews on site if convenient for participants.

Those who express an interest in taking part in the research will be asked if they require any further information about the study, and if they are happy to continue, and they meet the inclusion/exclusion criteria, an interview will be arranged. All participants will be required to sign a consent form prior to interview. The researcher will inform the nurse managers as soon as the required number of participants has been recruited and give them information about how nurses can take part in the second part of the research.

Interviews with patient participants

The researcher will visit pre agreed appropriate inpatient wards (as agreed with [REDACTED] who is in support of the research) and outpatients with leaflets about the research project and give potential participants information about the study. Patients who are interested in taking part will be given Participant Information Sheet so that they are aware of what participation will involve. Those who are interested will be able to contact the researcher directly.

Those who express an interest in taking part in the research will be asked if they require any further information about the study, and if they are happy to continue, and they meet the inclusion/exclusion criteria, an interview will be arranged. All participants will be required to sign a consent form prior to interview. If a potential patient participant contacts the researcher after the interviews have been fully recruited they will be given information about how to take part in the second phase of the research.

Stage two

Questionnaire Data Collection

For the second stage of the research large numbers of participants are required and therefore, a different approach to recruitment will take place. There will be posters advertising the study and leaflets placed around the hospital and wards for the attention of patients. Staff will be made aware of the questionnaire via an advertisement of the trust intranet and if permitted an email sent to staff nursing groups (via liaison with the Trust communications department). In addition nurse managers will also be provided questionnaire details to pass on to their nursing staff. Finally, the researcher will also be present in outpatient and inpatient departments to ask patients to complete the questionnaire. If they are interested in taking part once they have read the information sheet, their options for completion will include: immediately on paper, immediately online on the researchers tablet device, at a time of their convenience on paper with a paid for envelope to post the questionnaire to the researcher or to be given them a paper link to the access the website link to complete the questionnaire remotely.

A30-1. Will you obtain informed consent from or on behalf of research participants?

☒ Yes ☐ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

In order to participate in the study all participants will be required to and capable of giving their own informed consent. Adults not able to give consent will not be participating in the study.

The researcher will, seek the advice of ward managers when attending inpatient facilities to ensure that an inappropriate potential participant is not approached e.g. a patient participant who does not have capacity through ill health or medication use. As a Trainee Counselling Psychologist the researcher has a sound understanding of the ethical principles underpinning informed consent and has experience in assessing capacity.

For the first (interview) part of the study they will first be given a detailed written Participant Information Sheet and the researchers will clearly explain the study to potential participants. All participants will be encouraged to take appropriate time to think about whether they want to participate in the research so that they do not feel undue pressure from the researcher. If they wish to participate in the study, they will be given a consent form to sign. Once the researcher has received their consent, the researcher will confirm they are suitable participants (in accordance with the original exclusion and inclusion criteria) and arrange a suitable time for the interview.

For the second (questionnaire) part of the study (an online questionnaire) there will be participant information form, as a part of the questionnaire and participants will have to check a box on the form electronically that confirms that by answering the questions, they are giving their consent to take part in the research. The researcher will not be assessing capacity as in the majority of cases participants will be completing the questionnaire remotely. Where the questionnaire is being completed on paper in person consent procedure will be followed as in the first part of the study and all participants will be encouraged to take appropriate time to think about whether they want to participate in the research so that they do not feel undue pressure from the researcher.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

☒ Yes ☐ No

A31. How long will you allow potential participants to decide whether or not to take part?

For the first (interview) stage of the research the researcher will allow participants a minimum of 24 hours to decide whether or not to take part in the study. If however, if appropriate, whereby the participant has read the participant information form, wishes to take part, fits the inclusion/exclusion criteria and signs the consent form they will be allowed to participate before the initial 24 hour period. All participants will be encouraged to take appropriate time to think about whether they want to participate in the research.

For the second (questionnaire) stage of the research, the participant will decide how long they decide to take part as the questionnaire immediately follows the online information and consent statement. Participants can decide if they would like to complete it there and then or complete it at an alternative time.

If the participant is being contacted to completed the questionnaire in person the researcher will allow participants a minimum of 24 hours to decide whether or not to take part in the study. If however, if appropriate, whereby the participant has read the participant information form, wishes to take part, fits the inclusion/exclusion criteria and signs the consent form they will be allowed to participate before the initial 24 hour period. All participants will be encouraged to take appropriate time to think about whether they want to participate in the research so that they do not feel undue pressure from the researcher.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?(e.g. translation, use of interpreters)

Such individuals may not be suitable for this particular study, as verbal communication in English is essential in collecting viable interview and questionnaire data.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? Tick one option only.

- ☐ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.
- ☐ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.
- ☐ The participant would continue to be included in the study.
- ☐ Not applicable – informed consent will not be sought from any participants in this research.
- ☒ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)? (Tick as appropriate)

- ☐ Access to medical records by those outside the direct healthcare team
- ☐ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☒ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☒ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☒ Use of audio/visual recording devices
- ☐ Storage of personal data on any of the following:
 - ☐ Manual files including X-rays
 - ☐ NHS computers
 - ☐ Home or other personal computers
 - ☐ University computers
 - ☐ Private company computers
 - ☐ Laptop computers

Further details:

A digital dictaphone will be used to record all interviews. The data files will be encrypted password protected and stored securely.
 Personal contact information collected will be email addresses only if participants request to be sent information about the results of the study.
 Direct quotations will only be used if they are not identifiable.

A38. How will you ensure the confidentiality of personal data? Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.

This general statement is written in accordance with UK Data Archive recommendations. The statement is split into two sections, which separately address the protocol for ensuring confidentiality of personal data in the qualitative and quantitative phases of this research. Firstly I will outline the confidentiality of personal data within the quantitative research:

Confidentiality of Personal Data in Quantitative Research:

Researcher to remove direct identifiers from the dataset such as detailed personal information. Such identifiers are not necessary for this research.
 Example: Remove respondents' names or replace with a code. Remove email addresses, postcode information, and telephone numbers if these have been provided. (These will not be requested in the questionnaire but will be removed if entered into a free text box).

Researcher to aggregate or reduce the precision of a variable such as the respondent's age and place of residence. Coded or categorical variables which may be potentially revealing can be aggregated into broader codes.
 Example: Recording the year of birth rather than the day, month and year; and aggregate detailed occupational or diagnostic classification information into major occupational or diagnostic groups.

Researcher to generalise the meaning of a detailed text variable by replacing potentially disclosive free-text responses

with more general text.

Example: Detailed areas of medical expertise or diagnosis could indirectly identify a medical practitioner or patient. The variable could be replaced by more general text or be coded into generic responses such as 'one area of medical speciality', 'two or more areas of medical speciality', etc.

Confidentiality of Personal Data in Qualitative Research:

When anonymising qualitative material, such as transcribed interviews, identifiers will not be crudely removed or aggregated, as this can distort the data or even make them unusable. Instead pseudonyms, replacement terms or vaguer descriptors will be used. The objective will be to achieve a good level of anonymisation, avoiding unrealistic or overly harsh editing, whilst maintaining maximum content. This will be achieved by the following means:

Researcher will not collect disclosive or directly identifying data, e.g. the researcher will not ask for full names.

Researcher will anonymise indirect identifiers which, when linked with other publicly available information sources, could identify someone, e.g. detailed information on occupation, diagnosis or exceptional values of characteristics such as age. Anonymisation will take place at the time of transcription.

Researcher will use pseudonyms or replacements that are consistent throughout the project, e.g. use the same pseudonyms in publications or follow-up research

Researcher will use 'search and replace' techniques carefully so that unintended changes are not made, and misspelled words are not missed.

Researcher will identify replacements in text clearly, e.g. with [brackets] or using XML tags such as <seg>word to be anonymised</seg>

Researcher will create an anonymisation log of all replacements, aggregations or removals made and store anonymisation log separately from the anonymised data files.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

Only the chief investigator will have access to participants' personal data once they consent to participating in the study.

Storage and use of data after the end of the study

A43. How long will personal data be stored or accessed after the study has ended?

- ☐ Less than 3 months
- ☐ 3 – 6 months
- ☒ 6 – 12 months
- ☐ 12 months – 3 years
- ☐ Over 3 years

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

- ☐ Yes
- ☒ No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

☐ Yes ☒ No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

☐ Yes ☒ No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

☐ Yes ☒ No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

☒ Yes ☐ No

Please give details, or justify if not registering the research.

The research will be registered with and approved by the [REDACTED] [REDACTED] The researcher aims to register and publish the doctoral thesis at the end of the project. Options that are appropriate for this research will be considered in due course.

Registration of research studies is encouraged wherever possible.

You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? Tick as appropriate:

- ☒ Peer reviewed scientific journals
- ☒ Internal report
- ☒ Conference presentation
- ☒ Publication on website
- ☐ Other publication
- ☐ Submission to regulatory authorities
- ☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- ☐ No plans to report or disseminate the results
- ☐ Other (please specify)

A53. Will you inform participants of the results?

☒ Yes ☐ No

Please give details of how you will inform participants or justify if not doing so.

Arrangements will be made participants who desire to be informed of the overall results of the study if requested. The

results in the form of a summary sheet, will be posted or emailed to the participants, according to their stated preference.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

- ☐ Independent external review
☐ Review within a company
☐ Review within a multi-centre research group
☒ Review within the Chief Investigator's institution or host organisation
☐ Review within the research team
☒ Review by educational supervisor
☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:

The research proposal has been reviewed by City University's ethics committee (and granted ethics approval) and by both my research supervisor (Dr Don Rawson) and my field supervisor (Nicola Gale).

Following submission of the research, the thesis will be assessed by an internal and external examiner who read the thesis and then arrange for an oral examination (VIVA). Here, the researcher will be expected to discuss and answer questions about the work.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A56. How have the statistical aspects of the research been reviewed? *Tick as appropriate:*

- ☐ Review by independent statistician commissioned by funder or sponsor
☐ Other review by independent statistician
☐ Review by company statistician
☐ Review by a statistician within the Chief Investigator's institution
☐ Review by a statistician within the research team or multi-centre group
☒ Review by educational supervisor
☐ Other review by individual with relevant statistical expertise
☐ No review necessary as only frequencies and associations will be assessed – details of statistical input not required

In all cases please give details below of the individual responsible for reviewing the statistical aspects. If advice has been provided in confidence, give details of the department and institution concerned.

	Title Forename/Initials Surname
	Dr Don Rawson
Department	Department of Psychology
Institution	City University London
Work Address	Social Sciences Building, City University London, Whiskin Street London
Post Code	EC1V 0HB
Telephone	

Fax
Mobile
E-mail

Please enclose a copy of any available comments or reports from a statistician.

A57. What is the primary outcome measure for the study?

This questionnaire will be developed in the study using factor analysis - regarding the role of a compassionate nurse.

A58. What are the secondary outcome measures? (if any)

A59. What is the sample size for the research? How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.

Total UK sample size: 405

Total international sample size (including UK):

Total in European Economic Area:

Further details:

Stage 1

Up to 30 participants will be interviewed for stage 1 of the research.

Stage 2

A minimum of 250 (maximum 375) participants will be completing stage 2 of the study.

A60. How was the sample size decided upon? If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.

Stage 1

Up to 30 participants (15 patients, 15 nurses) will be interviewed for stage one of the research. This follows recommendations by Godin and Kok (1996) who suggest a sample size of approximately about 25 people from the population from which you will select respondents for the questionnaire study.

Stage 2

The sample size for a 25 item questionnaire is a minimum of 10-15 participants per item (Costello & Osborne, 2005). In the case of this 25 item questionnaire this would equate to 250 – 375 participants (approximately evenly weighted with nurses and patient participants).

A61. Will participants be allocated to groups at random?

☐ Yes ☒ No

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

Interview Data

Qualitative data from individual interviews with nurses, current patients and persons with experience of receiving NHS healthcare treatment will be analysed using a basic thematic analysis by manually coding the analysed data. The thematic analysis will be theoretical and thus explicitly analyst driven. It will provide more detailed analysis of some aspects of the data rather than a rich description of the data overall. This is in line with Braun and Clarke's (2006) definition which proposes that a theme captures important meaning from the data in relation to the research question and represents some level of patterned response in the data.

The information gathered through the thematic analysis will form the development of a questionnaire similar to the

format of the Cohen's Teacher's Role definition instrument (Finlayson & Cohen, 1967). It is hoped that analysis of the interview data will identify constructs prior to the deductive testing of the role under investigation. This information will be analysed and 160 items will be created. Through the use of a minimum of 11 and up to ideally 31 participants (from a student population in City University London) these 160 items will be reduced to 25 items by obtaining core agreement, identifying outliers with the use of the semi-inter quartile range. These items will be produced on a hybrid of a Likert (1932) and Thurstone (1928) type scale.

Questionnaire Data

The second stage of analysis utilized in this research is factor analysis which aims to create and test a unified construct of the range of behaviours and qualities that are manifestations of compassionate nursing care. Thus the construct validity of the questionnaire can be tested (Rattray & Jones, 2007). The ordinal quantitative data elicited by the questionnaire will be analysed using SPSS a statistics software package.

First the data will be cleaned to remove or correct corrupt or inaccurate data from the data set. Exploratory factor analysis will detect the construct which underlies the dataset based on the correlation between variables, which are in this case, the questionnaire items (Field, 2009). If the questionnaire is construct valid, all items together represent the underlying construct, meaning one's total score on the twenty-five items of the questionnaire should represent one's view on a compassionate nurses role. This analysis therefore, aims to test whether there are unified constructs in the range of behaviours and qualities that are manifestations of compassionate nursing care.

Reliability of the questionnaire will be calculated, on each factor identified in the exploratory factor analysis stage, using Cronbach's alpha (α) analysis. It will be assumed that a factor with an α of 0.8 is considered reliable, thereby demonstrating internal consistency (Field, 2009). Each questionnaire item will be analysed for its effect on the value of α , if α increases greatly when one item is deleted it will be considered for permanent deletion from the questionnaire. The same will be considered upon deletion of an item if it decreases the average correlation coefficient considerably or correlates lower than 0.3 with the total score of the questionnaire (Field, 2009).

Data from patients and health care professionals will be analysed together in one data set and will also be analysed separately if each sample reaches a size of 250 participants or more. This because the sample size for questionnaire is a minimum of 10-15 participants per item (Costello & Osborne, 2005). In the case of this questionnaire this would equate to 250 – 375 participants. This will identify if there are any quantifiable differences between the responses of nurses and patients.

Missing Data

If a questionnaire is partially completed, as stated in the participant information, I will assume that the participant desires to withdraw from the study and will therefore not include their data in the final data set. If a participant withdraws from the first phase of the research during the interview because they no longer want to take part I will not use this data for analysis. If however, the participant partially completes the interview because of other reasons such as time pressure and would still like their contributions to be included in the research I will use their data in the analysis and mention their partial completion of the interview in the results write up. Due to the nature of these participant groups (nurses and patients) it is possible that an interview may be interrupted or discontinued if there are medical demands or time pressures placed upon them, such as appointments, patient emergencies and other clinical duties e.g. ward rounds etc.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.

	Title Forename/Initials Surname
	Dr Don Rawson
Post	Lecturer and Supervisor for Professional Doctorate in Counselling Psychology Post MSc Diploma in the Practice of Counselling Psychology (Accredited as Part II of BPS Diploma in Counselling Psychology). City University
Qualifications	MSc (distinction) Counselling Psychology (Accredited as Part I of BPS Diploma in Counselling Psychology). City University PhD Social Psychology. London School of Economics and Political Science. Thesis: Authenticated Action and the Decision to Stop Smoking (1991).

Employer	BSc (Econ) 1st Class Hons. Social Psychology. London School of Economics and Political Science City University London
Work Address	Social Sciences Building, City University London Whiskin Street London
Post Code	EC1V 0HB
Telephone	01895820402
Fax	
Mobile	
Work Email	
Title Forename/Initials Surname	
Post	
Qualifications	
Employer	
Work Address	
Post Code	
Telephone	
Fax	
Mobile	
Work Email	

A64. Details of research sponsor(s)**A64-1. Sponsor****Lead Sponsor**

- Status: ☐ NHS or HSC care organisation
☒ Academic
☐ Pharmaceutical industry
☐ Medical device industry
☐ Local Authority
☐ Other social care provider (including voluntary sector or private organisation)
☐ Other

Commercial status:

*If Other, please specify:***Contact person**

Name of organisation City University London
Given name
Family name
Address Northampton Square
Town/city London
Post code EC1V 0HB
Country UNITED KINGDOM

Telephone

Fax

E-mail

Is the sponsor based outside the UK?☐ Yes ☒ No

Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a legal representative established in the UK. Please consult the guidance notes.

A65. Has external funding for the research been secured?

- ☐ Funding secured from one or more funders
☐ External funding application to one or more funders in progress
☒ No application for external funding will be made

What type of research project is this?

- ☒ Standalone project
☐ Project that is part of a programme grant
☐ Project that is part of a Centre grant
☐ Project that is part of a fellowship/ personal award/ research training award
☐ Other

Other – please state:

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?☐ Yes ☒ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:Organisation
AddressPost Code
Work Email
Telephone
Fax
Mobile

Title Forename/Initials Surname

Details can be obtained from the NHS R&D Forum website: <http://www.rdforum.nhs.uk>

A69-1. How long do you expect the study to last in the UK?

Planned start date: 20/02/2014

Planned end date: 28/11/2014

Total duration:

Years: 0 Months: 9 Days: 9

A71-2. Where will the research take place? (Tick as appropriate)

- ☒ England
☐ Scotland
☐ Wales
☐ Northern Ireland
☐ Other countries in European Economic Area

Total UK sites in study

Does this trial involve countries outside the EU?☐ Yes ☒ No**A72. What host organisations (NHS or other) in the UK will be responsible for the research sites? Please indicate the type of organisation by ticking the box and give approximate numbers of planned research sites:**

- ☒ NHS organisations in England 1
☐ NHS organisations in Wales
☐ NHS organisations in Scotland
☐ HSC organisations in Northern Ireland
☐ GP practices in England
☐ GP practices in Wales
☐ GP practices in Scotland
☐ GP practices in Northern Ireland
☐ Social care organisations
☐ Phase 1 trial units
☐ Prison establishments
☐ Probation areas
☐ Independent hospitals
☒ Educational establishments 1
☐ Independent research units
☐ Other (give details)

Total UK sites in study: 2

A76. Insurance/ indemnity to meet potential legal liabilities

Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? Please tick box(es) as applicable.

Date: 14/01/2014

30

139139/548409/1/695

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

- ☐ NHS indemnity scheme will apply (NHS sponsors only)
☒ Other insurance or indemnity arrangements will apply (give details below)

Insurance cover is in place for City University London students undertaking research.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

- ☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)
☒ Other insurance or indemnity arrangements will apply (give details below)

Insurance cover is in place for City University London students undertaking research.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

- ☒ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
☒ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Insurance cover is in place for City University London students undertaking research.

I also have professional liability insurance via a private insurance company for my role as a Trainee Counselling Psychologist.

Please enclose a copy of relevant documents.

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. For NHS sites, the host organisation is the Trust or Health Board. Where the research site is a primary care site, e.g. GP practice, please insert the host organisation (PCT or Health Board) in the Institution row and insert the research site (e.g. GP practice) in the Department row.

Research site	Investigator/ Collaborator/ Contact
Institution name	Title
Department name	First name/
Street address	Initials
Town/city	Surname
Post Code	

	Ms
	Emma
	Hollywell

PART D: Declarations**D1. Declaration by Chief Investigator**

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
4. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
5. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
7. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
8. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.
9. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
 - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
 - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
 - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
 - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
 - May be sent by email to REC members.
10. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.
11. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication*(Not applicable for R&D Forms)*

NRES would like to include a contact point with the published summary of the study for those wishing to seek further information. We would be grateful if you would indicate one of the contact points below.

- ☒ Chief Investigator
☐ Sponsor

- ☐ Study co-ordinator
☐ Student
☐ Other – please give details
☐ None

Access to application for training purposes *(Not applicable for R&D Forms)**Optional – please tick as appropriate:*

☐ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

Signature:

Print Name: Emma Hollywell

Date: 06/01/2014 (dd/mm/yyyy)

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.
7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Signature:

Print Name: Professor Martin Conway

Post: Associate Dean of Research

Organisation: City University London

Date: (dd/mm/yyyy)

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the Research Governance Framework for Health and Social Care.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

Signature:

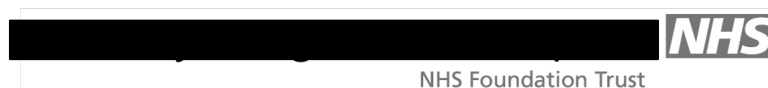
Print Name: Dr Don Rawson

Post: Lecturer and Supervisor for Professional Doctorate in Counselling Psychology

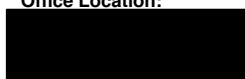
Organisation: City University London

Date: (dd/mm/yyyy)

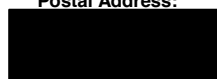
Appendix J: Research and Development Approval



Office Location:



Postal Address:



Tel: [Redacted]
Websites: w [Redacted]

FINAL R&D APPROVAL – NHS PERMISSION

14/04/2014

Ms Emma Hollywell



United Kingdom

Dear Ms Emma Hollywell,

Project ID: 13/0613 (Please quote in all correspondence)
REC Ref: 14/LO/0162
Title: Compassion and the NHS: The Role of the Compassionate Nurse

Thank you for registering the above study with the [Redacted] am pleased to inform you that your study now has local R&D approval (NHS permission) to proceed and recruit participants at [Redacted] subject to sponsor confirmation.

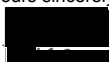
Please note that all documents received have been reviewed and this approval is granted on the basis of the key documents provided which are ethically approved by the Research Ethics Committee:

Document	Date
REC approval and REC approved documents	31/03/2014

As Principal Investigator you are required to ensure that your study is conducted in accordance with the requirements on the attached sheet. These include the conditions of your NHS permission.

Do not hesitate to contact a member of the team should you have any queries.

Yours sincerely



P.P Professor Monty Mythen
Director of Research and Development



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Appendix K: City University London Research Approval and Sponsorship



**School of Arts
and Social Sciences**
CITY UNIVERSITY LONDON

Department of Psychology
Northampton Square
London EC1V 0BB



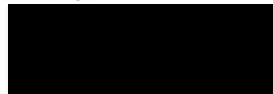
15 July 2013

Dear Sir/Madam,

Project Title: Compassion and the NHS: The Role of Nursing care

We confirm that we fully support the above research to be carried out by **Emma Hollywell** as part of her Doctorate in Psychology at City University London. We believe Emma to be a committed researcher with the ability to carry out this piece of work. City University will sponsor the research and has the appropriate indemnity insurance to cover the research.

Yours faithfully,



Professor Martin Conway
Head of Department



Carmai Pestell
School Registrar (Quality & Doctoral)

Part 3: Publishable Paper

‘This isn't just an item in a factory’:
Using Grounded Theory to
Conceptualise Compassionate
Nursing Care in the NHS

1.1. Abstract

Background: *Compassion is frequently discussed in relation to nursing. However, to date research in this area has been largely theoretical and empirical investigation has been limited. This qualitative study aimed to construct an understanding of the nature of compassion in nursing and what makes it possible, in order to address the paucity of research and lack consensus in this area.*

Methods: *Semi-structured interviews were conducted with six nurses and six patients across three hospital departments, with the resulting data systematically analysed and categorised in accordance with principles of constructivist grounded theory.*

Results: *This study has facilitated a broad and multifaceted understanding of the construct of compassion, which emphasised the delicate interpersonal nature of compassionate care that occurs between the nurse and patient. The study findings suggest that compassionate nurses play a therapeutic role for patients and that factors that inhibit and facilitate compassion play a powerful role in a nurse's ability to care. It also suggests that compassionate care has positive effects for both nurses and patients. These three aspects of the findings and their implications for cultivating compassionate care in the NHS form the focus of this paper.*

Conclusions: *The findings of the present study challenge the argument that feelings-based care practices for patients should be abandoned in favour of etiquette-based approaches and it contests contemporary wisdom that the best cost-effective measures are achieved through driving for efficiencies. Suggestions are made for supporting the emergence of compassion in healthcare and implications for nursing practice and future research directions are explored.*

Keywords: *Compassion; nursing; caring; healthcare; psychology; grounded theory.*