

TITLE:

A constructivist grounded theory study to explore compassion through the perceptions of individuals who have experienced nursing care

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ABSTRACT

Aim: To explore compassion from the perceptions of individuals with personal experience of nursing care.

Background: Although compassion is considered integral to professional nursing, increasing reports of care experiences illustrating a lack of compassion have challenged this. Despite political and professional guidance to reaffirm compassion as an underpinning philosophy of contemporary nursing practice, this provides limited insight into what compassion may involve. Contemporary evidence to inform understanding of compassion predominately arises from the professional perspective. This knowledge gap supported the rationale to explore compassion from the individual perspective.

Design: Constructivist grounded theory, underpinned by the theoretical perspectives of symbolic interactionism and social constructionism.

Methods: Data was collected via eleven individual interviews, a focus group discussion and three additional individual interviews during 2013-2015. Initial and focused coding, constant comparative analysis, conceptual mapping, theoretical memos and diagrams supported data analysis until theoretical sufficiency was determined.

Findings: Inter-related data categories emerged: *Self-Propensity for Compassion, Attributes for Compassion, Socialising for Compassion, Conditions for Compassion* and *Humanising for Compassion* (core category).

Conclusion: Compassion is a complex phenomenon, constructed by individuals through their personal experiences of nursing care and life experiences in the social world. In this study, participants perceived that compassion was fundamentally embodied by experiences of a humanising approach to nursing care. These humanising experiences were thought to be influenced by biological, psychological and socio-contextual factors. The study provides additional insight into compassion that requires further investigation with individuals in other care contexts, nurses and health care professionals.

INTRODUCTION

Compassion in nursing originates from traditional approaches to caring for the sick (Shelly and Miller, 2006), subsequently attributed to the philosophy of professional practice by Florence Nightingale (Straughair, 2012). However, emerging claims suggest that in contemporary nursing, compassion is often regarded as an aspirational aspect of practice (Burdett Trust for Nursing, 2006). Such claims have gained momentum, as increasing numbers of care experiences illustrating a lack of compassion have emerged (The Patients Association, 2009; The Mid Staffordshire NHS Foundation Trust Inquiry, 2010; The Parliamentary and Health Care Ombudsman, 2011). This has influenced public perceptions that a lack of compassion exists within the general context of nursing (Hewison and Sawbridge, 2016). In response, political and professional guidance has reaffirmed compassion as an underpinning philosophy of contemporary nursing practice (Department of Health (DH), 2010; Royal College of Nursing, 2010; DH, 2012). However, these reaffirmations provide limited insight into compassion, particularly in terms of what it entails

from the perceptions of individuals who have experienced nursing care. This study addresses this knowledge gap, providing new insight into compassion that has relevance to the international nursing context.

BACKGROUND

At the most fundamental level, compassion is defined as a recognition of suffering or vulnerability in others, invoking humane responses to offer comfort and alleviatory action (Dewar, Pullin and Tocheris, 2011; Frampton, Guastello and Lepore, 2013; Singer and Klimecki, 2014). Within the context of nursing, compassionate care is thought to be exhibited through personal attributes such as kindness, empathy and effective communication, and interpersonal skills which support the development of relationships to know the person, understand their individual needs and establish a partnership approach (Dewar and Mackay, 2010; Lown, Rosen and Martila, 2011; Bramley and Matiti, 2014; Van der Cingel, 2014; Durkin, Gurbett and Carson, 2018). Personal attributes and interpersonal skills are considered essential to compassion, supporting nurses to see beyond the individual as a passive recipient (Cornwell and Goodrich, 2009) and recognise their unique individuality by attending to ‘little things’ of significance (Perry, 2009). To achieve this, nurses may be required to go beyond the realms of standard nursing care practice (Aagrad, Papadopolous and Biles, 2018).

Kneafsey et al (2016) suggest that compassion arises from a complex interplay between personal attributes and interpersonal skills, supporting nurses to make connections, recognise feelings, become motivated, take action and sustain relationships with the individuals they are caring for. However, additional factors are thought to influence this, with emerging perceptions that compassion is primarily dependant on intrinsic personal attributes that are

present at birth, but which can be subject to further development through appropriate education (Kneafsey et al, 2016). Adamson and Dewar (2015) support the claim that education can cultivate compassion, however, others contest the effectiveness of such approaches to nurture compassion. Sinclair et al (2016) suggest that although compassion in nursing may be positively influenced by education, compassion fundamentally arises from intrinsic personal attributes. Extrinsic factors are also noted to have potential to influence compassion, with emerging evidence suggesting that contemporary ways of working (Burridge et al, 2017) and role modelling (Babei, Taleghani and Keyvanara, 2017) create wider challenges to implementing and sustaining compassion in the nursing care context.

Contemporary evidence therefore highlights the complexities of compassion and compassionate care, which is further impacted by the subjective and unique nature of how each individual perceives it (Dewar, Pullin and Tocheris, 2011). Current understanding of compassion predominantly arises from professional perspectives, with limited insight from the perceptions of individuals who have experienced nursing care. This highlighted a knowledge gap, supporting the rationale for this doctoral study.

THE STUDY

Aim

To explore compassion through the perceptions of individuals with personal experience of nursing care. The following research questions were addressed:

- What do individuals perceive compassion to involve?
- How do their personal experiences of nursing care contribute to this?

Methods

Design

The study was underpinned by the interpretivist paradigm, acknowledging that reality is dynamic, subjective and constructed by individuals within the context of their social environment. The theoretical perspectives of symbolic interactionism (Blumer, 1969) and social constructionism (Berger and Luckman, 1966) provided the philosophical basis for the study, supporting a constructivist grounded theory methodological approach (Charmaz, 2014) to focus on compassion from the perceptions of individuals with experience of nursing care. This inductive approach facilitated an in-depth exploration of subjective experiences to construct an emerging substantive grounded theory, derived from rich data reflecting multiple perceived realities, advancing the evidence base informing compassion in nursing. It also acknowledged the experience the researchers brought to the field, supporting ongoing reflexivity throughout.

Participants

The sample population was an established university 'Service User and Carer' group, comprising thirty-six individuals with experience of nursing care across a range of National Health Service, private and voluntary care contexts. Some individuals were involved in sharing personal stories of care with nursing students, whilst others informed curriculum development. This involvement had supported extensive reflection on their care experiences, positioning them as an appropriate sample with potential to share rich insights into perceptions of compassion in nursing. The researchers had previous limited contact with a small number of participants, during involvement with students to share their personal stories of care.

An invitation to participate and research study information was disseminated by e mail or post. Individuals who gave informed consent completed a sampling questionnaire to collect participant characteristics and specific details of their nursing care experiences. This information was collated into a sampling matrix (Machin, Machin and Pearson, 2012), providing a preliminary platform to support theoretical sampling. For example, the first participant was selected due to identifying positive perceptions of compassion throughout a range of nursing care experiences. As the study progressed, theoretical sampling was influenced by data analysis, guiding data collection to inform the emerging grounded theory (Charmaz, 2014). This involved selecting new participants from the sampling matrix or re-interviewing participants with potential to offer insight into the emerging issues and explicate construction of the grounded theory. Eleven individuals comprised the final sample (Table 1).

Data Collection

Data was collected by the principal investigator. Eleven individual interviews were conducted initially, followed by a focus group discussion and three additional interviews with participants involved in previous data collection. Semi-structured individual interviews were initiated using the primary question:

Can you tell me what you think compassion involves and give examples of how your experiences of nursing care have contributed to your understanding of this?

Probing techniques invited elaboration or revisited discussion points (Table 2), lasted an average of forty-nine minutes and were conducted in a location of the participant's choice, including university premises and individuals' homes. The focus group was more structured, lasting two hours and conducted in the university setting. It was supported by a topic guide (Table 3) to stimulate discussion around key emerging issues from data analysis, aiming to explicate the grounded theory (Charmaz, 2014). This approach established the fit of the

findings with participants (Glaser and Strauss, 1967), facilitating further insight to support the emerging substantive grounded theory. Each episode of data collection was digitally recorded, transcribed verbatim and subjected to preliminary data analysis to support theoretical sampling. This structured approach resulted in data collection spanning December 2013 to April 2015.

Ethical considerations

Ethical approval was obtained from the University Research Ethics Committee (HCESDS, 13/7/13). Participants were fully informed about the purpose of the research, gave ongoing informed consent and were aware of their ability to withdraw from the study at any point without consequence.

Data Analysis

Data was primarily analysed by the principal investigator, with a selection of transcripts reviewed by the co-investigators to corroborate emerging findings. Initial and focused coding techniques were used to determine data categories (Table 4). Initial coding fragmented the data into its component parts, whilst focused coding assimilated initial codes of significance into tentative category properties (Charmaz, 2014). Analysis was supported with conceptual mapping (Clarke, 2005), providing a visual representation to advance understanding of the findings. Theoretical memos and diagrams recorded emerging insights (Charmaz, 2014), whilst constant comparison (Glaser and Strauss, 1967) compared new data with previous data until theoretical sufficiency (Dey, 1999) was determined as no further concepts emerged. This approach progressed analysis to determine four data categories, all of which exerted influence on a fifth core data category representing fundamental perceptions of compassion in nursing.

Rigour

Trustworthiness and rigour is demonstrated in constructivist grounded theory studies through credibility, originality, resonance and usefulness (Charmaz, 2014). In this study, credibility is demonstrated through a transparent account of the research methods. Further original insight into individual perceptions of compassion in nursing is achieved, advancing knowledge in this field. Resonance is reflected through the findings, which illustrate the complexity and breadth of participant perceptions to provide deeper insights into compassion in nursing. Resonance is also reflected through the discussion, which seeks to make sense of the findings within the context of existing research and offer transferability to similar individuals and contexts. The emerging substantive grounded theory represents individual perceptions of compassion in nursing. This has usefulness in the everyday social world, by identifying implications to improve future practice and laying the foundation for further research.

RESULTS

Eleven individuals from a university ‘service user and carer’ group comprised the final sample, including two males and nine females aged 37 to 82 years. Data analysis identified the categories of *Self-Propensity for Compassion*, *Attributes for Compassion*, *Socialising for Compassion*, *Conditions for Compassion* and the core category of *Humanising for Compassion* (Figure 1). Each category is presented in turn and supported by verbatim quotes, which are attributed to individual sample participants.

Self-Propensity for Compassion

Self-propensity related to the nurse’s proclivity for compassion, arising from factors influenced by personality, disposition and character. Self-propensity was a pre-requisite foundation, from which an intrinsic disposition for compassion could ensue:

“it [compassion] has to be in everybody doesn’t it, you either have it or you don’t”
(P8)

Self-propensity was thought to support decisions to embark upon a nursing career,
influencing the nurse’s intrinsic motivation to care for others:

“there’s something in people, isn’t there, that makes you want to be a nurse and care
for people” (P5)

When nurses were deemed to lack self-propensity for compassion, it was perceived they had
chosen to pursue the wrong career path:

“there’s a lot of people on this earth who don’t have compassion... if you don’t
you’re in the wrong job...don’t be a nurse” (P8)

Differing levels of self-propensity amongst nurses were noted, suggesting that some nurses
possessed an enhanced self-propensity for compassion. This was exhibited by nurses who
seemed to have an intrinsic ability to go above and beyond the realms of what could be
regarded as typical nursing care practice, paying attention to small acts of kindness:

“some just have it in them to go that extra mile, I’m not sure why, they must just be
made like that... those little extra things, they make such an enormous difference”
(P1)

Attributes for Compassion

A range of personal attributes and professional interactions were identified as being
associated with compassion. Personal attributes included those associated with kindness,
being interested, assuming a gentle approach, engaging in effective communication, offering
reassurance, being observant and making connections:

“there are so many interpretations, to me it means, well it’s kindness, it’s often to do
with body language...put them [individuals] at their ease, to be open to them ... it’s
partly to do with your personality...there’s all sorts of things I’m not good at, but I’m
quite good with people, I like people, I’m interested in people...similarly in hospital,

and the same prerequisites there you know... some nurses are so excellent at it, you know, they're not sort of all over you but they're kind, they're gentle, they're sympathetic and they don't hustle you and bustle you around....it's the whole approach, and some people have this approach and others don't" (P1)

"They weren't just interested in the wound on my leg, they noticed I had a low mood...just being able to talk to her [the nurse] for, just for five, ten minutes...it made such a difference...she took time to listen...there's different ways of showing compassion. It's not necessarily having to sit with people and sob, it's just tuning into people" (P3)

Personal attributes appeared to support professional interactions for compassion. This included positive initial encounters to establish effective relationships, being involved in decisions about care, partnership working, a sense of equality in the care relationship and a non-judgemental approach:

"Compassion to me...it's from going in. It's how they receive you at the reception desk...how that nurse receives you and what she's like with you and how she treats you...in my experience, they've all made me feel like the most important person and very special...they have talked to me...told me what's happening...they just made that whole experience" (P4)

"I was given a choice...that made me feel included, like I mattered to them...I didn't feel like a spare part, more like I was on the same level as them" (P7)

Socialising for Compassion

Whilst acknowledging that self-propensity and attributes for compassion could be influenced by intrinsic factors, extrinsic influencing factors were also recognised. These related to experiences in the social world and involved exposure to education, role modelling and leadership. Education was deemed essential in the childhood years, exposing young people to compassion from an early age to provide a foundation for compassion in adulthood:

"I was taught about compassion at school, it was something we learned about when we were young...my mam was a nurse too, I learned a lot from her, she was always

helping people and it just seemed like a normal thing to do really...I think that's why I consider myself to be compassionate now" (P10)

To nurture this further, education in the formal university context was considered an integral aspect of undergraduate nurse education:

"Well, I think the right training is vital (P3)...Unless it's in-bred and it's there already. But you still need it nurturing, you still need it bringing out (P2)...If they understand, they feel far more confident when they go on the ward, they have a different approach to how they are going to be dealing with people, so education is paramount really (P11)"

Education in the postgraduate period was also an ongoing requirement, supporting nurses to sustain compassion in the care context:

"you need to have more training of qualified staff on the ward so that they have the same approach, it's no use having all the training coming in if they [students] hit a buffer when they go onto the wards" (P11)

Appropriate role modelling was a catalyst for compassion, with individuals purporting it could enable compassion, whilst inappropriate role modelling could inhibit it:

"If you haven't got good training, well then you are not going to be a good nurse. If you haven't got compassion or can see good role models, then you are not going to be a good nurse (P11)... If that nurse is going to teach other nurses that [uncompassionate practice], then it's just going to spread isn't it? (P3)"

Conditions for Compassion

The contextual conditions within which nurses practiced had the potential to affect capacity for compassion; human resource ratios were fundamental to this. Care contexts with higher human resource ratios could enable compassion, whilst care contexts with lower human resource ratios could inhibit compassion:

"there's not enough people on the battlefield, there always seems to be a shortage of staff on the ward and it's not the nurses fault. I think their workload is incredible...I knew they were doing their best, but it was just the lack of numbers...a big change from having one on one...there's maybe a couple of nurses on the ward for 12 or 20 patients... it's a bit like you're spoiled for care up there [intensive care]" (P2)

Participants noted that even when nurses possessed fundamental self- propensity and attributes for compassion, their motivation and capacity for compassion could be inhibited, due to increased workloads:

“some of them are so, so busy and short staffed, and I can understand that sometimes, you know, think oh I haven’t got the time for that...that must put a lot of pressure on them and that must make them sometimes show a bit less compassion...they might be compassionate and understanding, but I think I have got to give them the benefit that at times, they must be stretched so much that it must be very hard to show compassion” (P4)

Systems and processes of contemporary nursing practice had the potential to inhibit compassion, with the increasing use of technology impacting capacity for compassion:

“they might know how to programme my dialysis machine, but because of other work pressures they haven’t got the time to sit on your bed now and notice that you’re upset like they used to...with all this technology they know how to work the machine, but they haven’t got the time to sit and talk to you for five minutes...it’s really important because that’s where the real compassion comes in” (P3)

The need to meet key targets, complete onerous amounts of documentation and the organisational culture were identified as factors with the potential to inhibit compassion:

“they’ve got to put less emphasis on... targets, paperwork, key indicators and all the rest of it and think more holistically about people. Get the emphasis back on people...I think a lot of people would prefer to do that, but it’s just what they’re told by the big bosses to do” (P3)

Humanising for Compassion (core category)

Humanising for compassion was identified as the core category. This was characterised by individual experiences of being positioned at the centre of care, and treated as a human being with the ability to be involved in decision making processes.

Humanising was fundamentally dependent on nurses’ acknowledging the individual as a human being:

“I think compassion means treating you like a human being” (P1)

Humanising involved professional interactions which positioned the individual at the centre of the care experience, treating them as a unique person with the ability to contribute to decisions about their care:

“compassion...being involved and being treated like an individual, a human being in fact... it’s about relationships and mutual respect” (P7)

Humanising approaches required nurses to establish connections with the individuals they were caring for. This was achieved by taking the time to engage with the individual as a person, facilitating a sense of shared humanity:

“Compassion...it’s much more than feeling sorry for someone, it’s about nurses giving something of themselves to their patient- their time, their patience, their ability to listen and respond with a caring and humane approach, it’s basic stuff really like showing kindness, it’s about treating people like human beings” (P7)

The notion of recognising individuality was core to this, and the development of appropriate relationships to foster mutual respect were essential:

“Compassion for me is just seeing a human being there... you’re there to engage in a relationship with that other person” (P9)

When nurses’ capacity for compassion was influenced by extrinsic factors in the care environment, compassion could be inhibited and dehumanising approaches to care could ensue:

“They just didn’t have the time, too much paperwork, they were so busy...there didn’t seem enough of them...I felt like I was treated like a piece of meat, just another job to do...not like a real person at all” (P7)

Emerging Grounded Theory

An emerging grounded theory was constructed through advancing data analysis and conceptual mapping. This asserts that compassion is fundamentally embodied by individual

experiences of a humanising approach to nursing care, and influenced by complex relationships between self-propensity, attributes, socialising and conditions for compassion. Humanising experiences are influenced in the first instance by the nurse's self-propensity for compassion. This is exhibited through inherent personal attributes, which influence professional interactions that are underpinned by interpersonal skills to involve the individual in their care experience. Self-propensity for compassion can also be influenced by exposure to appropriate socialisation strategies, such as education and role modelling. However, conditions within the organisational context associated with leadership and the systems and processes of contemporary nursing practice can impact the nurse's capacity for compassion, consequently influencing the implementation of humanising approaches to nursing care. The emerging substantive grounded theory from this study therefore suggests that compassion is exemplified by humanising approaches to nursing care; the implementation of which is influenced by biological, psychological and socio-contextual factors.

DISCUSSION

The study explored compassion through the perceptions of individuals who had personal experience of nursing care. In accordance with the underpinning theoretical perspectives, it was apparent that individuals not only constructed their perceptions of compassion through their experiences of nursing care, but also through their experiences in the wider social world. This highlights the complexity of compassion, supporting the notion that compassion is somewhat intangible, due to subjective and unique perceptions of what it entails.

Participants perceived that nurses were primarily compassionate due to inherent biological factors, manifesting in personal attributes that reflected individual self-propensity for

compassion. Although evidence from the psychology arena has previously identified innate factors to influence characteristics of individual human personality (McCrae, 2011), this suggestion has only recently emerged from evidence specifically informing compassion in nursing (Kneafsey et al, 2016). Variations in human personality were highlighted in the findings, with differing levels of characteristic self-propensity for compassion demonstrated between nurses. This was particularly apparent in instances where nurses were thought to possess an enhanced disposition for compassion, exemplified by caring interventions that participants perceived surpassed baseline standards and involved small acts of kindness. This finding advances insight into compassion as an aspect of innate characteristic personality and supports existing claims (Perry, 2009) that attending to 'little things' is of significance.

Participants characterised compassion with a range of personal attributes and professional interactions. This supports previous studies which also identify personal attributes and professional interactions involving effective interpersonal skills, as fundamental to compassion (Dewar and Mackay, 2010; Lown Rosen and Martilla, 2011; Bramley and Matiti, 2014; Van der Cingel, 2014; Kneafsey et al, 2016; Sinclair et al, 2016; Durkin, Gurbett and Carson, 2018). However, the findings of this study provide further insight, specifically in relation to identifying that personal attributes and interpersonal skills were not only precursors for compassion, but also precursors to support humanising approaches to nursing care that positioned the individual at the centre of the care experience; the fundamental embodiment of what participants in this study perceived compassion to entail.

The findings advance understanding of the wider challenges to compassion, particularly in terms of education, role modelling and the systems and processes that underpin contemporary

practice. Social learning experiences were considered important influences to build upon self-propensity and attributes for compassion, shaping inherent psychological aspects of human personality to nurture compassion further. Developing competence for compassion was thought to begin in the early years, highlighted by claims that participants' own personal understanding of compassion had been initiated during childhood. Although commentators have acknowledged the influence of social and environmental factors on human character (Price-Mitchell, 2013), this has only recently emerged as a specific influence on compassion in nursing (Kneafsey et al, 2016; Babei, Taleghani and Keyvanara, 2017). Identifying that compassion in nursing can also be influenced through social learning experiences adds further understanding, advancing claims from the psychology field (Sanders, 2010) that exposure to compassion in childhood can cultivate compassion in adulthood.

Learning experiences in the formal nurse education environment were considered essential to cultivate compassion by participants. Although it has been acknowledged that nurse education can nurture competence for pro-social traits and behaviours (Brunero, Lamont and Coates, 2010), only recently emerging evidence suggests that competence for compassion can also be cultivated in this way (Adamson and Dewar, 2015; Kneafsey et al, 2016; Durkin, Gurbett and Carson, 2018). This study advances the assertion that education is vital to nurture compassion, supporting claims from the psychology arena (Roberts, Walton and Viechtbauer, 2006; McCrae, 2011) that personality traits associated with compassion are subject to characteristic adaptation. Participants regarded role modelling in the clinical environment as a vehicle to influence such adaptation, purporting that experienced nurses were positioned in a role to promote best practice and influence others within an environment in which compassion could flourish. Social learning theory (Bandura, 1977) provides some insight into role modelling, identifying that learning occurs in the social world in response to exposure to

experiences and behaviours which others attend, retain and reproduce. This claim is supported by Curtis, Horton and Smith (2012) who identify that practice experiences influence the development of professional values, often resulting in the realities of practice diminishing aspirational ideals for compassion. The study findings advance understanding of this further, identifying that positive role modelling in the care context is vital to nurture compassion, whilst negative role modelling can inhibit it.

The findings identified socio-contextual care environments as important to enabling compassion. This was dependent on adequate nurse-patient ratios and organisational cultures, systems and processes that facilitated a subjectivist, rather than an objectivist, approach to care. Staffing levels were highlighted as a significant factor influencing participant experiences of compassion. In care contexts with lower staffing levels, compassion was thought to be inhibited due to competing workload priorities. Previous research has identified correlations between low staffing, a lack of attention to patient surveillance and missed opportunities for fundamental care (Ball et al, 2013; Aiken et al, 2014), which others acknowledge can be minimised when staffing levels are adequate (Kalisch, Tschannen and Lee, 2011). The findings supported similar claims within the context of compassion in nursing, with participants noting that compassion was enabled when adequate staffing levels facilitated the nurse's ability to connect with the individuals they were caring for. In such conditions, participants perceived that nurses had sufficient capacity to balance caring interventions with technological priorities, supporting them to implement professional interactions for compassion through humanising approaches to care.

The findings suggested that a compassionate organisational culture was essential to cultivate conditions for compassion. Nurse leaders and those at the top of caring organisations were regarded as the primary role models for compassion, exhibited through leadership strategies that promoted a culture for compassion; supporting recent assertions from Kneafsey et al (2016). A ‘McDonaldisation’ effect has been perceived to influence the culture of nursing, creating the potential to inadvertently move the focus of care away from the individual, in favour of achieving targets and quality indicators (Bradshaw, 2009). The study findings illustrated similar circumstances, exemplified by nursing systems and processes which focused increasingly on technology, documentation and targets; shifting the focus away from the individual experiencing care. Contemporary nursing practices can foster ‘inattentional blindness’ (Mack and Rock, 2000) due to the nurse’s attentional capacity being invested elsewhere. The findings advance this claim in relation to compassion, identifying that nurses often did not appear to have capacity for compassion, due to managing simultaneous competing priorities for care. Subsequently, the nurse’s focus was often on technical tasks, rather than establishing interpersonal connections to facilitate a humanising approach to nursing care.

It is acknowledged that nurses spend considerable time on non-clinical interventions, leaving limited opportunity to engage in direct nursing care (Westbrook et al, 2011). Consequently, some nurses perceive that time for compassion is diminished, due to the need to manage multiple care activities simultaneously (Spinks, 2013). This was the experience of many participants in this study, who identified that even when nurses strived for compassion, their capacity to connect at a human level was impacted by the contexts they found themselves functioning within. As a result, professional interactions for compassion were affected and dehumanising approaches to nursing care emerged, leading to perceptions of a lack of

compassion. The key findings from this study therefore identify the complexity of compassion, highlighting implications for contemporary practice to support compassion in nursing.

Study limitations

The participants are a potential limitation to the transferability of the findings, due to characteristics including age, gender, and their established role in contributing to nurse education. Although the majority of participants were in the older age range, their experiences provide insight into compassion that may resonate with others. Due to sharing personal stories with undergraduate nursing students, participants were highly articulate due to extensive reflection on the experiences they had encountered. Rather than a limitation, this level of reflection offered a strength to the research in terms of generating rich data, particularly given the complexity of exploring the intangible nature of compassion. Participants drew upon diverse life experiences in the social world, often encountered some time previously. Although a potential limitation, these experiences were always recalled with detail and consistently translated to the nursing context. This supports the underpinning theoretical influences of the study, which claim that individuals construct their subjective perceptions of phenomena through experiences encountered with others in a diverse range of contexts in the social world.

CONCLUSION

Individual perceptions of compassion in nursing are complex, influenced by an interdependent relationship between biological, psychological and socio-contextual factors. These factors appear to be of key importance to compassion in contemporary nursing practice, highlighting implications that require due consideration:

- Recruitment and selection strategies should identify nurses with self-propensity for compassion, establishing a pre-requisite foundation from which compassion can be nurtured further.
- Nurse educators should develop curricula to address compassion, supporting student nurses to learn about the value of compassion through the experiences of others.
- The care context should be underpinned by an organisational culture to promote compassion, with nurse leaders paving the way to role model compassion in practice.
- Mentors should be selected for their compassionate values, seeking to instil similar values with the nurses they support in practice.
- Enabling conditions should prevail, with care contexts promoting appropriate leadership and systems and processes that are underpinned by a guiding philosophy for compassion.

The findings identified that positive perceptions of compassion in nursing fundamentally arise from individual experiences of a humanising approach to nursing care. Achieving equilibrium of the biological, psychological and socio-contextual factors that can influence compassion appears to be essential to facilitate this. The findings offer an emerging substantive grounded theory of compassion in nursing. This provides a platform for further research, supporting the nursing profession to advance understanding of compassion and reclaim it as an integral philosophy of contemporary practice.

TABLES:

Table 1: Sample Characteristics

Participant	Age	Gender	Sector where care experience occurred	Setting of care experience	Type of care experience	Time elapsed since care experience	Data collection strategy
P1	82	Female	NHS Private Voluntary	Hospital Community Own home Care home	Acute presentation Chronic illness	5 years	Interview
P2	55	Male	NHS	Hospital	Acute presentation	6 months	Interview Focus group discussion
P3	52	Female	NHS Private Voluntary	Hospital Community Own home	Acute presentation Chronic illness	ongoing	Interview Focus group discussion Additional interview
P4	59	Female	NHS	Hospital Community Own home	Acute presentation Chronic illness	2 years	Interview
P5	67	Female	NHS	Hospital	Acute presentation	1 year	Interview
P6	51	Female	NHS	Hospital	Acute presentation	2 years	Interview
P7	37	Female	NHS	Hospital	Acute presentation	3 months	Interview Additional interview
P8	58	Female	NHS Private	Hospital Care home	Acute presentation Chronic illness	ongoing	Individual interview
P9	63	Female	NHS	Hospital	Acute presentation	ongoing	Interview
P10	72	Male	NHS	Hospital Community Own home	Acute presentation Chronic illness	3 months	Interview Additional interview
P11	78	Female	NHS Private	Hospital Own home	Acute presentation Chronic illness	5 years	Interview Focus group discussion

Table 2: Example Probing Questions

“That’s an interesting point...can you tell me more about that?”

“When you were discussing...can you tell me how that made you feel?”

“You mentioned earlier that...can you explore that in a little more detail?”

“You stated that...can you explain what you meant by that?”

“You said that...how did that affect you?”

Table 3: Focus Group Discussion Topic Guide

Discussion Point	Example Questions
Personal Qualities/Attributes of Compassion	<p>A range of qualities have been identified from your interviews as important to perceptions of compassion:</p> <p>What other qualities do you feel are essential to compassion? Why are they important to you?</p> <p>Which qualities would you prioritise and why?</p> <p>What examples can you provide of how these qualities have been demonstrated through your experiences of nursing care?</p>
Enablers and Inhibitors of Compassion	<p>Some factors which can enable or inhibit compassion have been identified from your interviews as important to perceptions of compassion:</p> <p>What does this mean or signify to you?</p> <p>What factors have contributed to a positive experience of compassion for you?</p> <p>What factors have contributed to a negative experience of compassion for you?</p> <p>What impact does a positive or negative experience have on your perceptions of compassion?</p> <p>What other factors do you think can influence compassion? Can you provide any examples?</p>
A sense of personhood	<p>Take a moment to look at the following quotes which have been extracted from the data:</p> <p><i>“I think there’s too much emphasis on that [technology], rather than you know, seeing people as humans”</i></p> <p><i>“you just feel as if they’re less interested in you as a person; you feel more like a statistic”</i></p> <p><i>“it’s about treating people like human beings”</i></p> <p><i>“she doesn’t see an object in front of her she sees a human being, a person”</i></p> <p>What do they signify to you? What key message are they conveying to you?</p> <p>Can you provide any other examples of this from your own experiences of nursing?</p>
Further Discussion	<p>What other thoughts do you have to share about your experiences of compassion in nursing?</p> <p>Is there anything else that you would like to add?</p>

Table 4: Initial Codes, Focused Codes and Data Categories

Initial Codes	Focused Codes/Properties	Data Categories
Predisposition for compassion, influencing biological factors, arising from within, possessing inherent traits/natural quality, perceiving differing levels across individuals, pre-requisite quality	Intrinsic disposition for compassion	Self-Propensity for Compassion
Motivated for nursing, influencing personality factors, guiding career choice, proclivity to care, possessing pre-requisite qualities, motivation for nursing, supporting recruitment and selection	Intrinsic motivation to care for others	
Effective communicator, positive body language, active listener, connected, intuitive, considerate, understanding, attentive, observant, friendly, patient, respectful, positive attitude, interested, able to develop rapport, kind, approachable, tactile, sensitive, reassuring, caring, helpful, honest, enthusiastic, encouraging, pleasant, flexible, empathetic, gentle, humorous, motivated, intuitive, courteous, supportive	Personal attributes/dispositional traits for compassion	Attributes for Compassion
Empowerment, working in partnership, including the person, continuity, knowledgeable, promoting informed choice, negotiation, involvement, control, positive initial impressions, acknowledging individuality, maintaining confidentiality, sharing information, involving relatives, non-judgemental, developing positive relationships, ensuring positive reciprocity	Professional attributes/interactions for compassion	
Learning in the home environment, learning at school, learning in the social world, learning in nurse education, learning from those who have experienced nursing care, nurturing/cultivating compassion	Educating for compassion	Socialising for Compassion
Imitating others (nurses, mentors, nurse educators), influences of the care context, sustaining compassion, nurturing/cultivating/disseminating compassion, creating a culture for compassion	Role modelling for compassion	
Disseminating a vision for compassion, influence of nurse leaders, organisational culture for compassion, leading by example	Leading for compassion	
Staffing levels, enabling/inhibiting compassion, influence on workload, priorities for care, focus on clinical care, focus on tasks, shifting the focus from the person	Resources for Compassion	Conditions for Compassion

Technology, documentation, targets, time for compassion, capacity for compassion, competing priorities, influence of contemporary ways of working, advancing nursing roles, influences of organisational priorities	Systems and Processes for Compassion	
Focusing on the person, sharing a sense of humanity, humanising approaches to nursing care, being treated as a human being, not being objectified, recognising individuality/uniqueness, knowing the person	Humanising Approaches	Humanising for Compassion

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