In recent times there has been a push for nurses to show compassion in their clinical practice. Can education be used as a tool to improve skills in this area?

Improving compassionate care skills with education

In this article...

- Definitions of what constitutes compassion
- Debates on whether compassion can be taught
- Compassion fatigue and compassion satisfaction

5 key points

1. Articulating compassionate care presents a challenge to education as compassion manifests differently in different contexts and may require negotiation.
2. Compassionate care remains at the forefront of contemporary nursing and healthcare.
3. Self-reflection and emotional intelligence play important roles in delivering compassionate care.
4. Nurse leaders should act as role models in providing compassionate care.
5. Achieving recently highlighted recommendations may be unrealistic while compassion is unmeasurable.

Compassion is a cornerstone of safe nursing care. The Nursing and Midwifery Council (2015) has clear expectations about compassionate care, which Cummings and Bennett (2012) reinforced with the introduction of the 6Cs (Box 1). Recent reports have signified a drive to push compassion to the forefront of care and measuring it is a priority.

The 6Cs recommendations and the Francis (2013) report into care failings at Mid Staffordshire Foundation Trust highlight the need for change, while the education outcomes framework (Department of Health, 2013) seeks to link improvement in care and outcomes directly to education and learning. The framework states that continuing personal and professional development through education and training will instil respect for patients and ensure staff have the necessary compassion to enhance the patient experience. Compassionate care is directly linked to safer care, endorsing the use of tools for safety and quality improvements while focusing on small changes in attitudes and behaviours that aim to provide positive changes at ward level (Day, 2014).

Teaching compassion

Whether or not compassionate care can be taught is often debated. While Richardson et al (2015) believed caring, compassion and empathy can be taught, they acknowledged that education methods and tools need to be refined to achieve this. Van der Cingel (2014) suggested compassion is an intelligent judgement that can be gauged and, perhaps, taught. This builds on the work of Eason (2009) and Heffernan et al (2010), who identified the need for emotional intelligence and self-compassion in nurse leadership. Davison and Williams (2009a) suggested it is not possible to be compassionate without self-compassion and that, ultimately, self-dissatisfaction may affect care provision.

Although in its simplest form, compassion means treating others as you would wish to be treated (Van der Cingel, 2014). Davison and Williams (2009b) said the word is defined differently by different people and manifests differently in different circumstances. Articulating compassionate care therefore presents a challenge to education and may require negotiation. Breaking the term down into manageable and easily recognisable segments could provide a means for assessment and benchmarking approaches. However, Sturgeon (2010) suggested that, even if it was possible to accurately quantify...
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Discussion

Compassionate communication
Combined with time and skills development, the teaching and fostering of compassion will come naturally and contentment will follow. Ultimately, communication remains the key to conveying compassion, even in the most difficult of situations. In hospice care, for example, compassion must remain at the heart of person-centred care, requiring nurses to use their fundamental nursing skills to ensure this is clearly and considerately conveyed in every aspect of what they do, not only for patients, but for families, carers, friends, colleagues and volunteers.

Communication unites people during times of suffering and distress (Bramley and Matiti, 2014), creating the foundations for palliative care. In this field, with the exception of palliative interventions, treatment and interventions no longer serve a purpose – it is more important, as humans, to be near to each other (Saunders, 2005) but we often remain distant.

Recent publications suggest nursing has lost its humanity (Baillie and Black, 2015). However, some of this perception is due to events outside the profession’s control. For example, the abolition of the Liverpool Care Pathway removed the guidance that underpinned practice and supported compassion in palliative care.

The LCP offered guidance on assessing and communicating with patients and family members about their care plan and the potential benefits (and options) of pain relief and/or sedation. Its replacement, the five priorities of care (Leadership Alliance for the Care of Dying People, 2014), is less prescriptive so staff now have a more generic set of instructions instead of a detailed pathway of options. In addition, changes in the organisation of care provision means it often falls to healthcare assistants, support workers and volunteers to provide compassionate care (Stugeron, 2010). As nurses perform more hands-off tasks and HCAs provide increased hands-on care, the perception of nurses becomes less of a compassionate ideal. This has implications for the education and support of new staff and those with no or limited experience of assessing the needs of those likely to die within a few hours or days (Sykes, 2013).

A major failing of the LCP was communication of education and information within the multidisciplinary team and to patients’ families (Seymour and Horne, 2013). Other failings identified were resources and leadership – when combined, these act as a reminder of the failings identified by Francis (2013).

Parry (2013) stated that compassionate care and communication is resource-intensive in the time it takes to conduct conversations and to develop expertise, so it can put pressure on staff and resources. While education can reduce the time taken to develop expertise, it is unrealistic to expect improvements unless resources are made available to provide that education.

Richardson et al (2015) found that service users want nurses to be non-judgemental and patient-centred, which enforces the image of the loving nurse. Arguably, caring is the core component of nursing and, consequently, finding a balance between the technical aspects of the role and fundamental care skills is becoming increasingly challenging. Bradshaw (2014) questioned whether nurses can be primary care providers – as Francis (2013) suggested, as well as organisers and supervisors of delegated caregiver, as suggested by Willis (Royal College of Nursing, 2012).
Compassion satisfaction

Emotions and feelings are central to compassion. Roy (2013) asserted that compassion means to “suffer with”, since individuals cannot be compassionate without feeling in some way connected or a part of what is, being compassionate is tremendously demanding and can result in “compassion fatigue”. Fortunately, the negative connotations of compassion failures and compassion fatigue can be counterbalanced in a notion identified by Slocum-Gori et al (2011) as “compassion satisfaction”, which hinges on the emotional rewards of caring and offers a balance to the daily strain of nursing. There is a need for research underpinning the evidence base for enhancing compassion satisfaction and approaches that will counterbalance the risk of compassion fatigue.

Self-reflection

Compassion is a complex phenomenon to convey educationally, encompassing a wealth of thinking and feeling that can be conscious and unconscious. It is associated with conditions and morals that, when combined with nursing standards and expectations, can be overwhelming. Assumptions can be a hindrance to providing compassionate care and, consequently current training programmes for undergraduate nurses encourage the development of reflection skills and self-awareness.

For some, self-reflection comes naturally, but self-reflection education should be a requirement of mandatory updates for the whole multidisciplinary team, including HCAs, who may be relatively unaware of the need to spend time to reflect in the hospice setting. In this highly emotional practice the staff can easily become fatigued and this is often unrecognized. Delivery methods of education and training should be chosen carefully; Eby et al (2013) found online training to be significant. Delivery methods of education and training should be chosen carefully; Eby et al (2013) found online training to be significant.

Moving forward and measuring compassion

While measuring compassion remains a priority, there is little guidance on how this can be achieved, despite the fact that it is a significant challenge in education. Arguably, postgraduate modules aimed at teaching care and compassion are a direct response to the Francis (2013) report. Perhaps teaching compassion transparently at degree level in pre-registration nurse training programmes would ensure qualified nurses hold this core nursing skill, thereby addressing the issue for future nursing generations.

Francis (2013) made 290 recommendations covering all levels of healthcare from government to frontline professionals; this collectively aim to create a more compassionate NHS, demonstrating the scale on which change must occur. However, this is impossible to implement at ground level without support from government level down and it may, in fact, have the opposite effect on organisations – staff faced with constant change due to low staffing levels and increased pressures are at high risk of compassion fatigue. System failings, combined with staff reluctance to raise concerns (Francis, 2013), have made it easy for organisations and individuals to ignore poor care. Francis (2013) demonstrated how a care provider can score well in relation to targets while true aspects of care are failing and major crises are occurring.

Conclusion

Few would argue that it is important that nurses are able to deliver compassionate care, but there are uncertainties around how this can best be achieved, particularly in the current climate of limited resources. Further research is needed into how compassion can be taught and measured, as well as the notion and effects of compassion satisfaction and compassion fatigue, before we can be sure of designing education tools and methods that will help nurses effectively deliver compassion in practice.

References

Cummins J, Bennett V (2012) Developing the Culture of Compassionate Care: Creating a New...