

An Exploration of Compassionate Care in the Older Adult Care Setting

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Table of Contents

Abstract	viii
Acknowledgements	ix
Declaration	x
Index of Figures	xi
Index of Tables.....	xii
Index of Appendices	xiii
Index of Abbreviations.....	xiv
CHAPTER 1: Introduction & Organisation of Thesis	1
1.0 Introduction.....	2
1.1 Compassion and Health Care Professionals.....	2
1.2 Person-Centred Care	3
1.3 Older Adult Care Settings/Residential Care	4
1.4 Rationale for this Study.....	5
1.5 Literature Search Strategy.....	6
1.6 Structure of Work.....	7
1.7 Conclusion.....	8
CHAPTER 2: Compassion.....	9
2.0 Introduction.....	10
2.1 Compassion.....	10
2.2 Definitions of Compassion.....	11
2.3 Compassionate Framework.....	13
2.3.1 Compassion and Suffering.....	14
2.3.2 Compassion and Identification	22
2.3.3 The Emotion Compassion.....	26
2.3.4 Motives for Compassion	30
2.3.5 Conditions for Compassion.....	34

2.3.6 The Moral Significance of Compassion	36
2.4 Compassion and Nursing	40
2.4.1 Nursing.....	40
2.4.2 Patients.....	46
2.5 Factors that Enhance and Inhibit Compassion	49
2.5.1 Compassion Satisfaction.....	49
2.5.2 Burnout	51
2.5.3 Compassion Fatigue.....	55
2.6 Conclusion.....	58
CHAPTER 3: Person-Centred Care	60
3.0 Introduction.....	61
3.1 What is Person-centred care.....	61
3.1.1 Person.....	62
3.2 Defining Person-Centred Care	63
3.3 Why do we need Person-Centred Care	66
3.4 Impact of Person-Centred Care on Health Outcomes	67
3.5 How has Person-Centred Care Developed.....	68
3.6 Person-Centred Care in Practice	69
3.6.1 Patient	70
3.6.1.1 Patients' Experience of Person-Centred Care.....	70
3.6.1.2 Effects of Person-Centred Care	72
3.6.1.3 Participation in Person-Centred Care.....	75
3.6.2 Staff.....	78
3.6.2.1 Understanding and Incorporating Person-Centred Care	78
3.6.2.2 Work Environment.....	80
3.6.2.3 Staff and Person-Centred Care.....	81
3.7 Conclusion.....	84

CHAPTER 4: Methodology & Methods.....	86
4.0 Introduction.....	87
4.1 Research Aim & Objectives.....	87
4.1.1 Objectives	87
4.2 Theoretical Base of the Study	88
4.3 Research Philosophy	89
4.3.1 Positivist Paradigm	90
4.3.2 Interpretivist Paradigm.....	91
4.4 Research Design.....	91
4.4.1 Case Study	92
4.4.1.1 Rationale for using Case Study.....	93
4.4.1.2 Identifying the Case	94
4.4.1.3 Case Study Design	95
4.4.1.4 Limitations of a Case Study	96
4.4.2 Triangulation.....	97
4.4.3 Phases of the Study	99
4.4.3.1 Phase 1 Observations	99
4.4.3.2 Phase 2 Staff Questionnaires	99
4.4.3.3 Phase 3 Patient Questionnaires	100
4.4.3.4 Phase 4 Interpretation of Results	100
4.5 Population & Sample	100
4.5.1 Target Population.....	100
4.5.2 Sampling Method.....	101
4.6 Recruitment.....	102
4.6.1 Access to the Sample	102
4.6.2 Invitation to Participate.....	103
4.7 Data Collection.....	103

4.7.1 Data Collection Instrument	104
4.7.1.1 Observations	105
4.7.1.2 Questionnaires.....	106
4.8 Reliability and Validity of the Instruments.....	107
4.8.1 Construct Validity	107
4.8.2 Internal Validity	108
4.8.3 External Validity	108
4.8.4 Reliability.....	108
4.8.5 Quality of Interaction Schedule	109
4.8.6 Professional Quality of Life Scale	110
4.8.7 Person-Centred Climate Questionnaire – Staff Version	112
4.8.8 Person-Centred Climate Questionnaire – Patient Version.....	113
4.9 Ethical Considerations	114
4.9.1 Seeking Ethical Approval	114
4.9.2 Confidentiality	115
4.9.3 Vulnerability	115
4.9.4 Obtaining informed consent.....	116
4.10 Data Analysis	117
4.10.1 Data Entry	117
4.10.2 Missing Data	117
4.10.3 Analysis Plan	118
4.11 Conclusion.....	118
CHAPTER 5: Results.....	120
5.0 Introduction	121
5.1 Study Accrual.....	121
5.2 Socio Demographic Characteristics	124
5.3 Reliability of the Scales	126

5.3.1 Reliability of ProQOL Scale	126
5.3.2 Reliability of PCQ-S Scale	126
5.3.3 Reliability of PCQ-P Scale	127
5.4 Management of Missing Data	127
5.5 Results	128
5.5.1 Phase 1 – Observations	128
5.5.2 Phase 2 – Staff Questionnaires	131
5.5.2.1 Professional Quality of Life	131
5.5.2.2 Person-Centred Climate Questionnaire – Staff version	135
5.5.3 Phase 3 – Patient Questionnaire.....	137
5.5.4 Healthcare Professionals and Patient Scores on the PCQ.....	139
5.5.5 Comparison of the ProQOL to the PCQ-S.....	141
5.6 Key Findings	142
5.7 Conclusion.....	144
CHAPTER 6: Discussion.....	145
6.0 Introduction.....	146
6.1 Observed Care Delivered by Healthcare Professionals	146
6.2 Compassion Satisfaction, Compassion Fatigue & Burnout	148
6.2.1 Compassion Satisfaction.....	148
6.2.2 Compassion Fatigue.....	149
6.2.3 Burnout	150
6.2.4 Review of the ProQOL Findings	151
6.3 Person-Centredness of Healthcare Professionals	153
6.4 Patient Satisfaction with Person-Centredness.....	155
6.5 Relationships between Professional Quality of Life and Person-Centred Climate.....	157
6.6 Conclusion.....	158
CHAPTER 7: Conclusion and Recommendations.....	159

7.0 Introduction.....	160
7.1 Limitations of the Study.....	160
7.1.1 Research Design.....	160
7.1.2 Observation Tool	161
7.2 Recommendations.....	161
7.2.1 Recommendations for Clinical Practice.....	161
7.2.2 Recommendations for Future Research	162
7.3 Study Conclusion	162
References.....	164
Appendices.....	194
Appendix 1: Literature Search Strategy.....	195
Appendix 2: Studies on Compassion	199
Appendix 3: Studies on Person-Centredness	214
Appendix 4: WIT Ethical Approval Letter	237
Appendix 5: HSE Ethical Approval Letter	239
Appendix 6: Letter Seeking Permission to the Director of Nursing	242
Appendix 7: Letter Granting Access from Director of Nursing	244
Appendix 8: Information Sheets for Staff.....	246
Appendix 9: Information Sheets for Patients/Nominated Relatives	251
Appendix 10: Quality of Interaction Schedule.....	254
Appendix 11: Professional Quality of Life Scale	256
Appendix 12: Person-Centred Climate Questionnaire-Staff version.....	260
Appendix 13: Person-Centred Climate Questionnaire-Patient version.....	263

Abstract

Compassion and person-centred care are viewed as the gold standard when caring for patients. An increasing number of older adults are living in long term care settings and it would appear from recent healthcare scandals and reports that compassionate care delivery is experiencing challenges in such settings and that there are also issues with the staffs' professional quality of life which may be impacting on compassionate care delivery.

Therefore, the aim of this study was to explore compassionate care in the older adult care setting by examining the relationships between observed care delivery, professional person-centredness and quality of life and patient satisfaction with person-centred care. An exploratory, case study design was employed.

The literature highlighted the difficulties with measuring compassion. Thus, in this study, person-centeredness is used as a proxy measure for compassion. Healthcare professionals' quality of life was measured using the Professional Quality of Life Scale to examine for relationships to person-centred care, measured using the Person-Centred Climate Questionnaire–Staff version. Patient satisfaction with person-centred care was also measured, using the Person-Centred Climate Questionnaire-Patient version. Staff- patients interactions to assess care delivery was measured using the Quality of Interaction Schedule.

A HSE run long term care facility with 5 separate units was used as the study site. A purposive sample was recruited which included healthcare professionals (n = 54: nurses and healthcare assistants), patients (n = 56) or their nominated relative (n =15).

The observations of care identified high levels of positive interactions. Professional quality of life was determined to be higher for healthcare assistants in comparison to nurses, with healthcare assistants having higher levels of compassion satisfaction and nurses having higher levels of compassion fatigue and burnout.

High levels of person-centredness were acknowledged by both patients and staff and person-centredness was positively correlated with compassion satisfaction and negatively correlated with compassion fatigue and burnout within staff.

Overall the findings suggest that healthcare professionals need further support in order to improve professional quality of life and thus, increase compassionate person-centred care.

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Finally, to Eddie, my world away from study, thank you for being my retreat and for always being there for me.

Declaration

I, Fiona Kelly, declare that this thesis is submitted in partial fulfilment of the requirement for the degree of Masters of Science (MSc) and is entirely my own work except where otherwise accredited. It has not at any time either whole or in part been submitted for any other educational award.

Signed: _____(Candidate)

Date: _____

Index of Figures

Figure 1.1 Literature Search Strategy	7
Figure 4.1: Relationship of the Framework to the setting, participants and variables.....	89
Figure 4.2: Phases of the Study.....	99
Figure 4.3: Data Collection Methods	105
Figure 5.1: Study Participants	123
Figure 5.2: Interactions Observed	130
Figure 5.3: Verbal/Nonverbal Interactions	131

Index of Tables

Table 3.1: Relationship between Kitwood’s definition and derived concepts of person-centredness	63
Table 3.2: Definitions of Person-Centred Care.....	64
Table 4.1: Positivist vs. interpretivist approaches to consumer behaviour	90
Table 4.2: Relevant situations for different research strategies	93
Table 4.3: Inclusion criteria and rationale.....	101
Table 4.4: Sample Size.....	103
Table 4.5: Concordance between (a) coding and (b) observation and coding of QUIS interaction categories by independent raters.	110
Table 4.6: Cohen’s Kappa for QUIS.....	110
Table 4.7: Cronbach’s Alpha for ProQOL.....	111
Table 4.8: Scale Distribution and Cut off Scores for ProQOL	111
Table 4.9: Test-retest reliability of the English Person-centred Climate Questionnaire – Staff Version (PCQ-S)	112
Table 5.1: Socio Demographic Characteristics of Patient	124
Table 5.2: Socio Demographic Characteristics of Staff.....	125
Table 5.3: Cronbach Alpha Coefficient Scores for ProQOL in Comparison to Other Studies.....	126
Table 5.4: Cronbach Alpha Coefficient Scores for PCQ-S.....	127
Table 5.5: Cronbach Alpha Coefficient Scores for PCQ-P.....	127
Table 5.6: Interactions for each Ward.....	129
Table 5.7: Participants in the interactions	130
Table 5.8: ProQOL Descriptive Statistics & Independent t-test.....	133
Table 5.9: ProQOL one way between-groups ANOVA	134
Table 5.10: Mean and SD for PCQ-S.....	135
Table 5.11: PCQ-S one way between-groups ANOVA.....	137
Table 5.12: Mean and Standard Deviation of PCQ-P	138
Table 5.13: Healthcare Professionals and Patient Scores on the PCQ.....	140
Table 5.14: Healthcare Assistants and Patient Scores on PCQ.....	140
Table 5.15: Nurses and Patients Scores on PCQ.....	141
Table 5.16: Pearson Product-moment Correlations between PCQ-S and Compassion Satisfaction, Compassion Fatigue and Burnout	142

Index of Appendices

Appendix 1: Literature Search Strategy

Appendix 2: Studies on Compassion

Appendix 3: Studies on Person-Centredness

Appendix 4: WIT Ethical Approval Letter

Appendix 5: HSE Ethical Approval Letter

Appendix 6: Letter Seeking Permission to the Director of Nursing

Appendix 7: Letter Granting Access from the Director of Nursing

Appendix 8: Information Sheets for Staff

Appendix 9: Information Sheets for Patients/Nominated Relatives

Appendix 10: Quality of Interaction Schedule

Appendix 11: Professional Quality of Life Scale

Appendix 12: Person-Centred Climate Questionnaire-Staff version

Appendix 13: Person-Centred Climate Questionnaire-Patient version

Index of Abbreviations

ANOVA	Analysis of Variance
BO	Burnout
CF	Compassion Fatigue
CI	Confidence Interval
CINAHL	Cumulative Index of Nursing and Allied Health
CS	Compassion Satisfaction
DF	Degree of Freedom
HCA	Healthcare Assistant
HSE	Health Service Executives
MS	Mean Square
NHS	National Health Service
PCQ-P	Person-Centred Climate Questionnaire-Patient Version
PCQ-S	Person-Centred Climate Questionnaire- Staff Version
ProQOL	Professional Quality of Life Scale
QUIS	Quality of Interaction Schedule
SD	Standard Deviation
SPSS	Statistical Packages for Social Sciences
SS	Sum of Square
WIT	Waterford Institute of Technology

CHAPTER 1: Introduction & Organisation of Thesis

1.0 Introduction

This chapter outlines the background of the study, which is been undertaken to explore compassionate person-centred care in the older adult care setting and health professionals quality of life. Compassion will be briefly explained (section 1.1) as will person-centred care (section 1.2). Section 1.3 discusses residential care for older adults with section 1.4 providing the rationale for the study. The literature search strategy review is described in section 1.5, followed by the structure of the thesis in section 1.6.

1.1 Compassion and Health Care Professionals

Care and compassion have always been at the forefront of the healthcare professions (Nursing and Midwifery Council, 2009). Post (2011) feels that every healthcare professional should excel technically and practice with compassion. An Bord Altranais (2000b) defines the scope of nursing practice as the therapeutic relationship between the nurse and the patient that is based on trust, understanding, compassion, support and serves to empower the patient to make life choices.

Van der Cingel (2011) suggests that research surrounding the area of compassion is very under developed. This is further reflected when one considers the lack of agreement of the definitions of compassion. Indeed the term compassion is often used interchangeably with similar terms such as empathy, sympathy and caring. What compassion means and the context of how it can be achieved in everyday practice is far from clear.

It seems from the media reports in Ireland and the UK particularly that one of today's major concerns is that current healthcare professionals are no longer compassionate in their care of patients. This suggestion could be corroborated by the increased rise in complaints by patients and family members of poor standards of care for patients combined with the feeling that nurses may have lost their way within their profession (Maben and Griffiths, 2008).

Glasper (2012) states that the nursing profession prides itself on being compassionate. Healthcare professionals have been praised for their outstanding levels of compassion, (Johnson *et al.*, 2007). However, Mooney (2009) feels that the heart has gone out of

nursing and that today's professionals are not as caring as those of the past. The long deep-rooted image of the compassionate nurse may be at risk (Straughair, 2012; Mooney, 2009).

One must also consider that much direct care delivery is now being undertaken by non-nurses. In Ireland the 'care assistant' is now an increasingly present member of the care delivery team and thus, these carers must also be participants in compassionate care delivery. When one considers that the Francis Report (2013) especially cited poor care delivery by these largely untrained carers, one can see a further challenge to compassionate care delivery.

1.2 Person-Centred Care

Person-centred care is a recurrent theme within the nursing literature in recent years and is seen as the gold standard when caring for all patients (McCormack and McCance, 2010). It is seen as the integration of a person's beliefs, values and preferences in terms of the person's health whilst designing and implementing healthcare (Hebert, 2010).

Edvardsson *et al.* (2010a) and McCormack and McCance (2006) view person-centred care as shifting the focus of care. Central to such person-centred care is the need to believe that care should be provided to the patient's needs and not be task orientated, to be conscious of the illness as opposed to the disease and that patients should be viewed in a subjective manner in contrast to the objective or medicalised interest of medicine. This type of care removes the hierarchical structures within healthcare and puts the patient at the centre of the care (Love and Kelly, 2011).

Person-centred care has been seen to improve patients' quality of life and abilities to increase self-care (Sjögren *et al.*, 2013; Bruus *et al.*, 2012; Sidani, 2008), improve patient satisfaction levels (Wolf *et al.*, 2008) and it is the preferred method of care for many patients (Simmons *et al.*, 2014).

For staff, person-centred care allows the professional to see beyond the sick patient and view the patient as a person in their own right. This in turn improves relationships with

patients which, can ultimately lead to better patient compliance and satisfaction levels (McKeown *et al.*, 2010; Edvardsson *et al.*, 2010a; Clarke *et al.*, 2003).

The Health Foundation (2014) believes that in order for person-centred care to be present compassion must exist and thus, in this study person-centred care is being utilised as a proxy measure closely linked to compassion.

1.3 Older Adult Care Settings/Residential Care

Residential care refers to the long-term care that an adult receives in a residential setting as opposed to in the hospital or in the patient's home (Bri, 2015). Older adult care settings are set up to care for adults over the age of 65. The National Economic & Social Development Office (2012) in Ireland views older adult care as a range of services that are provided for older people who require assistance with basic activities of daily living including: assistance getting in and out of bed, bathing, dressing and eating. In the residential setting, this care is provided by professionals, such as registered general nurses and healthcare assistants.

Since 2009, mandatory standards, the National Quality Standards for Residential Care Settings for Older People in Ireland, govern the quality of this care (Health Information and Quality Authority, 2009). A set of 32 standards was set in place to ensure patient safety and well-being comprising whilst covering the patients' rights, protection, health and social care needs and quality of life of older people. It also includes standards for staffing, the care environment, governance and management of the residential centre. By incorporating these standards into residential services, the aim is to ensure vulnerable adults are cared for with dignity and respect. It also ensures equity of treatment across the whole sector and supports the aim of delivering consistent standards of service to residents regardless of the provider of the service.

Following the publication of the Francis Report (2013) in the UK, which was a public enquiry into extreme failings in care of older adult within an NHS hospital, it is imperative that all Irish residential settings adopt the standards into practice to ensure no older adults experience such shortfalls in care.

1.4 Rationale for this Study

With the ever increasing scrutiny on the nursing profession surrounding the area of compassionate care, there has been a notable increase in reporting uncompassionate care of older adults in care settings (Francis, 2013; Hehir, 2013; Parliamentary and Health Service Ombudsman, 2011). The Health Service Ombudsman (2011) published a report titled 'Care and compassion' that investigated complaints about the standard of care received by patients over the age of 65 within the UK. Of the 9,000 complaints that the Health Service Ombudsman received, approximately eighteen per cent were about the care of older adults, emphasising that, unfortunately, these cases are not isolated incidents. Within the report, it was identified that of the ten complaints, nine of the people died during or soon after the event. One point to note from this report is that the Health Service Ombudsman found that there were several common themes experienced by the 10 people throughout all the investigations including: suffering; indignity and distress; poor care; poor communication; failure to distinguish humanity and individuality of the people involved and failure to respond to the people with compassion, sensitivity and professionalism (Parliamentary and Health Service Ombudsman, 2011).

The context for healthcare and support is continuously changing with people's life expectancy increasing, which results in a greater number of older adults requiring support (Department of Health, 2012a). More older adults are now living in communal establishments (nursing homes and hospitals) than ever, with the average life expectancy of a person born in Ireland now 77.1 years (World Health Organisation, 2006). A review of the 2011 Irish census shows an increase of 14.4% in the older adult population since 2006 (Central Statistic Office, 2012). It is clear that with the rise in life expectancy comes an increased need to care for this older adult population in these communal settings. In order to provide them with the best possible compassionate care, there is a need to assess current practice in the older adult care setting, whilst taking into consideration the needs of the healthcare professionals carrying out this care.

1.5 Literature Search Strategy

A comprehensive literature search was undertaken to identify literature relevant to the study. Computerised searches of databases were completed, as it is seen as one of the most efficient methods to gain access to published studies. Databases that were used to identify the literature included the Cumulative Index to Nursing and Allied Health (CINAHL), Medline PubMed, Science Direct, The Cochrane Library and Wiley Online Library. Publication dates were not restricted. The library within the Waterford Institute of Technology was utilised for an extensive search of books and articles and the computer databases provided by the college, the Health Service Executives and the Nursing and Midwifery Board of Ireland were examined (Figure 1.1).

The initial objective of the search was to uncover and access all research studies surrounding compassion. Following this, another search was conducted to identify studies associated with person-centred care. A detailed account of the initial search strategies can be seen in Appendix 1.

In order to ensure as many relevant papers as possible were identified inclusion and exclusion criteria were put in place. The inclusion criteria included peer reviewed papers written in the English language, which focused on compassion, person-centred care, quality of life, policies and grey literature. The criteria for exclusion included papers that did not address compassion, person-centredness or professional quality of life.

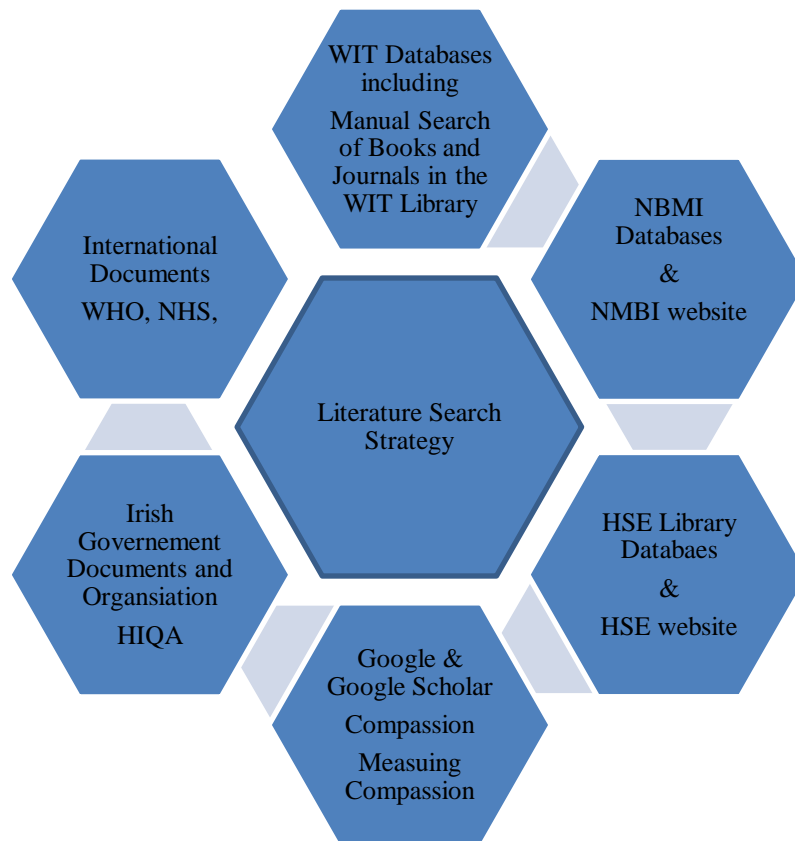


Figure 1.1 Literature Search Strategy

1.6 Structure of Work

The thesis is divided into seven chapters, with the literature review being presented in chapter two and three. Chapter 2 examines compassion. This chapter is divided into sections that explore compassion and a compassionate framework; compassion and nursing; and factors that enhance and inhibit compassion.

Chapter 3 explores person-centred care. It examines what person-centred care is; why we need person-centred care; how person-centred care impacts on health outcomes; and how it was developed. It is then viewed from the patients and staff perspective.

Chapter 4 presents the methodology and methods used in the study. This study adopted a single embedded case study design using four phases including: observations (phases 1), staff questionnaires (phase 2), patient questionnaires (phase 3) and interpretation of results (phase 4).

Results can be seen in chapter 5. This chapter demonstrates the reliability of the scales utilised within the study and presents the findings of each of the study objectives.

A critical discussion can be found in chapter 6. The subsections discuss the 5 objectives put forward within the study including: observed care delivered by healthcare professionals; compassion satisfaction, compassion fatigue and burnout; person-centredness of healthcare professionals; patient satisfaction with person-centredness; and the relationships between professional quality of life and person-centred climate.

Chapter 7 concludes the study. The limitations are identified and the recommendations arising from the study are presented.

1.7 Conclusion

This chapter introduces the key ideas behind this study. Compassion in terms of healthcare is briefly discussed along with person-centred care and older adult care settings. The rationale for the study is then put forward, with a view of the literature search strategy. The final section defines the structure of the thesis.

CHAPTER 2: Compassion

2.0 Introduction

The literature review is organised into two chapters and provides a review of the current literature surrounding compassion in health care. The background into the research being undertaken around compassionate care is explored. Section 2.1 looks at what is compassion and the range of definitions for compassion are reviewed in section 2.2. The compassionate framework as identified by Margaret Van der Cingel is discussed in detail in section 2.3. Section 2.4 examines empirical studies surrounding compassion with section 2.5 reviewing compassion and nursing. The final section (2.6) discusses factors that are seen to either enhance or inhibit compassion as identified in the literature.

2.1 Compassion

This section will review compassion, the origins of compassion will be explored and the importance of compassion for patients will be discussed. ‘Compassion is the quality or virtue of an individual to feel for someone else a strong sense of consideration for his/her despairing situation’ (Toledo-Pereyra, 2005, p. 157). It is thought to lie at the core of what it means to be human (Himmelfarb, 2001), with the meaning of compassion dating back to over two thousand years ago (Kanov *et al.*, 2004). Patterson (2011) notes that compassion has been deep rooted as an essential asset in Eastern and Western medicine and believes that compassion is a gift from within. The Dalai Lama states that people are born with compassion, that it is in their blood (The Dalai Lama and Culter, 2005).

Curtis *et al.* (2012) suggests that the origins of compassion are thought to be both innate and learned. For certain people, compassion may be part of a natural frame of mind that instinctively is present during patient care, whereas, other people may slowly build up compassion through life experience, clinical practice, and the reality that everyone is susceptible to uncertain situations like the patients (Chochinov, 2007). Thus, compassion can be innate and also partially cultivated. In both instances, the showing of compassion to another person often flows very naturally and can be seen to be quick and easy to incorporate into healthcare.

Compassion is an essential component when caring for patients and the presence or absence of compassion can leave lasting and vivid memories with patients and families regarding their experiences in the health care setting (Cornwell and Goodrich, 2009). It is important to highlight that what compassion means to each individual may vary depending on the individual and the circumstances, thus, emphasising that compassion is complex. Cornwell and Goodrich (2009) summarise that compassion involves viewing the patient as a person at all times during their care.

The literature consistently reports that compassion affects the effectiveness of treatment (Cornwell and Goodrich, 2009; Epstein *et al.*, 2005; Gilbert and Procter, 2006) (Cole-King and Harding, 2001), and patient outcomes are also improved when compassion is present (Post, 2011). Thus, compassion is regarded as an essential and integral component of nursing practice and an underpinning philosophy fundamental to the profession of nursing and is currently at the forefront of national and international policy, practice and debates (Lown and Manning, 2010; Cornwell and Goodrich, 2009).

2.2 Definitions of Compassion

Throughout the literature, there exists a range of definitions of compassion which will be explored in this section. In addition this section will explore compassion as an emotion and the different emotions connected to it, including sympathy, empathy and pity, and demonstrate that although these terms are regularly grouped together as an emotion family and used interchangeably, they all in fact have unique features.

Looking at the origins of the word compassion shows that it is derived from the Latin word *com* (together with) and *pati* (to suffer) and can be taken to literally mean ‘to suffer with’ (The Oxford English Dictionary, 1979). Goetz *et al.* (2010) defines compassion as the feeling that arises in witnessing another person’s suffering which subsequently motivates a desire to help alleviate that suffering. They identify compassion as an emotional state that involves the use of particular subjective feelings, but do not identify what these feelings are.

It seems that compassion in general is directed towards another person and involves experiencing their suffering in order to ease their pain (Firth-Cozens and Cornwell, 2009). This can be achieved by just being there with the person or from simple kind gestures such as a smile. Compassion is seen as an unselfish concern for another individual's undeserved misfortune (Nussbaum, 2001).

Youngsen (2008) also believes that compassion is “the humane quality of understanding suffering in others and wanting to do something about it”(p. 2). This definition ties in with Jacky Thomas and Emma Seppala's views of compassion. From their perspectives' compassion is the innate human capacity to understand another person's plight and to feel empathy for their existential plight (Seppala *et al.*, 2013; Thomas, 2013).

However, Greenberg (2011) recognises that it is not necessary to literally share the other persons' pain. The important factor in his view for compassion to be present is to become intimate with our humanness and to be aware that we all share similar fears of suffering or misfortune that other people experience.

Professor Castledine (2005) goes one step further in his definition of compassion and identifies compassion as an essential component of caring. He views compassion as putting oneself into the others situation and responding with sympathy and understanding. Professor Castledine feels that in order for compassion to be present, the person must imagine themselves in the situation, so as to be able to provide compassion.

Compassion in Lazarus' (1991) opinion is an emotion that is conjured up through the feeling of personal distress at the suffering of another and wanting to relieve that suffering. He recognises similar terms to compassion which appear in research including sympathy, empathy and pity.

It is evident from the literature that a universal definition of compassion is far from clear however; the literature does demonstrate that compassion is a complex construct with many dimensions including: affective, cognitive and behavioural and that the definitions incorporate similar aspects about compassion within them. The common threads highlighted from the definitions seem to be that compassion is a human quality, in responding to another person's suffering/misfortune whilst having the desire to help ease their suffering/misfortune. In a very simplistic manner, Chochinov (2007) defines compassion as 'a deep awareness of the suffering of another coupled with the wish to relieve it' (p. 355).

Additionally, it can be noted that compassion appears to be intertwined with similar terms such as sympathy, empathy and pity. The next section will review the connection between these terms and compassion as an emotion.

2.3 Compassionate Framework

Compassion is a complex phenomenon, so it was essential to utilise a framework that incorporates the important components required for compassion. Following an extensive literature search strategy (Appendix 1) and review of the literature, Margaret Van der Cingel's framework appeared the most comprehensive and applicable (Van Der Cingel, 2009).

Van der Cingel carried out a PhD in compassion. Using qualitative methodology, Van der Cingel looked at compassion in the care of older people with chronic disease and at the nurses that cared for them. The framework identified six areas that raise questions and contradictions on the debate of compassion in relation to nursing care including: suffering, identification, emotion, motives, conditions and moral significance. Van Der Cingel (2009) suggests that all these aspects within the framework are specifically important to nursing care and for further research of compassion within the nursing domain.

Therefore, compassion will be reviewed in the context of the framework set out by Margaret van der Cingel, addressing six of the main issues: compassion and suffering, compassion and identification, the emotion compassion, motives for compassion, conditions for compassion and the moral significance of compassion. Each of these elements will be examined in the context of the available empirical studies, and therefore, that may lend evidence that these components provide a comprehensive understanding of compassion.

2.3.1 Compassion and Suffering

Time and again compassion has been highlighted as being a core concept for nursing (Chambers and Ryder, 2009), in that it may unite people during times of suffering and distress (Van Der Cingel, 2009). This section will explore how suffering may be a component of compassion and how people/patients cope with suffering. The importance of compassion within nursing for those who are suffering will be discussed and the suffering that patients can experience as a result of being within the healthcare environment will also be discussed.

Chambers and Ryder (2009) believe that “compassion is a profound feeling, which is brought about by witnessing the pain or distress of others” (p.2). This seems to hold true regardless of the discipline of nursing. The majority of nurses work in an environment where they are surrounded by adults and children, who are affected by pain or distress, be that physical or emotional.

Suffering can be seen therefore, as a universal human experience which is commonly encountered by those working within the nursing profession (Gunby, 1996). It is described by Cassel (1982) “as a state of severe distress associated with events that threaten the intactness or wholeness of the person” (p.9). Cassel considers such suffering to be a consequence of personhood in which a person’s body does not suffer but the person does. Rodgers and Cowles (1997) view suffering to be “an individualised, subjective, and complex experience that involves the assignment of an intensely negative meaning to an event or a perceived threat” (p.1048).

In Western philosophy sufferers are typically depicted as a subject of tragedy and object of compassion (Spelman, 1997). Many societies see suffering as something that must be eliminated. Medical professionals also believe that suffering should be relieved and the governments similarly are constantly aiming to improve human suffering. Nevertheless, in spite of best efforts, millions of people worldwide are suffering (Scholler-Jaquish and Johnston, 2007).

Suffering is seen as a human condition that resists, through the bearing of pain or distress, the flow of living (Kleinman, 1995). While often thinking that such distresses are not normal, one has to remember that life is not made up of all good experiences and that one will experience some challenging situations during a lifetime (Moore, 2002). With that being said, when a person is experiencing suffering, it is clear that there is a heavy presence and vulnerability that can be felt (Scholler-Jaquish and Johnston, 2007). Suffering both tests and challenges a person. It leads a person to demonstrate strengths, weakness and capabilities (Hall, 2004).

When a person suffers or is confronted with the suffering of another person, many questions tend to arise. This can lead people into feeling that everything they have worked for may be at risk and can leave the person in a fragile and uncertain state. In general the natural reaction to suffering is to detach oneself from the vulnerability if possible (Scholler-Jaquish and Johnston, 2007).

Van der Cingel asserts that suffering is something that is not measured so therefore, it is important to assess the size of the loss to establish how serious the suffering is (Van Der Cingel, 2009). Suffering can arise from many sources. It can be caused by death, physical injuries or disorders, old age, disease or can also be the result of social isolations, hopelessness or fear that the future will bring vulnerability and loss (McCabe, 2007).

Morse *et al.* (1992) describes compassion as “a strong emotion or sentiment stimulated by the presence of suffering that evokes recognition and mutual sharing of the despair or pain of the sufferer. It demonstrates acceptance of the sufferer’s plight. But rather than being an expression of caregiver’s sorrow, the compassionate caregiver echoes the sufferer’s sentiment and shares in the suffering” (p.80). Morse is therefore, in agreement with Van der Cingel.

Van der Cingel's study (2011) examined compassion in care of older adults with a chronic disorder and the nurses' who cared for them and identified the subjectivity of suffering. This need to acknowledge that suffering is subjective was explained by one of the nurses in her response to suffering 'One suffers when one says he suffers'. The study established that the suffering endured by most patients with a chronic disease was not that of pain or breathing difficulties, it was the everyday issues that concerned them, including the loss of possibilities and the thought of being a burden on people. This then highlights that suffering impacts on peoples' personhood.

In order to cope with suffering, people/patients often attempt to find meaning within their suffering (Pollack and Sands, 1997), either through religious beliefs or based on their past and present situations (Black, 2007). A case study carried out in 2007 by Black with 2 residents and 2 staff in a long-term care facility highlighted that participants utilised their past and present experiences to interpret their current suffering. The study results demonstrated that if a person can find meaning in their suffering, they can maintain a measure of control over their suffering. By allowing the person to gain some meaning of their suffering, transcendence may occur as the person has the potential to retain their identity (Wayman and Gaydoes, 2005). However, with such a small sample size, it is impossible to draw a definite conclusion regarding the influence of such seeking of meaning in suffering.

In section 2.2, it was seen that Chochinov (2007) had defined compassion as 'a deep awareness of the suffering of another coupled with the wish to relieve it' and per se is directly connected to suffering (p.355). Thus, suffering could be seen as an instigator for compassion and thus, awareness of suffering is an imperative trait for the nursing profession seeking to be compassionate (Schantz, 2007).

Torjuul *et al.* (2007) examined the ethical challenges nurses experienced in surgical units in relation to compassion. Ten surgical nurses were recruited to participate in one to one interviews. Interviews were interpreted using phenomenological hermeneutics; providing clarity to the narratives of the nurses' experiences. Two of the main subthemes that emerged from the findings were closeness to suffering and compassion. Nurses recognised the need to be close to patients and relatives and to identify the suffering that was occurring. One nurse quoted "We see their suffering, anguish and struggle in a different way to the physicians" (p. 525). It was also noted that nurses found it

challenging when a patient was suffering as a result of medical treatment. Furthermore, the nurses' expressed the view that there was an increase in the sensitivity felt towards patients the longer that they continued in the profession. This study highlights that when nurses identify with patients and the suffering experienced, they respond with compassion.

Eriksson presents a theory that patients' suffering can be seen as a motivator for caring and that easing this suffering is one of the main aims of care (2002; 1997). Eriksson (1997) believes that suffering is a basic category of caring and it incorporates the patient's whole experience of life, health and illness in every sense, including physical, mental and spiritual. This concept of suffering could in fact bring about a new element to caring as it shifts the focuses from symptoms and disease, to suffering, implying suffering compromises of an ontological element. Although suffering is routinely associated with negative connotations, it also has the potential to bring about new life and reconciliation.

One of the challenges nurses face is to share in the suffering of a patient. Nurses and all healthcare professionals witness suffering on a daily basis within the working environment. When discussing healthcare professionals reactions to suffering, although there may be a wish to remain detached from the situation and care for patients from a distance the profession requires all professionals to be engaged and provide compassionate care to patients and as such, it is necessary for them to be involved and respond appropriately to the patient that is suffering (Scholler-Jaquish and Johnston, 2007). Although this is the aim that all healthcare professionals should aspire to attain, unfortunately, many patients feel they are being left to suffer in silence and that in fact the healthcare setting itself is causing the patients to suffer more than the medical problem.

Arman *et al.* (2002) conducted a study examining the suffering amongst women with breast cancer and reported that suffering was a 'field of forces', as described by the women, with five themes emerging. One theme that was noted was 'suffering related to health care'. A significant amount of the suffering the women experienced resulted from experiences in health care. Women found that a satisfactory level of physical care was provided however, emotional care and attention to general things were deemed not to be

at an appropriate level. The participants within this study felt that when healthcare professionals cared using the pure biomedical paradigm that it was seen as refusing to accept and care for the mind and the body as one and patients felt it was doing more harm than good. It is clear that if a patient's suffering is not being addressed then compassionate care is not being provided.

A further study carried out by Arman *et al.* (2004) explored the meaning of patients' experiences of suffering related to healthcare from an ethical, existential and ontological perspective. Sixteen women from four different healthcare settings in Sweden and Finland participated in the study and all women had breast cancer at the time of the study. Utilising a phenomenological methodology and data from the study in which the theme first emerged (Arman *et al.*, 2002) data were analysed from interviews and narratives were transcribed. The findings were presented in three points with each consisting of its own theme.

The first point was the ethical perspective in which the theme that emerged was 'the caring relationship that fails to materialise and the carer's choice'. The ethical dimension of the patient suffering as a result of healthcare was perceived as attitude and action that occurred within the caring relationship. Patients felt that suffering in this sense was as the result of the nurse-patient relationship having failed to develop or that the patient themselves were not viewed as fellow human beings. Patients noted a lack of time and information to be factors that hinder both of these issues. It also identified that patients were aware of the options that healthcare professionals had when interacting with them. It was believed that one had a choice on whether to be open with a patient or to be task orientated. As represented by the patient's own words "but she does not take the time, perhaps, to listen to patients, she has only got those fleeting moments for examining them" (p. 251).

Healthcare professionals never set out to cause additional suffering to patients, yet, patients in this study felt additional suffering. This occurred in professionals hiding behind work routines and healthcare culture. Some patients acknowledged that carers may

require courage both internally and externally to open up to the patient whilst standing up to external work pressures. This is reflected in the following patient quotation “for it is a question of daring to sit down, of daring to meet this, not to say we must pass on, for it is of course easier to do that, as it were....” (p. 252). Patients tried to protect themselves from disappointment by then avoiding contact with the carers which leads to additional stresses and suffering. It is important that healthcare workers are aware how the lack of interaction with patients can add significant suffering to the patient.

The second point reported by Arman *et al.* (2002) was the existential perspective. The key theme was ‘not being regarded as a whole human being with experience and needs’. Many women believed that they had been treated as a number within the hospital system, or just a body or as a diagnoses, which subsequently increased suffering and insecurities. This leaves the women to bear all the troubles and continue on an undignified fight in an existential sense. Patients experience a great deal of suffering when they are required to fight for equitable care. As reflected in this patient’s statement “everything depends on myself, I can’t feel I get any support from health care” (p. 252).

Many women held the opinion that the existential circumstances were not a priority within health care. Instead, the culture health care had adopted focused primarily on curing the cancer, whilst ignoring or explaining away any other issues. These women were looking for sympathy, support and the opportunity to express their worries but were faced with referrals to other services and organisations for support. By ignoring the mental and spiritual suffering of patients, it has the potential to leave these patients feeling embarrassed and ashamed to be experiencing such emotions. Identifying the women in the study as individuals was another finding within the existential point. Participants felt like the routines that were currently practiced within the four hospitals were a reduced and inhumane form of care.

The final point articulated by Arman *et al.* (2002) was the ontological perspective. The main finding was ‘an imperceptible call for help in a disintegrating, incomprehensible life’. The previous study by Arman *et al.* (2002) highlighted how close cancer and death as a phenomena were linked, in fact, they were almost inseparable. The participants felt

that many of the calls for care and conversation were quite often in vain. The suffering experienced was prolonged and many questions were raised about life and outcomes. Participants said that in time, it was established that very little was done in assisting women to understand life and its meaning.

Another study examining the suffering caused by care in elderly patients also found supporting evidence from patients and relatives that the care that was provided by healthcare professionals was resulting in additional suffering for the patients (Svanstrom *et al.*, 2013). This study highlighted that in the older adult population, the risks of illness and disabilities increases, leading the older adult to face changes that can result in the person requiring an increase in dependency and care, which further exposes the individual, increasing their vulnerability and likelihood to experience different forms of unnecessary suffering. Four key themes were found from interviewing 25 patients and/or relatives including: an absence of the other person in care, an absence of dialogue, a sense of alienation and a sense of insecurity. Patients within the study identified small things that left them feeling uncertain about interactions and if the healthcare professions were present within the interaction. Being unsure of who would be caring for the patient on any given day and when the next interaction would be, left the patients feeling uninvolved and not in control of their care. The importance of treating each patient as a person was recognised, as well as ensuring healthcare professionals approached each patient in this manner and not as somebody who needs care or a task that needs to be completed within the working day. If a care giver does not actively participate in an interaction and leave a desired trace in the patient's world, the patient is left with a feeling of loneliness, which in turn, tends to make the patient become more passive.

The use of dialogue can be used to help anchor the patient into the everyday world and support the patient. One patient demonstrated the joy from dialogue: "They joke with me to make me happy. They listen to me and make jokes with me and then you feel as you really are a human being" (Svanstrom *et al.*, 2013, p. 5). However, another patient had a completely different experience: "Well, they do not listen to what I say and then I do not listen to them either, that is the way it is. Some people you may connect with every time you meet them and with others less so". When asked to elaborate on how this connection

made the patient feel the patient stated “this connection really means a lot to me. It is worth a great deal” (p. 5).

Patients felt that from one interaction to the next, they were unsure how it would go and that part of it depended on the mood the carer was in at that time. It is essential that healthcare professionals are made aware of the impact that the mood and manner of the actions within the healthcare setting have and further contribute to suffering for patients.

It is important that health carers work to reduce the patient’s suffering as opposed to the patient suffering being related to health care. The dignity of patients can be very easily violated for numerous reasons including patients not being taken seriously and staff not believing what patients are saying (Arman *et al.*, 2004). With the ever increasing pressures that are felt within care environments, it is imperative that healthcare professionals work with patients and do not use their authority to decide what is best for the patient as this can lead to additional suffering.

Within the human experience, suffering is related to life itself or to illness or disease that cannot be avoided. However, it is clear that suffering which is related to care needs to be addressed (Svanstrom *et al.*, 2013). It might be that by focusing on compassion and ensuring it is present in practice, that this could perhaps be a stepping stone to reducing the suffering related to care.

It is clearly impossible to think that nurses can always relieve a patient’s suffering; however, they can facilitate patients in finding a meaning to their suffering by incorporating compassion whilst caring for them. When health care providers understand a patient’s view, they can better assist a suffering patient. This can be achieved by witnessing the patient’s suffering and providing support which acknowledges the patient’s suffering by listening and creating a supporting, healing environment (Deal, 2011).

Compassion therefore incorporates comforting the sufferer and not just for the physical pain they may be experiencing (McCabe, 2007). Van der Cingel (2009) feels that

compassion is the appropriate response when a person suffers unpredictable permanent limitation or losses.

It seems therefore that compassion is the optimum response to the suffering of another, and this suffering allows the patient to find meaning within it, if they have a supportive health care professional to assist in this process. This was seen across a range of healthcare settings, including the area of interest to this study, older adult care.

“Suffering does not happen to us; we happen to suffer. Suffering is what we choose to do with pain” (Younger, 1995, p. 55). A fitting response by healthcare professionals when suffering is witnessed is to be alert and to use imagination to gain perspective of what the patient is experiencing. Compassion and suffering require the nurse to be courageous when caring for patients where questions and situations have no easy answers (Scholler-Jaquish and Johnston, 2007).

2.3.2 Compassion and Identification

The next element from Van der Cingel’s framework that will be discussed is identification in relation to compassion. Margaret Van der Cingel acknowledges that many philosophers believe compassion is dependent on empathy, identification and imagination (2009). Each of these will now be explored.

Prior to this exploration, it is important to gain an understanding into the social neurosciences in relation to recent findings surrounding the existence of empathetic mirroring neurons and how this relates to developing emotional connections with people. Recent neuroscience evidence now appears to associate a distinct emotional mirror neuron system with the human capacity for empathy and compassion (Rizzolatti and Sinigaglia, 2008).

When a person experiences an emotion or carries out an action, certain neurons fire. However, when observing another person carrying out this action or experiencing an emotion or if one imagines either of these, the same neurons will fire again, as if the person is experiencing the situation. The empathetic neurons connect individuals to other people, resulting in people being able to feel what another person is feeling and may be

what is required for a person to feel compassion for another. In order for the neurons to respond, they must be triggered by imagination which initiates emotional feedback and thus allows self-reflection. In short, the mirroring neuron does not distinguish between itself and others, thus, allowing a person to feel the same emotion if they themselves were in the situation. The rapid understanding that occurs within this mirroring process is an essential factor required for empathy and compassion, which makes up the majority of complex inter-individual relationships. This evidence links humans with having a prewired capacity to make deeply intimate, emotional connections with others (Kelley and Kelley, 2013).

Empathy is seen as a prerequisite for compassion. It requires the person to identify themselves in relation to another person by using imagination. A study conducted by Bray *et al.* (2014) aimed to assess healthcare professionals and pre-registered students' understanding of compassion, focusing on the role of education in compassionate practices. A mixed method approach was utilised and data were collected from a total of 352 participants, with 14 of these also completing interviews. Upon asking participants to choose from eight statements about their perceptions of the understanding of compassion, acting with warmth and empathy was the most selected statement, and thus, was seen as the leading attribute for compassion.

Peter Abelard (1079-1142) proposes that suffering causes heart break which in turn creates an interior movement of compassion and instinctive empathy that allows people to be saved from their suffering (Armstrong, 2011).

Compassion is concerned with the misfortune of others and Aristotle believed that it will only be felt by persons who have encountered suffering and have an understanding of what it is to suffer and that by identifying when suffering is present one can identify that the sufferer requires empathy (Nussbaum, 2001). Aristotle also emphasises that a person will not experience compassion if they believe themselves to be above suffering. The question then arises, what is required to feel compassion.

How does one identify the need for compassion? Identification allows a person to ascribe the qualities and characteristics of another person. It can involve the feelings or responses that are considered appropriate (The Oxford English Dictionary, 1979).

Identification is seen as a vital component which gives the person an insight into comprehending how that person is feeling in a metaphysical way (Schopenhauer and Payne, 1998). It is clearly impossible to assume that two people can feel the exact same feelings, however, it is the aspect of understanding those feelings that initiates the affective component of compassion (Scott, 2000).

Pask (2001) views identification as part of the nurse's duty. The nurse must be receptive to their patient and have the ability to detect what is salient from the patient's perspective. Nurses must demonstrate sensitivity whilst acquiring all the details to ensure they have a greater understanding of what is significant for the person and thus, they can respond appropriately. Von Dietze and Orb (2000) believe compassion involves the 'deliberate participation in another person's suffering, not merely [the] identification of the suffering, but identification with it'.

As discussed in section 2.3.1, Torjuul *et al.* (2007) conducted a study looking at compassion in a surgical care unit. This study found that identification was acknowledged as a component within compassion. According to the nurses, by identifying similarities with the patients, be it being the same age, a mother or having children, they were able to gain an insight into the loss and suffering the patient may be living with. One of the nurses revealed that by connecting with the patient's circumstances the ability to empathise with the patients and family became possible.

In order to gain an understanding of how serious the suffering an individual is experiencing, it is imperative to have all the information surrounding the sufferer. Van der Cingel (2009) points out that there will be occasions where the information will be clear, for example, when somebody loses a family member this suffering is obvious and warrants compassion. Yet, one cannot dismiss the other losses until all the facts are present and a greater understanding of what the loss means to the person has been established. Time with the person is necessary to better understand their points of view and interests. If this is not achieved, the loss is then unknown and the suffering may continue but appear invisible to others. Teuber (1982) feels that compassion involves reading the other person, while holding back one's own opinions and interpretations.

Christiansen (2009) supports this theory by believing that knowledge of the person allows nurses to work and care for patients.

Van der Cingel (2009) considers it logical to include imagination, a necessary element in understanding another person's feelings. Imagination in terms of compassion involves pretending that the situation is occurring to oneself, as opposed to the person who is actually suffering. However, there is a risk of losing a vital element of compassion by using self-reflection, as compassion is based on focusing on the other person instead of oneself. Imagination can be used in a variety of ways, but to use it to extract compassion, one needs to 'de-self oneself' (Van Der Cingel, 2009). This incorporates appreciating other things in life that you may not consider important, but are important to others. The more one can 'de-self', the more compassion they can identify with the person about how they are feeling. A person, who finds it hard to 'de-self', would be more inclined to attend to their own interests. There is a fine balance between over identification as it tends to decline with the result being a lack of compassion (Richmond, 2004). Compassion asks of a person to temporarily side line their own beliefs and values. To achieve this, one must be able to differentiate another person's needs over their own (Van Der Cingel, 2009).

Van der Cingel's (2011) study recognised identification and imagination as significant factors necessary for compassion. The interviews within the study brought to light that nurses have used their imaginations to allow themselves to identify with the patient's situation. The nurses utilised how they would feel or how they would behave under the patient's circumstances. It was also noted that personal experiences assisted some nurses in identifying with patients.

Imagination is an essential component needed to assess a person's vulnerability. Nussbaum (2001) labels this as the eudaimonistic argument for compassion; in which every individual runs the same risk of going through difficult scenarios in life. Nussbaum argues that if one cannot recognise what suffering would be like for themselves, how can they possibly know the significance of suffering at all.

This brings to light another factor which may be required for compassion; it is reasonable to assume that a relationship of some description is necessary in order to obtain this personal information and identify another person's suffering. This relationship allows one to assess the relevance of the loss to the person (Van Der Cingel, 2009). Yet, it also has

the potential of causing the patient to show less emotion, as personal attachment to the nurse may impede this. One wonders if this means health care professionals should be distant with the person and risk losing the very relationship that is required for compassion.

Unfortunately, there are down sides to both of these options as too much compassion can lead to the healthcare professional sacrificing themselves for their patients (Lazarus, 1991), but too little compassion can result in neglect for the patients. Compassionate care matters to patients and more importantly the presence or absence of compassion leaves lasting and vivid memories with patients and families regarding their experiences in the health care setting (Cornwell and Goodrich, 2009). Carse (2005) feels it is vital to find a happy medium between the two, for the patient and the healthcare professional.

It is clear to see that compassion is a complex phenomenon. Identification requires the individual to be aware of another person's perspective, which incorporates a certain degree of 'de-self'. Compassion requires a person to put aside how they might feel if they were experiencing this situation, as compassion is all about the other person. However, empathy, identification and imagination assist in providing compassionate care for the other person.

2.3.3 The Emotion Compassion

The next element of Van der Cingel's framework that will be discussed is compassion as an emotion. Compassion is seen as a painful emotion by Martha Nussbaum and as a distinctly moral emotion (2001). Margaret Van der Cingel (2009) believes compassion is an emotion that focuses on another person's difficult circumstances and it is important that it is accepted as an emotion. An alternative word for emotions is 'passions', thus, compassion could be seen as a strong feeling from which it may be difficult to escape. This section will firstly examine what is an emotion and how they impact on humans. The theoretical perspective of emotions will then be discussed and the difference between feelings and emotions will be reviewed.

Firstly, it is important to highlight what an emotion is in order to further discuss the emotion family in which compassion belongs to. Emotions are designed to deal with inter-organismic encounters between people or people and animals. Ekman (1992)

believes that the primary function of an emotion is to mobilise the person to deal quickly with important interpersonal encounters. It seems that emotions are reactions to issues that seem very significant to our welfare that can occur so quickly that we are unaware of what set the process off in our own mind (Ekman, 2003).

Lazarus (1991) identifies that emotions play a central role in the significant events in our lives. He believes that much of what we do and how we do it is directly correlated to our emotions and what generates those emotions. It is even thought that emotions could contribute to physical and mental health and illness; positive emotions to health and negative to illness. Lazarus (1991) views emotions as lying at the centre of human experience and adaptation.

Some of the most basic emotions are seen to act as a family of emotions, in such that they are related by common characteristics. Goetz *et al.* (2010) views sympathy, empathy and pity as being part of an emotion family of compassion-related states that have comparable features to compassion, in that they aim to reduce the suffering of another. Ekman (1992) describes the emotion family as a group of emotions related by common characteristics including physiological reactions and signal behaviours, trends in core actions and main appraisal processes.

Emotions play a pivotal role in the major events in people's lives and people tend to be influenced by their emotions and the events that cause them. Emotions are thought to lie at the core of the human experience. Each emotion is defined by many characteristics including behavioural, physiological and above all psychological (Lazarus, 1991). The object of each emotion differs and is generally associated with someone or something. The purpose of compassion is the relieving of the suffering of another person. It is assumed that the thoughts that one has on the suffering of another person help to maintain support for compassion as a present emotion.

Describing compassion as responding with humanity and kindness, the Department of Health (2012a) highlight how it can ease and comfort another's suffering. By respecting another person compassion becomes more than just being kind to them, it becomes an emotional connection (Goodrich and Cornwell, 2008).

The theoretical underpinning of emotions is something that causes mixed opinions. Many viewpoints, including the stoic and rationalistic believe that emotions are unrestrained forces or physiological irregularities, concluding that compassion originates in innate instinctive responses (Taylor, 1999). Current opinions on emotions have developed a different perspective of theories. The physiological aspect of emotions has been researched by scientists and puts forward the prospect of a biological mirroring process occurring in the neural system of the brain when a person reacts to emotions of others (Schulz *et al.*, 2007). However, most current theories believe that emotion theories are made up of cognitive, affective, volitional and/or behavioural characteristics (Nussbaum, 2001; Charland, 1997). Emotions amongst people tend to show a great variation as they are seen as an individual phenomena (Lazarus, 1991).

Feelings and emotions are two terms that are frequently used interchangeably, yet, the literature identifies them with clear differences. Feelings are thought to be a physical experience requiring sensory perception. Feelings for example include pain and pleasure. A feeling of pain can be a sensation felt in a specific area of the body that can be the result of an injury and as such has a physical cause. Whereas, emotions are more complex in nature in that they are governed by thoughts. Emotions allow one to determine if the benefits or harm of a situation have been assessed. The cause of emotions is not necessarily linked to a physical cause. Emotions can lead people to feel anxious, fearful, happy or sad. Nussbaum (2001) believes that without a thought, there can be no emotion. Compassion as an emotion requires a person to have a specific thought. So, although a person may witness another suffering, unless they process a thought about that suffering, they are unlikely to demonstrate compassion (Van Der Cingel, 2009; Lazarus, 1991).

Many questions surrounding emotions arises over the relevance and rationality of the emotion. A qualitative study conducted in the Netherlands asked 30 nurses and 31 patients about the feelings and thoughts they experienced when being compassionate. The majority of them felt that both were present during compassion and that they occurred almost in unison with each other or in very quick succession, so much so, that many found it difficult to differentiate between the two (Van der Cingel, 2011).

Lown *et al.* (2011) incorporates emotional support when defining compassionate care for patients. A study conducted by Lown *et al.* (2011), surveyed 800 patients and 510 physicians with the aim of improving compassionate care. The study found that the majority of patients and physicians agreed that health care outcomes were dependant on effective communication and emotional support and that compassion and the elements that make up compassion were very important in care.

“Compassion is a reaction of emotion felt by an individual witnessing another person’s plight or misfortune” (Kret, 2011) (p. 29). A descriptive study was carried out by Kret (2011), in which 100 nurses and 100 patients partook to examine the qualities of a compassionate nurse. Patients rated their nurses as compassionate and nursing compassionate qualities were deemed to be caring, attentive, dedicated, approachable, professional and keeping the patient informed.

Torjuul *et al.* (2007) conducted a study as described in section 2.3.1. Some of the findings involved discerning the challenging emotions encountered when experiencing the suffering of patients. The most frequent description when experiencing this suffering was “It touches/moves me” (p.526). Other emotions that were felt included: ‘heavy’, ‘demanding’, ‘tough’, ‘energy consuming’, ‘physically and emotionally draining’ and ‘exhausting’. Nurses also expressed the feeling of frustration and distress when caring for a patient who was unlikely to recover from their illness; as it was felt that the suffering could not be relieved.

Nussbaum (2001) argues that emotions involve judgements or appraisals. Being vulnerable tends to be the route that leads people to their emotions. However, it is the emotions themselves that in the case of compassion, recognises the pain and suffering experienced by a person as negative due to the affect they are having on the person’s life (Nussbaum, 2001). Morse *et al.* (1992) sees compassion as a strong emotion that requires two people to share in suffering, it is the reaction of emotion that occurs when witnessing another person’s misfortune (Kret, 2011). Nussbaum (2001) regards compassion as the basic social emotion that is used to ease another person’s misfortune or suffering.

2.3.4 Motives for Compassion

The fourth element of Van der Cingel's framework concerns the motives for compassion. Following determining compassion as an emotion that involves identifying another person's suffering in the previous section, this section will consider how thoughts and emotions are linked in relation to compassion. It will review why a thought process is necessary for compassion and how compassion is only possible within an interaction with another person. The importance of the human relationship will also be discussed, along with what motivates a person to act compassionately; and whether it is an altruistic or egotistic act.

Firstly, in order for a person to be motivated to feel compassion, a thought process is needed; in which thoughts are not just fleeting glances but they are remembered. This along with structural thinking patterns enables a person to support their own values (Van Der Cingel, 2009).

Secondly, it is necessary to clarify who are the persons' within the interaction. The individual that feels compassion generally is seen as the person that is witnessing the scenario or is interacting with the person, thus, in a health care context, this compassion is thought to arise in the nurse or other health professional (healthcare assistant); whereas the sufferer, in the health care context the patient, is seen as the object of compassion.

This highlights the different perspectives that are then becoming incorporated into the human phenomenon of compassion, as a result of individuals differing thought processes. For example, if one nurse is of the viewpoint that autonomy, individuality and free will are essential for patients, then they will inevitably have a different stance on suffering, in comparison to a nurse who prioritises relationships and human solidarity (Snow, 1991).

In order for compassion to be present, a human relationship is required. This is why it is vital for nurses to build up a rapport with patients to ensure that a relationship has been established. Within this relationship, compassion can only occur if a conversation is occurring between the nurse and the patient (Kelley and Kelley, 2013).

Fry *et al.* (2013) considers that compassionate care within the nursing profession requires nurses to negotiate the relationship between emotional and physical well-being. A study

conducted by Fry *et al.* (2013) examined nursing praxis, compassionate care and interpersonal relations in order to establish if compassionate care is a core nursing skill that supports interpersonal relations. A qualitative exploratory study was carried out in three hospitals in Australia with 16 specialist nurses being observed within the work environment. The observations identified how the specialist nurses utilised experiences from nursing and caring compassionately to facilitate interactions and relationships with patients. In order to act compassionately, nurses relied on effective communication and interpersonal relations. Other themes that were identified included positive body language and emotions in nursing praxis. Positive body language was acknowledged as eye contact, touch, using small talk and humour as well as empathy. This study highlights the importance of compassionate care within the nursing profession and also highlights how a relationship is necessary for compassion to occur.

It is also necessary to remove compassion from words with similar meanings including pity, empathy and sympathy. These words are closely related to compassion but are not synonymous with compassion's ideals. The Greek word *Eleos* is used by Nussbaum and translates directly into the word 'pity'. However, Nussbaum believes compassion or pity can be translated while acknowledging that these words are not synonyms.

The question then arises as to what motivates a nurse to act compassionately. It could be that compassion is not possible given the fact that the nurse is not the person experiencing the suffering. The relationship between the nurse and the patient could be seen as an unequal one, in regard to the fact the nurse can continue on with their life whilst the patient has limitations placed over theirs. The risk of an unequal relationship could lead to the potential abuse of power leading to acts of egoism. (Van Der Cingel, 2009).

Altruism vs egoism is one of the debates that surround compassion. Schopenhauer and Payne (1998) believe that compassion portrays an image of goodness, viewing compassion as the opposite to evil, which requires that absence of egoism. Compassion is commonly related to an altruistic action which is concurrent with Mannion's (2002) theory that compassion is a virtue. As a result, one can ascertain that goodness is integral to compassion, as it is also the situation in empathy and sympathy. However, goodness is not perhaps integral to pity. Pity is described as the feeling of concern for another who is

thought to be inferior to the person and results in a condescending relationship (Nussbaum, 2001). Therefore, it can be regarded as a motive for compassion.

However, Nussbaum (2001) disagrees that the helping that is conjured by compassion is always truly altruistic. Nitschke *et al.* (2004) believes that compassion can be egoistic and may include pity and its downsides (Cartwright, 1988). Pity can have very negative effects for patients if used in the healthcare settings by nurses including humiliation and inferiority which can ultimately lead to a lack of trust.

Van der Cingel's (2011) study examined the similarities and differences between compassion and pity. Looking at the similarities, both emotions involved feeling sorry and understanding the other person's plight. Yet, the patients felt that pity was associated with negative connotations. Pity was defined by participants as feeling sorry for a person in a patronising manner, which left them victimised and powerless. This, in turn, left the nurses in a position where they were unable to support their patients.

Nitschke *et al.* (2004) also considers compassion to be an act of doing good in order to be seen in a good light. This is working under the assumption that compassion is often considered to be accompanied by the thought process, that the situation could occur to oneself. Thus, it could be fair to say that compassion could hold an element of self-interest.

Nussbaum (2001) contests this opinion and feels that a person is not compassionate, purely for self-motivated reasons, or fear of being in the same bad situation. Acknowledging that it is significant for a person to feel their own vulnerability, as it can open up the route to the emotion, Nussbaum believes that it is the emotion that identifies the pain the other person is experiencing as a bad thing, because of what it is doing to the other person's life. Being aware that the compassionate person is clear about the differences between themselves and the sufferer, the compassionate person values the sufferer as part of a circle of concern.

Compassion gains meaning from people and people can act in egotistic and altruistic ways. A relationship based on egoism will undeniably lose out on compassion as the person is not available to the sufferer. The act of compassion involves the person wanting

the best for the sufferer. It does not involve putting someone else before oneself and vice versa; as the person suffering is evidently the one worse off.

Hudacek (2008) believes that the caring practices and the knowledge that nurses experience and share in the duty of work helps to connect all nurses worldwide. Hudacek (2008) carried out a qualitative study to examine nurses stories to gain an insight into caring practices. By utilising Giorgi's methodology for existential phenomenology, nurses gave a description of a caring event that made a difference to the life of the nurse and the patient. Two hundred nurses participated from the United States, Slovakia, Tokyo, Tekrit, Argentina, Australia and Cuba. After analysis of the descriptive narratives provided by the nurses, seven caring dimensions were identified: Caring, compassion, spirituality, community outreach, providing comfort and going the extra distance. In line with the compassion dimension, Hudacek reports that nurses from all locations within the study highlighted compassionate caring within the caring stories. Thus, compassion was seen as a universal outcome within the study. Participants' narratives demonstrated the emotional and physical presence required for compassion and the benevolence and sincerity that was used when describing compassionate care was also noted.

A passage from one of the nurse's narratives highlights the different factors that can motivate compassion. '[My patient] was 17 [years old] and dying of acute lymphocytic leukaemia. She had been diagnosed with leukaemia when she was 11 years old. While other kids were playing, she was enduring chemotherapy. She knew she was sick and dying. At that moment, I realised this was another gift of nursing, helping people to "die well." Not to die alone, but loved with family and friends at their side' (Hudacek, 2008, p. 127).

Compassion is seen to require a thought process in which people retain values. A prerequisite for compassion is that an interaction must occur between two individuals and a human relationship is also essential. Compassion is seen to be motivated in many ways. It can result as an act of altruism or some claim it to be an act of egoism however, the main aim of compassion is to alleviate the suffering of another which ultimately rules egoism out as a motive.

2.3.5 Conditions for Compassion

Continuing with Van der Cingel's framework, this section considers the conditions that are required for compassion. It seems that compassion is known to be elicited when a person is experiencing a certain level of seriousness of suffering which could potentially lead to loss. In the section on motives for compassion it was identified that a specific thought is needed and that compassion was at its most sincere when the needs of the person who was suffering were the priority.

This leads one to believe that compassion does require certain conditions to be present. Carr (1999) offers a basic guide to the three conditions considered necessary for compassion. Included in these conditions is that compassion requires an appreciation of another person's suffering; that compassion evokes a sympathetic response of distress for the person witnessing the suffering; and a desire to ease this suffering by helping the distressed person.

Aristotle had a complex definition for compassion that was based on the notion that compassion was present as a result of pain. There were three key conditions that were required for compassion. Firstly, the misfortune that occurs to the sufferer must be seen as a serious threat to the person's well-being. Secondly, the suffering must appear undeserved. Finally, the compassionate person must believe themselves to be susceptible to similar suffering or vulnerability (Deigh, 2004; Nussbaum, 2001). This intricate judgement of the components of compassion is simply evaluative and not eudaimonistic as Nussbaum (2001) incorporates into the factors for compassion.

Nussbaum (2001) agrees with two of the three conditions that Aristotle puts forward for compassion including the size of the misfortune and undeserved suffering. Proposing that in the case of undeserved suffering, the sufferer must be non-blameworthy and without fault, Nussbaum feels this is an essential component for compassion. Aware there are exceptions to this circumstance, where a person has come to suffering as a consequence of their own fault; it is felt that once the suffering is out of a proportion to the fault then a compassionate response should ensue. Nussbaum recalls Aristotle's opinion that an undeserved suffering individual awakens a person's sense of injustice and thus, compassion would not be present without undeserved suffering (Nussbaum, 2001).

However, Nussbaum (2001) contests the third condition, stating that it is unnecessary for a person to feel at risk of being in similar circumstances as the sufferer. He feels it restricts Aristotle's definition and so replaces it with an unequivocal eudaimonistic one where a person is aware of the welfare of the object of their compassion and its importance. Conscious that by being vulnerable to the misfortunes of others can lead one to recognise how vital another person's well-being is, Nussbaum believes it is actually the understanding of the person's misfortune as opposed to the possibility of one being in similar circumstances that is ultimately necessary for compassion (Deigh, 2004; Nussbaum, 2001).

Compassion also requires other conditions in order to be effectively demonstrated. Firstly, a human relationship is required as previously identified in section 2.3.4. This is why it is vital for nurses to build up a rapport with patients to ensure that a relationship has been established. Within this relationship compassion can only occur if a conversation is occurring between the nurse and the patient (Kelley and Kelley, 2013).

Secondly, communication is essential in order to allow this relationship to develop and to ensure compassion is communicated to patients. Communication can be demonstrated in two ways, verbal and nonverbal. Kelley and Kelley (2013) believe that when compassion is communicated effectively to patients, it has the ability to be transformative within the relationship. However, when inadequate communication occurs between the nurse and the patient, it can ultimately create more suffering as a result of the care provided as it can cause the patient to have a sense of insecurity in an already unfamiliar environment (Svanstrom *et al.*, 2013). Therefore, it is vital that nurses and all healthcare professionals have the ability to communicate effectively with the patients in order to facilitate compassionate care.

A verbal technique is the traditional method of communicating by mouth and includes: clear language that can be understood by both people within the conversation, clarity and brevity, vocabulary, denotative and connotative meaning, pacing, timing and relevance and humour. Nonverbal communication techniques include; body orientation, meaning to face one's body towards the patient when it is possible to do so; eye contact, occasional eye contact can be a significant factor in making a connection with the patient; and head nods. All these nonverbal techniques simply communicate to the patient that the nurse is

interested and listening to the patient; and voice tone and rhythm, ensuring that the tone and rhythm are synonymous to what is being said by the nurse.

Shaltout *et al.* (2012) describes how positive nonverbal communication can lead to powerful clinical benefits and carried out a study within this area exploring the impact of exposure to a form of nonverbal communication. Using healthy volunteers, this study tested two strategies (tactile and nontactile), delivered over two different time periods (10 and 20 minutes) in which a practitioner aimed to communicate compassion to the participants using nonverbal communication. Twenty subjects participated in the intervention during which the practitioner was meditating and autonomic measuring equipment was set up on both subjects. The results demonstrated that all participants remained blind to the interventions of meditation that was occurring as part of the nonverbal communication. Heart rate was seen to significantly decrease in subjects during the intervention which supports the theory that nonverbal communication of compassion has an effect on the autonomic nervous system thus, highlighting the benefits compassion can have within an interaction. However, due to the small sample size, this study would need to be replicated on a larger scale with patients as the subjects.

2.3.6 The Moral Significance of Compassion

The final element of Van der Cingel's compassion framework that will now be discussed is the moral significance of compassion. This includes consideration of the decision making process that is involved in providing compassion; whilst examining how a compassionate decision is determined. Finally, this section will look at the different beliefs surrounding the moral actions of compassion.

Moral significance relates to a cognitive or thinking element before one may or not decide to act in a compassionate manner (Carr, 1999). Fritz Cates (2003) feels that compassion involves a deliberate process of decision making in which a person must be conscious of the need for compassion. This then suggests that people can choose to be compassionate or not.

Although this appears contradictory, if compassion is an innate action as previously suggested, Van der Cingel (2009) emphasises that the decision making process can be

something that occurs in either a step by step method or it can be a spur of the moment reaction. In terms of healthcare professionals, these spur of the moment decisions are based around the clinical picture which results in a clinical judgement. Nurses and healthcare assistants can at times tell a lot about a patient's condition from just a glance. By using their clinical judgement, they establish a feeling about a certain patient, and thus, the need to delivery care.

However, this process is thought to not actually be a feeling, but to be an accelerated interpretation of the presenting signs and symptoms that the patient is displaying which are recognised due to the healthcare professional's clinical expertise (Cioffi, 1997). Cioffi (1997) describes this process as intuitive judgement. For the nursing profession, it seems that the use of reflection plays a significant factor in assisting in making these spur of the moment decisions and thus, making the decision to provide compassionate care. By utilising previous caring experiences and being aware of subtle changes in a patient's behaviour or appearance, a nurse can identify links from the past that can facilitate their care of patients' in the future. Common-sense, understanding, the skill of know-how and a deliberative rationality can also further assist the nurse to make these quick judgements. It is thought that this process is applicable to compassion and thus, compassion can be spoken of in terms of how to practise compassion.

Viewing compassion as a decision making process brings about the question, how is this decision determined. As stated previously, compassion acknowledges the suffering of another person. By recognising the suffering, it gives one an option of how to respond to it by using actions or behaviours that demonstrates the desire to alleviate the suffering, hence the volitional aspect of compassion as detailed by Carr (1999).

In order for compassionate care to be identified as present, it is essential that such care is shown in a clear and discernible manner. This can be achieved through communicating verbally or non-verbally, by assisting the person/patient or by just being with the person/patient. It seems the nature or manner or method by which the compassion is provided is not the priority, it is that compassion is shown as the priority. When compassion is denied as a result of a lack of acknowledgement of the suffering present, the suffering and loss become devalued and ignored. This brings to light that every

healthcare professional has a choice which can be seen as a decision making process as to whether or not to recognise the suffering of another (Van Der Cingel, 2009).

A study carried out by Armstrong *et al.* (2000) in the UK investigated compassion as a moral virtue, whilst examining compassion in a group of psychiatric nurses. It utilised the Delphi method and semi-structured questionnaires to acquire information from 26 nurses in round one, 22 nurses in round two and 14 nurses in round three of the questionnaires. Eight themes emerged. The 2 key themes were 'the nature and role of moral virtue in psychiatric nursing' and 'the meaning and importance of compassion in psychiatric nursing'.

Under the theme of the moral virtue, the nurses were asked to prioritise what was considered to be the most important element when making a decision to resolve a case with a patient. Of the 23 responses, 15 choose 'patients rights' as the main priority. Lists of personal attributes were also rated in association to moral virtue. Honesty, fairness and compassion rated in the top three. When questioned on 'what are moral virtues' and 'why do your choices count as moral virtues', just under half of the participants defined morals as a positive characteristic that can have a positive effect on oneself or others. Whilst just under a quarter of participants felt moral virtues assisted in deciding whether something is right or wrong. It seems therefore in line with what was suggested by Van der Cingel that compassion includes a moral significance.

The choice to be or not to be compassionate and partake in another's suffering brings about a moral dimension to compassion. A compassionate person assists the person suffering through certain emotions including pain, grief and anxiety. Yet, compassion does not resolve the suffering that is felt; it exposes the emotions making them more prominent but the sufferer now has a person to share their experience thus, reducing the isolation. Healthcare professionals should be utilising this response when faced with patients who are suffering as a result of a loss or a change in circumstances. Being compassionate has the potential to open up the pathways to be with someone during their misfortune.

To further explore compassion as a moral virtue, it is argued using a Kantian perspective that nurses and other health care professionals have a moral duty to be compassionate as a result of a duty arising from being a member of a profession (Sytsma 1997).

However, it is also argued that such a 'moral duty' viewpoint could lead to healthcare professionals carrying out their care as per protocols instead of caring with passion and compassion, whereas, the counter argument is that emotion as a motive for compassion could also be an unreliable motive? This debate seems set to continue, but ultimately, the important issue for health care is that compassionate care is provided.

One further issue that may arise when considering compassion with a moral significance is that failure to do so may lead to a failure to address a person's/patient's suffering with the ultimate result being that the person experiences more suffering. Non acceptance or acknowledgement of suffering can lead to an outcome of creating more harm for the sufferer as their problem remains invisible or even if visible, unaddressed by people around. This then causes hopelessness to the individual experiencing the suffering.

Compassion has the ability to provide comfort for those who are suffering; comfort allows people to be aware that they are not on their own in the situation. Compassion identifies what a person has experienced, it acknowledges and makes visible the emotions and feelings that were exposed and offers support to remove the isolation that was felt. It seems that compassion is more likely for healthcare professionals. For example the International Council of Nurses (2012), outlines that nurses must demonstrate professional values including compassion.

This section clearly outlines Van der Cingel's (2009) compassionate framework which addresses the main concern for compassion and care in nursing and research. Suffering appears to be a major component required for compassion to be present, in which the person who witnesses the suffering wishes to alleviate it for the sufferer. By acknowledging the suffering of another person it allows them to find meaning within the suffering and helps to ease this suffering. To facilitate compassion and the alleviating of suffering one must be able to identify when compassion is required. This is thought to be established through empathy, identification and imagination. Empathy allows the person to identify themselves in relation to another person with the use of imagination.

In order for compassion to be present Van der Cingel proposes that it must be seen as an emotion. Compassion is viewed as a painful emotion which links to a family of emotions. Motives for compassion were reviewed and it was found compassion can only occur within an interaction with another person. Conditions for compassion and the moral significance of compassion were also discussed and how they affect compassionate care.

2.4 Compassion and Nursing

The previous section explored compassion using Van der Cingel's framework as a basis for the components of compassion. This section now considers patients and nurses views of compassion and compassionate care. Following an extensive literature search strategy (Appendix 1) research studies surrounding compassion from the nurses' and patients' perspectives were identified (Appendix 2). This section will initially discuss the nursing studies and then will proceed to review the studies that incorporate patients.

2.4.1 Nursing

Nursing is viewed as both a science and an art. Both elements are of equal importance. However, it would seem that the development of the science aspect of nursing seems ahead of the art. Jean Watson (1981) proposes that the art of nursing is primarily focused on communicating with patients to gain an insight into the experiences of being a patient and an understanding of emotional responses felt with these experiences. When a nurse is caring for patients, Watson (2008) believes that developing a trusting, therapeutic relationship is fundamental in order for caring to be present between the nurse and patient. Effective communication can assist in developing a trusting relationship. Patients who see the nurse as being open, warm and empathic tend to be more open and receptive with nurses. This in turn can ease the patient's anxieties and concerns (Lowey, 2008; Kennedy Sheldon *et al.*, 2006). Being caring to patients is perceived in certain actions including; listening to stories, taking time with the patient, getting to know the patient and just being with the patient. A compassionate nurse is seen as one who conveys a warm and caring attitude whilst taking the time to value and understand worries, values and aspirations which the patient may have (Czerwiec, 1996).

Health care professionals want to be able to care for their patients with humanity and decency; aiming to care for all patients as they would want for themselves and their families (Goodrich and Cornwell, 2008). It seems that nurses want to be able to show compassion to the patients they care for and for many professionals it may have been the motivational factor in their decision to enter into their career (Straughair, 2012; Goodrich and Cornwell, 2008)

Van der Cingel's (2011) qualitative study into compassionate care and the relationship between older people with chronic disease and nurses, interviewed thirty nurses. It was found that the nurses saw compassion as listening, being attentive, confronting, a helping attitude, involvement, understanding and presence. Furthermore, it was seen that nurses felt you had to imagine yourself within the person's situation. Several nurses reported using this technique and their own professional and personal experiences to relate to the patient. One of the nurses from the study stated "You cannot know from theory how painful it is if you don't recognise a part of it. It doesn't have to be the exact same experience, but you need to draw upon something" (Van der Cingel, 2011, p. 681).

In another study carried out by Dewar and Nolan (2013) involving staff (n=30), patients (n=10), and families (n=12), seven words were identified as factors to achieving compassion: connection, compromising, courageous, considerate, curious, celebratory and collaborative. It would appear that nurses feel that compassion is made up of many different elements. This may explain the challenge in finding a widely accepted definition of compassion.

Compassion can also be seen as the little things that nurses do for patients. Graber and Mitcham (2004) examined the 'compassionate clinicians' by carrying out interviews with 24 clinicians who were classed as exemplary individuals. Ten nurses were included in the study and they described how compassion and caring can vary from introducing themselves to patients and explaining that they would be caring for them, to regularly asking patients if there is anything that they needed help with. Other gestures included smiling, using a friendly tone of voice, getting to know the patient, making eye contact and asking permission prior to assisting the patient. By performing these small kind gestures, it can help the clinician view the patient as a unique person and aid in establishing a trusting relationship.

Nurses have continually expressed their concerns that they do not have adequate time to care for patients properly and that tasks, routines and documentation take priority over the holistic care of the patient (Pearcey, 2007; British Journal of Nursing, 2004). This has the potential to frustrate nurses due to the lack of fit between their values and the quality of care they are able to provide. A survey carried out by the British Journal of Nursing (2004) identified that nurses felt that they were unable to give actual nursing care to patients.

The survey by the British Journal of Nursing included over 300 hundred nurses; the results of which showed that almost 90% of the nursing staff felt they were unable to care for the patients properly in the time provided. Nurses indicated that there was a danger of the profession losing sight of its clinical heritage and that certain job responsibilities within direct patient care were at risk of being downgraded and diminished. When asked how staff morale could be improved, nurses suggested less government interference, stronger leadership and greater support from managers. The survey demonstrated that the nurses took a great sense of pride in the clinical aspect of their work, but felt they lacked the time to carry out these duties to the best of their abilities due to the paperwork which superseded practical care. This can trigger frustration in nurses due to the lack of fit between their values and what they can provide and could potentially lead to compassion fatigue or burnout. Although this survey took place almost ten years ago, the findings may still be relevant to current practices, perhaps even more so due to increasing demands on healthcare.

Indeed, a recent international study conducted by Ausserhofer *et al.* (2014), with 33,659 nurses from 488 hospital across 12 European countries found that the most prevalent nursing-care tasks which were left undone were 'comfort/talk with patients', with 'developing or updating nursing care plans/care pathways' and 'educating patients and families' also marked as being prevalent. The results showed that lower levels of care tasks left undone were found in more favourable work environments including when nurse to patient ratios were lower and when nurses did not have to complete non-nursing duties. This study demonstrates how the work environment and organisational factors have an impact on the care that staff can provide to patients. Nurses appear to have a coping mechanism which allows them combat the work struggles and focuses them on a more task orientated care.

It seems that providing compassionate care may have benefits for the provider as well as the recipient. Burton and Stichler (2010) carried out a study testing 6 hypotheses one of which was to assess if compassion satisfaction was positively correlated with nursing care. A correlation approach was employed, using a convenient sample of 126 nurses in 1 academic medical centre. Data was collected using 4 validated research instruments: 1. The Mueller McCloskey Satisfaction Scale, 2. The Professional Quality of Life Scale, 3. The Stress in General Scale and 4. The Caring Behaviours Inventory. Burton and Stichler (2010) found that the hypotheses was reinforced by being statically significant ($P < 0.001$), thus supporting a moderately positive connection between compassion satisfaction and nurse caring approaches. The study findings support that through compassion satisfaction, nurses use self-actualisation to carry out duties. It also identifies the positive association between happiness, work meaningfulness and patient satisfaction (Leiter *et al.*, 1998).

However, it does not appear that compassion is always highly regarded by nurses. A study discussed in section 2.3.2 which looked into the understanding of compassion by professionals and pre-registered healthcare professional identified that in many participants' opinions, compassion was not the most important attribute required, that in fact, knowledge was the number one priority (Bray *et al.*, 2014). Compassion was seen to contribute to all aspects of care, but yet, being knowledgeable, safe and experienced was more important in the professionals' and students' opinions. Many participants believed that compassion and knowledge were of equal importance and that in order for high quality care to be delivered effectively compassion has to be intertwined within it. One participant quoted "I don't think they can be separated" (p. 483). It is clear from this study that opinions differ on where compassion lies in terms of its importance to the profession.

Another finding noted from Bray *et al.* (2014) was that many of the qualified healthcare professionals felt that the training programmes for healthcare professionals were concentrating on knowledge base and that students were lacking the caring aspect of the profession and that these programmes did not prepare students adequately to care with compassion. Herdman (2004) identifies this as one of the current concerns facing the nursing profession as it transitions into a graduate profession. She suggests that intellectual abilities and technical skills are becoming a higher priority resulting in a loss to caring and compassion.

Currently, there is no evidence to back this claim that a degree graduated nurse is negatively affecting patient care, nor is there evidence to support that less qualified staff would improve patient outcomes. However, it is agreed by the Royal College of Nursing (2012) in the Wills Report that the benefits of a graduated profession within the healthcare setting is needed to “improve the quality of care and deliver and manage complex skilled care in an increasingly fast paced health system” (p. 30).

Edinburgh Napier University and NHS Lothian (2012) developed a leadership in compassionate care programme, with the aim to embed compassionate care as an essential element of all nursing practice and education in National Health Service Lothian in the UK and beyond. Using action research with appreciative inquiry and relationship centred care a four point plan was put in place to establish Beacon wards, to facilitate the development of leadership skills, to focus on the undergraduate curricula and to support newly qualified nurses within the first year of working. Patients, families, staff and students were included within the data collection methods.

The first strand of the programme was to set up the Beacon wards that would stand as centres of excellence for providing compassionate care with the overarching purpose to gain a greater understanding of what compassionate care looks like and to develop key indicators and processes that can identify and enable compassionate care to occur, four wards were chosen to participate. A Beliefs and Value Clarification practice development method was used, formal and informal observations took place using the Quality of Interaction Tool, image work was utilised, as were the use of Emotional touchpoints. Key themes were identified including: caring conversation, flexible, person-centred risk taking, feedback, knowing me, knowing you, involving, valuing and transparency and creating spaces that work, the environment.

Programme 2 was set up to support and facilitate key individuals to develop as leaders. Participants gained information in relation to Relationship Centred Care; The Senses Framework, Appreciative Inquiry, Transactional Analysis, Emotional Intelligence and the FISH philosophy. Participants described changes within themselves following the training and information programme including: improved confidence, assertiveness and the ability

to delegate, which are all key leadership attributes. Furthermore, participants felt a sense of purpose and achievement.

Part 3 of the programme was to embed the values of compassionate care within the learning, teaching and assessment of the undergraduate nursing and midwifery curriculum at one specific University. This section was divided into two phases which firstly involved carrying out focus groups with lecturers and students in order to gain an insight into the views, values, attitudes and engagement surrounding the principles of compassion within education and practice. Results from this phase included; understanding and demonstrating compassion; is there a cost to being compassionate; and can compassionate care be learned?

Phase 2 then used these findings with the aim of enriching the learning, teaching and assessment of compassionate care within the curricula by developing and delivering action projects. The findings from this phase were using stories within the curricula, feedback to placement areas, developing relationships and assessing compassion, supporting lectures, identifying compassion at recruitment and incorporating compassionate care within personal development planning process.

The final phase of this study involved supporting newly qualified nurses through tailored study days which occurred 5 times within a year. Focus groups were carried out and found that the support newly qualified nurses received was varied, with participants noting the difference between the level of support as an undergraduate as much higher than that as a qualified nurse. The key findings identified the need for preparing undergraduates for the reality of nursing and the need for managers of care settings to ensure effective support systems are in place.

This study identifies the skill, support and training that are required to carry out compassionate care and the importance of working with the patient during care. All staff and undergraduates need to be continually encouraged and the emotional aspect of caring for both must be addressed to ensure high levels of care continue.

The literature in this section provides a clear view of nurses understanding of compassion and how diverse the attributes of compassion within nursing appear to be. One of the struggles facing nurses surrounding compassionate care appears to be the inefficient time

to provide such care for patient. Other factors that must be addressed to ensure the presence of compassionate care within nursing are the emphasises that nurses place on compassion and the current teaching methods for student nurses.

2.4.2 Patients

The main aim of Van der Cingel's (2009) study was to create a framework to allow a greater understanding of compassion. Questions were put to participants surrounding the effects of compassion in which several facets were identified. The first being that compassion yields information from patients which can invariably assist in helping to achieve patient care outcomes, resulting in compassion being used as a tool to care when it is used. The second finding demonstrated that nurses believed that compassion eased 'the difficult patient' scenarios. Patients from the study were concerned about being a nuisance to nurses, yet the nurses had a great understanding for why patients would act in a difficult manner. The nurses accepted responsibility for establishing the reasoning behind this behaviour; calling it a professional task. This ties in with the theories that suggest not acknowledging the suffering only increases the suffering. Finally, participants in the study agreed with the statement that 'compassion contributes directly to the quality of care according to those who promote compassion as the essence of nursing (Maben *et al.*, 2009). Patients found that compassion was a motivator to encourage striving to achieve the best of one's ability and it was also felt that it impact positively on recovery times (Van der Cingel, 2011).

A study undertaken by Christiansen (2009), acknowledges the significance of effective interpersonal skills and expressive qualities required in nursing when providing compassionate care. Christiansen's study utilised a longitudinal, micro ethnographic design and gathered observational data in which four nursing students were videotaped assisting patients during morning care to explore the authenticity of concern for patients. Findings demonstrated that authentic concern varied with each student and was expressed using body movement, voice and style. Christiansen (2009) recognised the range of traits that can be portrayed including being approachable, having a casual manner, easy conversations with patients, showing attentiveness, being committed and using eye contact and touch to exhibit concern for patients. It was also noted that posture played a significant role in representing authentic concern for patients, positioning oneself towards

the patient was identified as being important. Authentic concern which was identified in the actions of the participants in this study can be linked to compassion which requires person/nurses to show concern for a person suffering. This study highlights the different qualities that nurses bring to the forefront when caring for patients and that it is important that nurses utilise their assets to effectively provide compassion for patients.

A further study by Edwards (1998) explored the importance of touch and space within patient care. Observation and semi-structured interviews with 7 nursing staff and 6 elderly patients were conducted and analysed using an anthropological perspective. Edwards (1998) highlighted the importance for nursing staff and all healthcare workers to sit down with the patient at eye level or lean in towards the patient when having a conversation. However, the study acknowledged that as a result of professional socialisation, many nurses tend to keep a distance from the patient; this was revealed when many nurses admitted to speaking to the patient from the end of the bed instead of entering the patients space, which was defined as inside the curtained area.

Another study carried out by Berg and Danielson (2007) sought to examine patients' and nurses' experiences of caring relationships within the hospital setting using interpretive phenomenological interviews. Interviews were conducted with seven patients and six nursing staff in a Swedish hospital. The findings were divided into themes in which patients identified 'maintaining dignity' and 'a feeling of vulnerability' and nurses identified 'a purposeful striving' and 'an arduous compassion'. Patients utilised their own competence to work with the nursing staff in order to assist in forming caring relationships believing it was partially their responsibility. They were aware of the strain that the nurses were experiencing during the working day and but felt that the care was still present despite the burden the nurses appeared under. However, findings demonstrated despite this, patients' felt exposed noting fear, lack of engagement, information, and the availability and continuity in the care provided. A quote from a patient highlights the turnover of staff during a patient's stay in hospital, "there were new auxiliary nurses, nurses and aids every day (p.502)". Another issue identified by the patients was that patients' felt a lack of confidence or security in the caring relationships. It was felt that patients met so many nurses and doctors, yet, still were unsure who was responsible for their care.

Although the patients happily accept they are part of the caring relationship with nurses and believe that they too are responsible within the relationship, it appears that they do not always have the opportunity to participate in the relationship, due to the strain on staff and the high changeover of staff between different shifts.

From the nurses' perspective, findings demonstrated that nurses used 'one's own competencies when forming caring relationships within the busy environment of the hospital. Some nurses felt that although the interactions with the patients may be brief, they were sure to make the most of the interaction whilst being open minded, flexible and listening to the patients. Nurses were also aware of the limitations that impacted on building caring relationships. Caring with arduous compassion was identified by nurses as they provided care of patients in strained situations, which impacted on the time spent with patients.

Nurses were conscious of the time needed to be compassionate, but felt that interactions were often disturbed thus, interrupting the interaction. The strain of working under these pressures was often reduced when a patient validated the nurses' efforts and when the nurses have confidence in the patient and in the participation of care.

Nurses believed being task orientated was sometimes the only way to proceed with a day's work when the work load was so demanding, assuming that the patients understood. The final aspect the nurses noted was 'being aware of what is needed'. This is in regards to respecting the patients' as well as the nurses' integrity. Irrespective of the strain within the environment, nurses aimed to engage with patients and remain positive in a bid to keep a pleasant environment.

It is clear from this study that both the nurses and the patients are aware of the strain that the health care professionals experience on a daily basis. However, many patients still feel that the care they are receiving is considerably task orientated with which the nurses in this study have agreed, when the demand surpassed the resources. Although nurses aim to provide a unique caring experience for all patients, it unfortunately seems to be falling below par for some patients as they understand the pressure the nurses are under but, nevertheless feel let down.

This section reviews compassion from the perspective of the nurses and patients. It is clear to see from the nursing studies that staff have a desire to care for their patients with the utmost respect, dignity and compassion however, it is suggested that their biggest concern in achieving such levels are not having adequate time and thus, it appears it may be an issues within the organisation preventing such care being delivered.

The patients acknowledged several components as being essential for compassion to be present in care. These included: communication; a relationship and dignity. Patients found that being cared for compassionately was a motivator and had the potential to decrease hospital stays by increasing recovery times.

This section highlights that patients view compassion as essential when receiving care from healthcare professionals. Being compassionate towards patients assists professionals within their caring duties as they receive information more readily from patients which, in turn creates a more person-centred environment. Compassion is also seen to help in situations where patients are perceived as difficult and is cited as contributing to the quality of care. Patients see communication and expressive qualities including nonverbal techniques as imperative when a person wishes to be compassionate. Compassion is seen as a motivator to encourage patients to achieve more in everyday life.

2.5 Factors that Enhance and Inhibit Compassion

This section will review three concepts that are been seen to either enhance or inhibit compassionate care. Section 2.6.1 will discuss compassion satisfaction; burnout and compassion fatigue will be reviewed in section 2.6.2 and 2.6.3 respectively.

2.5.1 Compassion Satisfaction

Compassion satisfaction is seen as the joy, purpose and meaning that is derived from working as a caregiver (Flarity *et al.*, 2013). It incorporates the positive aspects of work that help to nourish a clinician (Bride *et al.*, 2007). Stamm (2012) describes compassion satisfaction as the degree of pleasure that one extracts from helping others and the feelings of positively contributing to the work place, colleagues and society. Coetzee and Klopper (2010) also believe it results from the invigoration and inspiration from sharing

in a patient's suffering. Compassion satisfaction is less clearly defined in the literature in comparison to its negative counterpart compassion fatigue (Coetzee and Klopper, 2010), however, it has been identified as an important factor in predicting nurse caring (Burtson and Stichler, 2010). Compassion satisfaction develops from the emotional rewards of caring for another person in a health care context; clinicians feel a sense of return or incentive by seeing a change for the better in patients and families.

A qualitative study conducted by Graber and Mitcham (2004) interviewed 24 compassionate healthcare clinicians to identify specifications, interventions and interpersonal relationships with patients. The results acknowledge that compassionate clinicians did not attempt to distance themselves from patients during care and instead developed a warm, empathetic relationship with the patients. The participants appeared to be able to integrate the mind and heart into work without sacrificing objectivity in practicing compassionate care. Healthcare professionals that provide compassionate care tend to in turn achieve compassion satisfaction. From this study it is suggested that compassion satisfaction is a motivational factor that has a positive impact on recruitment and retention.

Hegney *et al.* (2014) carried out a self-report exploratory cross-sectional survey in Australia with 132 nurses from a hospital setting. Using the Professional Quality of Life Scale and the Depression Anxiety Stress Scale, the objective of the study was to explore compassion satisfaction and compassion fatigue in terms of the potential of contributing to factors of anxiety, depression and stress. The findings demonstrated that at risk nurses stress and depression scores were significantly higher than nurses with higher compassion satisfaction scores with, about 20% of respondents having positive reinforcement from work profile that involved high compassion satisfaction and moderate to low burnout and compassion fatigue symptoms. The results from this study highlight that nurses benefit from interventions that increase compassion satisfaction which in turn can enhance retention.

Compassion satisfaction is an essential component required to care for patients with compassion. From reviewing the literature, the majority of literature focuses on compassion fatigue and burnout however, if they can be reduced this will directly impact on the levels of compassion satisfaction.

2.5.2 Burnout

A factor that has been identified in the literature as a possible impingement on compassion is burnout. Burnout is defined as an overpowering invasion of stress that can affect one's health and work performance leading the professional to distance themselves from their patients due to physical, emotional and mental exhaustion (Potter *et al.*, 2010; Leiter and Maslach, 2005; Maslach, 1982). In turn, people become angry, ineffective, apathetic, depressed and depersonalised. Burnout has the capability to dominate and interfere with a person's ability to function (Joinson, 1992).

The term burnout initially appeared in the 1970's and was associated amongst people working within the human services (Maslach *et al.*, 2001). The literature focused on the work relationship, and the difficulties that can arise when the relationship goes breakdown. Maslach *et al.* (2001) highlighted that in the 1970's, burnout was thought to be caused by staff being emotionally exhausted and depersonalised and it was seen that staff were emotionally depleted and had a loss of motivation and commitment.

Current literature identifies three components to burnout: exhaustion, cynicism (depersonalisation) and inefficacy (Leiter and Maslach, 2005; Maslach *et al.*, 2001) and that it can occur in any setting (Joinson, 1992). These three components are briefly discussed to give an overview of each.

Exhaustion is seen as the central component of burnout and is the clearest way that burnout can be visualised from this complex syndrome. In general, when a person experiences burnout, exhaustion appears as one of the most prevalent factors (Maslach *et al.*, 2001). Exhaustion reflects the stress dimension of burnout, but lacks the ability to demonstrate the relationships aspect within the work environment. The response mechanism of exhaustion is to put distance between oneself and one's work in order to manage the work overload. Thus, within the healthcare setting, exhaustion can lead to the healthcare professional being incapable of providing care suitable to the patient's needs (Maslach *et al.*, 2001).

Cynicism (depersonalisation) is the act of putting distance between the patient and the healthcare professional by choosing not to acknowledge a person's unique characteristics. Caring for a patient is more achievable when the person is taken away from the patient and seen as an impersonal object involved in one's work day. Exhaustion and being discouraged are contributing factors that can result in cynicism (Leiter and Maslach, 2005; Maslach *et al.*, 2001).

Inefficacy (reduction in personal accomplishment) is thought to occur as a result of the other two components of burnout. Within the work environment, if healthcare professionals are chronically overwhelmed by the work load which causes the development of exhaustion or cynicism then the likelihood is a depletion of the healthcare professionals sense of effectiveness as they are unable to carry out caring duties effectively. Inefficacy appears to occur more as result of a lack of resources, whereas exhaustion and cynicism are thought to be related to work overload and social conflict (Maslach *et al.*, 2001).

The stress associated with working in a caring environment has been recognised as an occupational hazard that can affect both health and work performance (Leiter and Maslach, 2005). What the worker actually feels and experiences as stress can be assumed to play a mediating role between the external job demands/stressors and the work related outcomes (absenteeism or illness). Job burnout is a stress phenomenon which arises as a prolonged response to chronic interpersonal job conditions.

Healthcare professionals including nurses and healthcare assistants have an increased risk of developing burnout due to the nature of their caring profession (Vahey *et al.*, 2004). This is due to the ever increasing demands placed on healthcare professionals due to an increase in workload, organisational factors and understaffing (Potter *et al.*, 2010; Poghosyan *et al.*, 2010; Vahey *et al.*, 2004). As a result, healthcare professionals lose the ability to cope with the work environment and tend to distance themselves from the patients and lose interest in the caring nature of the profession. This in turn makes it impossible for nurses to provide compassionate care if they themselves are suffering from burnout.

Leiter and Maslach (2009) conducted a study to examine if burnout impacted on nurses turnover intentions in Canada. Data was collected from 667 nurses working within hospital and community settings utilising a questionnaire package with the Maslach Burnout Inventory-General Scale, the Areas of Work life Scale and 3 questions on turnover intentions of staff. Results revealed that there was significant correlation between burnout and the nurse's intention to leave jobs. The nurses' work lives increased the prediction of burnout and this consequently led to a higher risk of staff turnover. Cynicism (depersonalisation) was seen as the key dimension for turnover. Nurses that were psychologically withdrawn from work highlighted intentions to leave the profession/job completely. This study identifies that stress in work leads to burnout, which in turn has the potential to cause nurses to leave the profession. If burnout is prevalent within the work place it is clear that compassionate care would be compromised, and can consequently resulting in reduced patient satisfaction with care.

Vahey *et al.* (2004) investigated the correlation between nurse burnout and patient satisfaction in the United States. The study conducted was a cross-sectional survey of nurses (n= 826) and patients (n= 621) from forty urban hospital settings across the U.S. The findings from the study indicate that nurse burnout is a significant factor that determines how satisfied patients are with their care in healthcare settings. Vahey *et al.* (2004) acknowledges that improvements in nurses' work environment could potentially reduce nurses' burnout levels and turnover rates, while increasing patient satisfaction with care. This in turn could be seen as a method for increasing compassionate care within the care setting.

A study carried out by Gibbons (2010) aimed to explore the relationship between sources of stress and psychological burnout. Using final year nursing students based in Canada, 171 questionnaires were completed including: The Index of Sources of Stress in Nursing students; The Generalized Self-Efficacy Scale; The Maslach Burn-out inventory; The Marlowe-Crowne Social Desirability and the Brief COPE. The results highlighted that sources of stress that were most likely to lead to distress were often seen as predictors of wellbeing than sources of stress that lead to positive, good stress. Support, dispositional control and self-efficacy were also seen as significant indicators of stress. One of the main findings was that avoidance coping was identified as the strongest indicator of burnout. This study identifies that in order to reduce burnout to increase compassion one must

ensure that all spectrums of the nursing professions are involved in strategies on how to manage stress and reduce burnout. By incorporating this into nurse training, it could lead to a reduction of burnout in later years for nurses and thus reduce the turnover rates of nurses.

Glasberg *et al.* (2007) examined the factors that could cause burnout in healthcare professionals in a study conducted in Sweden. Within a hospital setting, 423 healthcare professionals completed questionnaires including: The Maslach Burnout Inventory; The Stress of Conscience Questionnaire and The Perceptions of Conscience Questionnaire. The findings showed that factors associated with emotional exhaustion were 'having to deaden one's conscience' and 'stress of conscience' as a result of the lack of time available to provide the necessary care for patients, the demands of work impacting on home life and a feeling of not being able to reach others' expectations.

Depersonalisation (cynicism) resulted from 'having to deaden one's conscience' and 'stress of conscience' from a lack of living up to expectations and from having to compromise on one's own aspirations to provide good care and a lack of social support from colleagues. This study provides an example of the expectations that healthcare professionals have when caring for patients and what affects this. All healthcare professionals must be attentive to inner feelings and patients' feelings in order to prevent burnout, thus, increasing the potential of improving compassionate care.

A further study carried out by Leiter *et al.* (1998) set out to examine the relationship between burnout, the intention to quit and meaningfulness of work within two hospital settings. Nurses (n = 711) completed the Maslach Burnout Inventory; the Meaningfulness at Work and answered two questions on the intention to quit. Patients (n = 605) completed the Patient Judgement of Hospital Quality Questionnaire. The results demonstrated that patients' views on the quality of care corresponded to the relationship nurses had with work. On units where nurses found work meaningful, patients were more satisfied with all elements of the time spent in hospital, whereas, the units where nurses were feeling more exhausted or had a higher intent to quit showed patients were less satisfied with the elements of care. This study emphasises the importance of nursing on patient satisfaction. Given that a correlation exists between a happier nurse and a happier patient, it is fair to

assume that by addressing factors that result in burnout for staff, improvement could be expected in the quality of care which can allow compassion to present within the care.

Poghosyan *et al.* (2010) carried out an international study to explore the relationship between nurse burnout and ratings of the quality of care provided from six countries including: the U.S., Canada, U.K., Germany, New Zealand and Japan with 53,846 nurses. The results found that higher rates of burnout were linked with lower rates of quality of care, independent of nurses' ratings of practice environment. This study suggests similar findings to the previous study, in that, if burnout is reduced amongst nurses this may be an effective strategy for improving quality of care which ultimately increases compassion.

It is clear that burnout significantly impacts healthcare professionals' ability to provide high quality compassionate care, which in turn leads to patients being dissatisfied with the care being received. In order to effectively improve the quality of care which may lead to more compassionate care, it is necessary to address the causes of burnout.

2.5.3 Compassion Fatigue

Compassion fatigue is seen as a unique form of burnout that affects people in caregiving roles. It is thought to result due to a progressive and cumulative process that comes about from prolonged, continuous and intense exposure with patients and their suffering that incorporates the use of oneself (Joinson, 1992). Characteristics include irritability, chronic fatigue, dread of going to work, aggravation of physical ailments and a lack of enjoyment in life (Potter *et al.*, 2010).

Figley (2002, p. 11) defines compassion fatigue as state of tension and preoccupation with the person or cumulative traumas of persons and is the result a caregiver can experience when caring for others and feels it is caused by giving high levels of energy and compassion over a continued period of time to person suffering. Flarity *et al.* (2013) views compassion fatigue as the negative effects related to witnessing trauma, pain and suffering of patients.

It differs from burnout in that burnout is seen as a cumulative stress from the demands of daily life with a state of physical, emotional and mental exhaustion as a person becomes

incapable of coping within one's environment, in particular in the work environment (Maslach, 1982). The end result from burnout tends to lead towards healthcare professionals leaving the work place. Burnout is seen as being more associated with the environmental factors including: overcrowding, high workload, unrealistic patient expectations which leads to a feeling of frustration, exhaustion, hopelessness, anger and depression (Flarity *et al.*, 2013). The concepts of compassion fatigue and burnout are closely related and sometimes ambiguously defined.

It seems that the introduction of compassion fatigue was first noted in 1992 by Joinson and it further appears that due to the nature of the nurse's role, nurses are very susceptible to it. Joinson (1992) discussed that compassion fatigue is thought to be heightened in caregivers because essentially when a nurse or healthcare assistant is delivering care to a patient they are also delivering themselves within that care. Moreover, Joinson identified that due to the human need being infinite, caregivers can reach a point where no more can be done for a patient and expectations, be that of the patient or the caregiver, cannot be met. Finally Joinson notes that while working as a caregiver, numerous roles must be undertaken by the caregiver which can be psychologically conflicting.

Nowadays, compassion fatigue is a familiar term. For example a CINAHL search from 2013-1992 revealed 167 journal articles with compassion fatigue as the key word however a search using the term compassion fatigue prior to 1992 yielded no results.

Opinions vary into what causes compassion fatigue; factors identified as being linked to the development of compassion fatigue include: systemic barriers, lack of support, a loss of the ability to nurture, increase in sophisticated medical technologies, increase in responsibilities, and being unable to meet expectations (Austin, 2011; Coetzee and Klopper, 2010; Burtson and Stichler, 2010; Frakes, 2010; Joinson, 1992)

The emotional labour that is involved in working in health care can be a source of stress in itself and the idealistic view that society holds of nurses may further increase this stress. If a nurse works with the feelings of stress and the behaviour he/she exhibits is not replicating their emotional state (e.g. they are smiling but really feel angry,) then there is a higher risk of becoming emotionally detached from the patients and the work

environment as a self-protecting mechanism which can lead on to compassion fatigue or burnout (Brotheridge and Grandey, 2002; Gross and Levenson, 1997).

Firth-Cozens and Cornwell (2009) highlight the increased levels of self-reported stress noted in the health services as opposed to the general working population. These stresses can be as a result of high self-criticism which inevitably leads to lack of compassion towards oneself. This chain of events has the potential to lead to a lack of compassion towards the patients (Gilbert, 2009; Firth-Cozens and Cornwell, 2009).

Abendroth and Flannery (2006), using a non-experimental descriptive design study, investigated the prevalence of the risk of compassion fatigue in hospice nurses. Using the Professional Quality of Life Scale (which measures both compassion fatigue and burnout), a sample of 216 nurses completed the questionnaire. The findings established that stress, trauma, anxiety, life demands and excessive empathy (leading to blurred professional boundaries) were the key contributing factors of compassion fatigue risk.

Melvin (2012) carried out a study to explore the prevalence of compassionate fatigue in hospice and palliative care nurses and examine the nature of its effects and what coping strategies are available. Using a descriptive qualitative design, semi-structured interviews took place with six nurses. From the findings, it was clear that all six nurses understood the risk of developing compassion fatigue with one nurse experiencing it at the time of the interview. Three themes emerged including: risk for compassion fatigue from repeated exposure to deaths for an extended period of time; physical and emotional cost of providing such care; and setting boundaries/health coping strategies. One of the overarching findings was if nurses did not have adequate coping strategies, the risk of developing compassion fatigue increased. Although this study was conducted in a hospice and palliative care setting, it can be compared to older adult care units as nurses deal with death regularly due to the nature of the clients. It can then be suggested that the older adult care setting must ensure effective coping strategies are in place for staff to help minimise the effects of compassion fatigue.

Smart *et al.* (2013) conducted a cross-sectional survey study to investigate compassion fatigue and compassion satisfaction rates using the Professional Quality of Life Scale in a community setting in the U.S. with 139 staff members. Results highlighted that staff

working in general medical settings had higher levels of burnout in comparison to those working in critical care units. This may be as a result of the staff-patient ratio as it would be less within the critical care setting. High sleep levels were also seen to be correlated with less burnout. The relationship between compassion satisfaction with compassion fatigue and burnout were negatively associated, whereas, compassion fatigue and burnout were positively associated. This could lead one to believe that if compassion satisfaction can be increased, compassion fatigue and burnout can be reduced.

A qualitative study to explore how effective a multifaceted education program is in decreasing compassion fatigue and burnout whilst increasing compassion satisfaction in emergency nurses was carried out by Flarity *et al.* (2013). Data were collected from 2 emergency departments in the U.S. with 73 nurses participating in the study which used a pre-/post-test design. The first level of the intervention involved a four hour interactive group seminar titled “Compassion Fatigue Resiliency”. In the second level of intervention, multimedia resources were made available or given to participants. The Professional Quality of Life Questionnaire was used as the pre-/post-test measurement. The results demonstrated that a statistically significant increase in compassion satisfaction and a decrease in burnout and compassion fatigue, highlighting that the use of effective education and support can improve compassion satisfaction whilst reducing compassion fatigue and burnout.

Nurses have a duty to compassionately care for their patients; this in turn exposes them to pain, trauma and suffering on a daily basis (Coetzee and Klopper, 2010). It is important that all healthcare professionals are aware of compassion fatigue and the appropriate way to respond to it. Having the knowledge of what determinants put healthcare professionals at risk of developing compassion fatigue could potentially help identify those who are at risk and allow appropriate interventions or preventative measure to be utilised to help maintain optimal delivery of healthcare while ensuring professionals safety.

2.6 Conclusion

In conclusion, it can be seen that compassion contains many attributes and every individual can have a different understanding of what they believe compassion to be. This provides some insight into why it might be difficult to find a universal definition of

compassion. The compassionate framework established the necessary elements required for compassion.

This review has enabled the identification of relevant literature based around the topic of compassion including factors that enhance or inhibit compassion. The literature identifies that nurses are unhappy about certain situations within the work place as, they do not have the time to care for patients as they would deem necessary. Studies also demonstrated that patients perspective and acknowledge how compassion can be linked to improving patient outcomes.

It is clear from the literature review just how complex compassion is as a phenomenon however, one thing is clear that compassion is perhaps easier to identify when it is not present than perhaps when it is present.

CHAPTER 3: Person-Centred Care

3.0 Introduction

This chapter forms part two of the literature review and reviews the literature in relation to person-centred care (PCC). The first section will look at what exactly person-centred care is. Section 3.2 looks at the definitions of person-centred care with section 3.3 discussing why person-centred care is necessary. This is followed by the impact on health outcomes (section 3.4) and how person-centred care was developed (section 3.5). The final section (section 3.6) examines person-centred care in practice from the perspective of the patient and the staff.

3.1 What is Person-centred care

Within the nursing literature person-centred care can be seen as a recurrent theme. Person-centred care is the term that refers to the therapeutic relationship between a healthcare professional and a patient, and between healthcare professionals (Manley and McCormack, 2008). Person-centred care aims to ensure that a patient is an equal partner in their health care (Royal College of Nursing, 2015). To achieve this healthcare professionals work in collaboration with the patients who utilise the services with the aim of increasing the patients knowledge base, skills and confidence in order to facilitate them to make informed decisions about their own health and health care (The Health Foundation, 2014).

The main aim of person-centred care is to place the patient into the centre of all that the service does. Person-centred care can be achieved by healthcare professionals advocating for the patient's needs, respecting their beliefs and values, protecting their rights and actively incorporating them in their care. In doing so healthcare professionals promote kindness, consideration, respect, dignity, privacy and autonomy (Lewin *et al.*, 2007; de Witte *et al.*, 2006; Schoot *et al.*, 2005a; Schoot *et al.*, 2005b). By actively including the patient's wants, needs and preferences into how their care is delivered, higher patient satisfaction levels can be attained, which in turn has the potential to improve patient outcomes. Care and support is accessible for all patients with person-centred care when it is within the culture of the hospital organisation (Royal College of Nursing, 2015).

Alharbi *et al.* (2012) views person-centred care as considering all essential elements for a patient including: patient's abilities, future plans and goals, the patient's rights and their

integration into the environment. The role of person-centred care is to empower patients and to remove the passive role that healthcare systems have previously expected patients to play and transform that into the patient being an active participant. The partnership that develops between the patient and the healthcare professional is seen as one of the core elements of person-centred care and is achieved by communication and understanding with the patient (Alharbi *et al.*, 2012).

To effectively achieve person-centred care, all healthcare professionals must be proficient at communicating with patients to allow the establishment of relationships built on trust and to ensure that patients are fully educated surrounding their care and the possible options and obstacles that stand before them to allow them to make, informed decisions regarding their care and treatment.

Within the literature the terms person-centred are interchangeable with patient-centre care. It is also referred to as client centred or individual-centred (McCormack and McCance, 2006). Though the name may change the concept of person-centredness does not and remains person focused, with the person being an active member of the healthcare team (Berwick, 2009). For the purpose of clarity within this literature review person-centred care will be used throughout.

3.1.1 Person

In order to establish a great understanding of person-centeredness, it is important to first examine the concept of 'person'. McCormack (2004) discusses the philosophical context of the word 'person' and highlights the need for the word to be viewed as more than a biological species but that it is in fact encapsulating the characteristics of persons that embody humanity through challenging and important circumstances during one's life. Immanuel Kant's work places significant shared value on the person and their inherent worth, believing that all persons ought to be treated as ends in themselves and not as a means to another's end (translated by, Sullivan, 1990).

However, McCormack (2004) feels that it is possible to imagine circumstances where a person is not treated in such a manner and uses the example of treatment decisions being centred around the cost as opposed to the effect on the person's quality of life. Such care

was identified particularly in bigger institutions in care of the elderly through-out history as patients were not treated as persons and were required to follow strict rules set up by the organisation in order to serve their needs above the needs of the older adult patients (Norton *et al.*, 1976; Goffman, 1961).

Kitwood (1997b) acknowledges that persons do not exist in isolation, but that personhood is manifested and captures the intrinsic worth of persons. Writing from Kitwood (1997a) highlights the importance of focusing on the person as opposed to the disease.

3.2 Defining Person-Centred Care

There are a variety of different definitions used in the literature to define person-centred care. The Health Information and Quality Authority (2009, p. 76) define person centred as “a term applied to the ethos adopted by facilities which seek to tailor their services to the particular needs of individual residents. It also describes it as an open, listening and empathetic communication approach which fosters wellbeing, rehabilitation and healing”.

Kitwood (1997b, p. 8) defines person-centredness as “a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust”. McCormack (2004) proposes that if this definition is utilised for person-centredness then four characteristics can be extracted from the definition and put at the core of person-centred nursing including being in relation, being in social world, being in place and being self.

Table 3.1: Relationship between Kitwood’s definition and derived concepts of person-centredness

Concept	Link to Kitwood’s Definition
Being in relation	Persons exist in relationships with other person
Being in social world	Persons are social beings
Being in place	Persons have contact through which their personhood is articulated
Being with self	Being recognized, respected and trusted as a person impacts on a person’s self of self

Table 3.1 demonstrates how the latter characteristics tie into Kitwood’s definition (McCormack, 2004, p. 33). Manley and McCormack (2008) defines person-centred care as the therapeutic relationship between the healthcare professionals and the service users, and between the healthcare professionals themselves.

Table 3.2 shows other definitions for person-centred care found within the literature review; each of these definitions fits within Kitwood’s original concept of person-centred care.

Table 3.2: Definitions of Person-Centred Care

Author	Definition of Person-Centredness/Centred Care
Bastiaens <i>et al.</i> 2007	Enabling a person to take an active role in deciding about and planning their care
Ferguson <i>et al.</i> 2013	The term used to infer that the patient is at the centre of the care initiatives
Kitwood 1997	A standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust
Lewin <i>et al.</i> 2001	Healthcare providers share control of consultations, decisions about interventions or the management of health problems with patients
Manley & McCormack 2008	The therapeutic relationship between the healthcare professionals and the service users, and between the healthcare professionals themselves.
McCormack & McCance 2006, 2010	A particular approach to practice that occurs through the development and promotion of healthful relationships amongst all healthcare providers, patients and family members and others significant to them. It is formed on the basis of respect for persons, an individual’s right to autonomy, mutual respect and understanding.
Moore 2008	Understanding the patient as a unique human being
Radwin 2003	Care that is personalised to meet the patients individual needs and to be consistent with the patients preferences
The Health Information and Quality Authority 2009	A term applied to the ethos adopted by facilities which seek to tailor their services to the particular needs of individual residents. It also describes as an open, listening and empathetic communication approach which fosters wellbeing, rehabilitation and healing

However, a UK independent charity organisation The Health Foundation (2014) views the term ‘person-centred care’ as having no clear single definition of the concept as it can be used to refer to various principles and activities. This can be seen from table 3.2 in which no two definitions are the same yet, they encompasses characteristics of what person-

centred care is. The reason believed for this stems from two areas; firstly, person-centred care is a newer concept and thus new evidence continues to emerge and the concept continues to evolve. Secondly, the virtue of person-centred care is that it is individualised to the patient receiving care.

Yet, such subjectivism can lead to a dilemma in terms of what a patient's requirements, desires and situational needs may be and these needs might differ in the patient's eyes to that of the healthcare professionals. These needs may change over time for the individual. As a result The Health Foundation (2014) identify four principles for person-centred care: 1. Affording people dignity, compassion and respect. 2. Offering coordinated care, support and treatment. 3. Offering personalised care, support and treatment. 4. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life. These four principles can be seen within definitions in table 3.2.

McCance *et al.* (2009) discusses the lack of a widely accepted definition for person-centred care and sees person-centred care as treating a person as an individual. McCormack and McCance (2006) also acknowledge that certain scholars use the term patient-centred care as opposed to person-centred care, however, the argument then arises that the partnership that develops between the patient/person and the healthcare professional must be built on shared appreciation for the other's humanity.

Lewin *et al.* (2001) agrees that person-centred care is not well defined even though it is a widely known phrase and put forward that patient-centred care is shared control of consultations, decisions about interventions or the management of health problems with patients.

As there is no clear definition of person-centred care, Bruus *et al.* (2012) identifies what authors in this field agree on and this is that patient-centred care takes the patient's values, needs and preferences, autonomy and self-sufficiency in to account whenever possible (Lewin *et al.*, 2007; de Witte *et al.*, 2006; Schoot *et al.*, 2005a; Schoot *et al.*, 2005b). Person-centred care is seen as the extent to which the healthcare professional selects and delivers interventions that are both respectful and responsive to the needs and values of each patient (Lauver *et al.*, 2002).

The Person-Centred Practice Framework that is developed by McCormack and McCance (2006; 2010) defines person-centred practice as a particular approach to practice that occurs through the development and promotion of healthful relationships amongst all healthcare providers, patients and family members and others significant to them. It is formed on the basis of respect for persons, an individual's right to autonomy, mutual respect and understanding.

This section reviewed the definitions used to describe person-centred care. It highlighted the concerns that at present, there is no clear definition. Person-centred care is seen to require being with the person in a relationship, recognising, respecting and trusting the patient as a person and valuing the person's needs and preferences whilst promoting autonomy and self-efficacy including shared decision making.

3.3 Why do we need Person-Centred Care

Person-centred care has been viewed as a holistic approach to caring (Morgan and Yoder, 2012). It is seen as the gold standard of care within dementia care (McCormack and McCance, 2010). With the ever increasing media reports about the shortfalls within the hospital settings particularly with the care of older adults (Local Government Association, 2012; Parliamentary and Health Service Ombudsman, 2011; Nursing Homes Ireland, 2014), the need for person-centred care is at an all-time high. Over the last two decades person-centred care has moved forward as the favoured model of care (Health Information and Quality Authority, 2012; The Health Foundation, 2011; The King's Fund, 2011).

It is clear that the current challenges facing all healthcare professionals including budget restrictions and increased workloads leads to stresses however, the question that needs to be answered is, is patient-centred care a priority or a plesantry.

It could be assumed that the provision of person-centred care is an ethical requirement for healthcare professionals including nurses and healthcare assistants. This is evident when one considers the four principles that The Health Foundation (2014) discussed in section 3.2. If these principles were not present when caring for patients one would be choosing to care without dignity, compassion or respect and would treat the disease as opposed to

the patient. In effect not providing person-centred care would be breaching ethical codes of practice for healthcare professionals.

3.4 Impact of Person-Centred Care on Health Outcomes

Setting aside the ethical aspect, another factor that calls for person-centred care is the fact that many patients within today's modern society wish to be involved in their health care. Person-centred care can facilitate this as it includes shared decision making and self-management of care where this type of care is possibly a knock on effect and can be seen in terms of patient experience, satisfaction with care and better health outcomes (Wolf *et al.*, 2008; Suhonen *et al.*, 2005). Studies that have examined the relationship between person-centred care and outcomes have demonstrated that by involving patients in the decision making process an improvement in functional status was noted (Kaplan *et al.*, 1989). A greater adherence to medical advice with improved health outcomes was found when person-centred care was present during a consultation (Safran *et al.*, 1998) and when no person-centred care was experienced patients experienced poorer health and symptoms (Fremont *et al.*, 2001).

The Health Foundation (2014) discusses the benefits of person-centred care including: the ability to allow patients with long-term conditions to participate and manage their own care and health thus, improving clinical outcomes. The potential reduction in overuse of hospital services as patients become more involved in their care can lead to increased patient satisfaction. The increase in compliance with treatment plans as shared decision making allows the patient to be happy with the treatment plan and medication regimes. It can also benefit healthcare professionals as patients become more empowered and engaged in their care, staff performance and morale may increase.

McCormack and McCance's (2010) theoretical framework emphasises that the concept of person-centred outcomes as a result of delivering person-centred care include; high levels of satisfaction with care; involvement with care; feelings of well-being and the creation of a healthful culture.

3.5 How has Person-Centred Care Developed

The exact origin of person-centredness is unknown, but the term ‘person-centre’ was first used in the early 1960’s by psychologist Carl Rogers in relation to psychotherapy. A key element of the term ‘person-centred care’ in those times which is still an integral part of the present view is empathy. Empathy is seen as the willingness to withhold passing judgement and to view the other person’s perspective.

The 1970’s saw the introduction of the move towards a biopsychosocial model of health by George Engel as opposed to the medical model. This model is seen as a requirement for person-centred care. A further pioneer in the area of person-centredness in the 1980’s was Tom Kitwood from Britain who introduced the concept of person-centred care for people with dementia. An Bord Altranais (2000b; 2005), the statutory body for nursing and midwifery in Ireland advocates the biopsychosocial model when caring for patients which was defined by George Engel as an alternative to the biomedical model (Borrell-Carrio *et al.*, 2004). Believing that in order to understand and respond to a patients’ suffering Engel felt that healthcare professionals must attend to the biological, psychological and social factors of the disease or illness which in turn gives the patients a feeling of being understood (Borrell-Carrio *et al.* 2004, Fleisher and Feldman 1999) as opposed to the biomedical model which focuses on the scientific, pathological and physiological terms of a disease and can undoubtedly be noted from the advances in health care. When caring using the biopsychosocial model, healthcare professionals need to look at the patient as a whole and ensure that they create an environment that achieves the patient’s physical, mental and social potential whilst promoting safety and maintaining dignity (An Bord Altranais, 2005; 2000a). It is imperative that the biopsychosocial model is adhered both within the third level institutions and the hospital setting.

In the 1990’s the Chronic Care Model was developed and the idea of person-centredness began to emerge to address the apparent deficits in the support for people with long-term conditions. It wasn’t until 2000 that the Institute of Medicine responded to an earlier published report called “The Urgent Need to Improve Health Care Quality” and thus aims were put in place to facilitate this improvement, one of which was to include person-centredness in care. Since then the idea of person-centredness began to steadily take off

and was aimed at achieving personalised, coordinated care (Department of Health, 2000), whilst enabling and empowering patients (Wanless, 2002).

In 2010, person-centred care received a major boost following the publishing of the Francis inquiry surrounding the provision of care at the Mid Staffordshire NHS Foundation Trust. The report emphasised the importance of caring with dignity, compassion and respect for all attributes of person-centred care (Francis, 2013).

In Ireland, the Health Service Executives (2010) published a guide specifically based on enhancing the care for older adults and incorporated throughout the document is the concept of person-centred care. It views person-centred care as being important for the provision of care to residents and it also enables healthcare teams to function in an effective way.

Currently, person-centred care seems to be a focal point within the healthcare sectors in Ireland. Many organisations including the Health Service Executives (2010), Health Information and Quality Authority (2012) and An Bord Altranais (2009) view person-centred care as an integral component of caring for hospitalised patients.

3.6 Person-Centred Care in Practice

The role of person-centred care is to ensure that a patient is an equal partner in the healthcare system. This is thought to be not only beneficial to patients as it increases greater satisfaction with care, but it can also result in a more cost effective health care system (Royal College of Nursing, 2015). In order for this to become a reality, person-centred care must be present in all the healthcare organisations. Royal College of Nursing (2015) recognises four key areas that need to be present for person-centred care: respect and holism, power and empowerment, choice and autonomy, in addition to empathy and compassion.

This section will review person-centred care from the perspective of the patient and the staff, including the studies surrounding person-centred care (Appendix 3)

3.6.1 Patient

Traditionally, patients played the passive recipient of care that was delivered under the premise that the healthcare professional knows what is best for the patient (Stiggelbout and de Haes, 2001). Pearson (2006) discusses the ‘sick role’ that a patient can adhere to once they agree to submit to the doctor’s directives and in doing this the patient is affectively relieved of society duties by the healthcare professional. Currently, however, all fields are acknowledging the importance of person-centred care. Person-centred care sees the individual as having an active role with members of the healthcare team and thus is as such a member of the healthcare team (Fredericks *et al.*, 2015). Hebert (2010) views person-centred care for the patient as incorporating one’s values, beliefs and preferences into the healthcare design for that specific patient. Thus, it integrates patients’ ideals into the care design and services that are to be provided (Berwick, 2009). It is important therefore, that we are aware of what it is that patients perceive as person-centred care. This section reviews studies surrounding patients’ experiences of person-centred care, effects of person-centred care and participation in person-centred care.

3.6.1.1 Patients’ Experience of Person-Centred Care

This section will review studies that explore how patients experience person-centred care and what person-centred care means to the patient. A qualitative research study conducted by Marshall *et al.* (2012) explored patients’ experiences of care received and reviewed patients’ opinions on what person-centred care meant to them in the surgical ward of a general hospital setting it found that of the ten patients who were interviewed, patients could assign meaning to the term person-centred care but that they lacked familiarity with the concept of person-centred care. From the data collected two themes were identified: the staff that delivered the care and the system where the care took place.

Staff were seen as caring, to the point that patients viewed the staff and caring as synonymous rather than separate. Within the theme, staff, three subthemes emerged: being attentive; making an effort and connectedness. Being attentive was seen as arriving in a timely manner when called, attention to small details and was valued by patients. Making an effort appeared in all ten patients’ interviews, which patients identified from staffs’ actions including going ‘the extra mile’ for a patient. Connectedness was related to the relationships formed with staff and how patients were aware of an understanding and

respect between each other regardless of the hierarchical nature within the care setting. Patients emphasised the importance of being treated like a person as opposed to a patient and felt a greater trust within the relationship built on such a level. The second theme, the system, was viewed in a negative manner highlighting three subthemes: resources; culture and waiting. Resources were a prevalent theme with patients mentioning facilitates such as the food and bedding in a negative light, indicating the physical environment impacts on the caring experience for patients. Patients also commented on the workload that staff were currently working under was too high. The culture of the hospital setting left some patients feeling disempowered due to the perceived power imbalance. Whilst others felt the waiting times were undesirable but had come to accept its part within the hospital setting.

It is clear from this study that patients have a great appreciation for the care received from staff, however, it is felt that perhaps the hospital system itself is causing problems. It would also appear from the subthemes within the theme staff, that person-centred care is present within this hospital care setting as staff were seen to use elements of what person-centredness has been defined as.

However, with the small sample size that was purposively selected one could argue that the results are not generalisable as a certain type of patient may have been selected. Another factor which needs to be considered too is the setting for the study. Given the obvious differences between the hospital and residential care settings one may wonder if comparisons can be made however, given that all settings are currently experiencing staff shortages and increased workloads, one can assume that the study carried out in a different setting could yield similar results.

Kvåle and Bondevik (2008) investigated what is important for patient-centred care from a cancer patients perspective in a Norwegian hospital. Twenty patients were interviewed with three main themes being identified. The first theme empowerment, highlighted patient's wished to be respected, listened to, given honest information and be valued. The second theme shared decision making about treatment, patients' wished to be asked for their opinion, have information about the treatment but the majority of patients opted to let the doctor make the final decision as they were the professional with the expertise. The final theme partnership in nursing care, patient's wished to partake in decisions regarding their daily life and care. Patient's revealed they felt closer to nurses than doctors and saw

the nurse as more of a partner within the caring team. Findings from this study demonstrate that empowering patients with information can lead to a united decision on care treatments, which can ultimately lead to better satisfaction with care. Each theme can be identified as a dimension within the person-centred care definitions.

Little *et al.* (2001) also found that partnership was a requirement for patients when exploring patients preference for a patient-focused approach with General Practitioners. Good communication and health promotion were also seen as a necessity.

This section identifies the patient's experience of person-centred care. The literature reflects the definitions put forward by patients on person-centred care. These studies highlighted that being attentive, caring, making an effort, being connected, empowerment, sharing in decision making and partnership are aspects required for person-centred care.

3.6.1.2 Effects of Person-Centred Care

This section will review how person-centred care affects patient care in areas such as patient satisfaction and quality of life in light of the studies conducted in the area.

While the literature surrounding person-centred care discusses how it benefits patients, Wolf *et al.* (2008) examined the effects person-centred care has on patient satisfaction and quality of care. A randomised study was carried out with two groups of 18 patients with a control group and an intervention group of patients who were due to undergo bariatric bypass surgery. The intervention group received a telephone call 24 to 48 hours prior to admission by a nurse who was trained in person-centred care and discussed the hospital stay, concerns and questions. This nurse was then present to admit the patient on the day of the admission. The control group received traditional care that was routine for the hospital setting. The results demonstrated that the intervention group had higher rates of satisfaction and quality of care than the control group, suggesting that person-centred care can in fact improve care standards for patients. The additional care that was provided within the intervention group was minimal and this care was only present at the beginning of the admission process which could imply that first impressions leave lasting impressions for patients.

Similar results can be seen in a study conducted by Jackson *et al.* (2001) with 500 patients who attended a physician using a quantitative design to assess the predictors of patient satisfaction. Results demonstrated that over half the patients were completely satisfied with their care immediately post visit. That number increased at 2 weeks and 3 months. Older patients (over 65) who had better functional status were most likely to be satisfied. Unmet expectations were seen to decrease satisfaction throughout. Information given to patients was seen to increase satisfaction. Communication was seen as an important aspect with patient satisfaction. This study highlights that by assisting older adults to regain functional status that there is a potential to increase satisfaction levels, which leads one to believe that when caring for older adults, if at all possible, the care should aim to increase independence through high quality care which can be achieved by person-centred care.

According to McLaughlin and Kaluzny (2000), patient-centred care promotes the quality of care delivered. Sidani (2008) carried out a non-experimental repeated measure study reviewing the effects of person-centred care on patient outcomes in relation to acute care nurse practitioners using repeated measures at three time points. The overall feelings from the 320 patients that participated within the study were that person-centred care was present in the caring approach. Patients felt they were encouraged to participate in their own care and the decisions involved in their care to a moderate extent. They reported individualised care to a moderate level. The use of person-centred care was seen to be associated positively with self-caring abilities and satisfaction with care.

Suhonen *et al.* (2005) explored person-centred care, quality of life and patients satisfaction with nursing care in Finland using a cross-sectional, descriptive, correlational design. Inpatients from surgical units were recruited to the study with 279 participating completing questionnaires. Findings presented that individuality was supported through certain nursing activities. They also showed that the more individualised the patient care was the higher the level of patient satisfaction with the care. Patients were least satisfied with their information needs.

Sjögren *et al.* (2013) also found similar findings when examining person-centredness and its link to residents well-being in dementia care units. Surveys were distributed to staff and to residents of 156 care units with 1,482 staff and 1,471 residents completing the

surveys. Results showed correlations were noted with higher person-centred care and abilities to perform activities of daily living. Furthermore residents with higher person-centred care also rated having a higher quality of life in comparison to residents with lower levels.

When person-centred care is present for patient interactions, significant improvements have been reported in physical outcomes and a reduction of boredom (Brownie and Nancarrow, 2013). A study undertaken by Parlour *et al.* (2014) in Ireland aimed to investigate the relationship between patients' perceptions of person-centred climate and patient experiences. Using a quantitative approach, two surveys were distributed to 345 patients including the Person-Centred Climate Questionnaire-Patient version. The results highlighted that the majority of patients deemed they were treated with dignity and respect while in the hospital setting. A higher score for person-centredness was seen to have had a more positive effect on patient experiences. However, almost half the patients surveyed expressed a wish to be more involved in decisions about care and treatment which is an integral component in person-centred care. This is an area that must be addressed in order to achieve person-centred care.

Dignity and respect are high on patients priorities when being cared for as seen above by Parlour *et al.* (2014). Woolhead *et al.* (2004) examined dignity in older age from the perspective of the older adult in the United Kingdom. Utilising a qualitative approach, focus groups and interviews were carried out with 70 participants. The findings demonstrated strong evidence that dignity was salient to the concerns of older adults. Data collected found it was a multifaceted concept with three major themes: 1. Dignity of identity (self-respect/esteem, integrity, trust). 2. Human rights (equality, choice). 3. Autonomy (independence, control). Participants acknowledged that at times during caring dignity may be in jeopardy rather than being enhanced. Dignity is an important component of person-centred care and it is clear with the terms trust, choice and control that person-centred care must be present in order to maintain patients' dignity.

The effects of person-centred care for patients can be seen clearly throughout the above studies including increased satisfaction with care, improved quality of life, empowerment and it is seen to be associated positively with self-caring abilities.

3.6.1.3 Participation in Person-Centred Care

Patient participation in person-centred care is an important factor that will be explored in this section. Abrahamsen *et al.* (2014) conducted a study to examine the extent to which patients with diabetes, heart failure or haematological cancer wish to participate within care. Using surveys, 1,173 inpatient and outpatient patients in Denmark partook in data collection. Patients completed a 117 itemed questionnaire that looked at the adequacy of information, patients' participation preferences, the patients' attitude to participation and the perceived participation. A finding showed 90% of patients wished to be consulted in the decision making process with 89% considering participation as very important and 89% feeling that the information received was adequate. Preference for participation when making the decision found just over half the patients wished to let the staff make the decision, whilst 25% did not want the staff to make decisions on their behalf. The perceived participation was recognised by 72% of patients. These findings demonstrate the importance of involving patients within the decision making process and making the process a shared decision. By providing patients with adequate information and support, many patients were satisfied, with over half trusting the staff to make the necessary decisions on their behalf.

The word trust is seen to appear in conjunction with person-centred care (Abrahamsen *et al.*, 2014; Ferguson *et al.*, 2013). Fiscella *et al.* (2004) explored the notion of patient trust in relation to person-centred care behaviours of primary care physicians. Audio tapes of two unannounced standardised visits with 100 physician occurred and 4,746 patients completed a survey from the physicians practice. The results indicated that the scale used to measure patient experience of disease and illness was independently associated with patients' rating of trust for the physician. A one unit standard deviation (SD) increase in this score was associated with 0.08 SD increase in trust (95% confidence interval 0.02-0.14). For every additional minute spent with the physician patients' trust was seen to increase by 0.01 SD (95% confidence interval 0.0001-0.02). These findings suggest that a physician's verbal behaviour during an encounter is associated with trust from the patients' perspective. However, no older adults were included in this study as the age range for patients was from 18-65.

Putting the patient back into person-centred care is a study investigating patient's experience of person-centredness (Ferguson *et al.*, 2013). Patients and family members were interviewed to gain a greater understanding of the patient's experience. The study

found that the expectations of patients for the involvement in care varied. Emerging themes were identified surrounding patient expectations, satisfaction with the quality and patients involvement in care including: 1. Patients wished to feel valued and respected. 2. Trust between patients and healthcare professionals was vital for a positive relationship. 3. Effective communication of necessary information was deemed important. 4. Patients perceived that the team relationship existed primarily with the physician (although other professionals were acknowledged). 5. A general satisfaction with care delivered (Ferguson *et al.*, 2013).

Issue surrounding communication with and amongst healthcare professionals were identified. Younger patients indicated they were more assertive in attaining information and decision making with healthcare professionals (Ferguson *et al.*, 2013). This may indicate that the younger generation are adapting to the patient-centred care model more readily than that of the older generations who were brought up with the approach that the doctor knows best. With the ever increasing advances in information technology patients now have the ability to investigate the symptoms experienced and thus, are more likely to want to be involved in the care provided and require detailed information about findings as is necessary when caring in a person-centred manner. The Patient First Report in Saskatchewan acknowledges that up to 56% of patients have undertaken some research prior to attending a physician (Saskatchewan Ministry of Health, 2009).

The question then arises as to what older adults prefer when it comes to being involved in care. Bastiaens *et al.* (2007) explored primary health care in 11 European countries to assess older adults preferences for involvement in care. Interviews were conducted with 406 older adult patients who attend a primary healthcare setting. Results were categorised into four sections: 1. The doctor-patient interaction. This was seen as an important aspect of patient involvement. Three themes emerged: communication/information, the relationship and decision making. 2. GP related issues. It was felt that GP's need to facilitate patient involvement through positive attitude and enabling. 3. Patient related issues. Age related issues including forgetfulness, poor sight, hearing and mobility can complicate patient involvement. Low levels of education was also seen to inhibit certain patients. Some patients chose not to be involved in care. 4. Contextual factors. Time spent with patients was an important factor and was seen to help older people gain a better understanding. Shorter times with the GP were seen as a barrier to actively participate in

care. From this study one can determine that there are many factors that impact and inhibit older adults' choice to be involved in care.

The previous study identified a low education level as a factor impeding patients in person-centred care (Bastiaens *et al.*, 2007). Educational inequalities in person-centred care were studied by Rademakers *et al.* (2012) in the Netherlands. This study focused on patients' preferences and experiences using questionnaires (n = 1,019) as the method of data collection. The results highlighted that patients had positive experiences with person-centred care and that they rated it highly. No educational inequality in regards to the amount of person-centred care received by patients was noted. However, the findings suggest that the educational level was directly related to the degree of importance attributed by patients to specific points of person-centred care. Patients with lower educational levels rated all three aspects (shared decision making, understandable explanations and being able to ask questions) as less important. Gender was seen to also demonstrate a disparity between groups with females rating person-centred care as more important than males in all three aspects of care, irrespective of the educational level.

Patients over 45 years of age were seen to consider all three aspects of care as more significant than younger patients. This could suggest that older patients require more support, whilst younger patients as identified by Ferguson *et al.* (2013) study above found that younger patients were in fact more confident to attain more information and be involved in decision making. This study identifies adults with lower education levels place less preference on person-centred communication style.

From this section it is clear that some patients have a clear desire to be completely involved in the care and decisions that are made surrounding healthcare, whereas other patients are happy to be informed about the options but would rather leave the decision making to the professionals. Both of these scenarios have demonstrated person-centred care, once it is what the patient wants, and once effective communication was utilised to educate the patient and ensure an understanding of the decisions that were put before them. Shared decisions making allows the patient to be a participant within the caring process and is seen as a central key to person-centred care.

3.6.2 Staff

Healthcare professionals including nurses and healthcare assistants, healthcare organisations such as hospitals, hospices and residential care units and governments all frequently discuss and document one of the main objectives in caring as being the delivery of person-centred care (McCance *et al.*, 2011). Many departmental and national strategies place person-centred care as a key factor including the ‘National Service Framework for Older People (Department of Health, 2001); ‘Future Health: A Strategic Framework for Reform of the Health Service’ (Department of Health, 2012b); and within many professional organisations including An Bord Altranais (2009) and the Royal College of Nursing (2015).

Person-centred framework can be seen within the nursing discipline and consists of three factors: quality, skills and characteristics of the nurse, healthcare environment where care is delivered; the actual person-centred process that describes how care is delivered and though what activities; and the outcomes of the implementation of person-centred care. McCormack and McCance (2006) believe that all these play a part in order to achieve person-centred outcomes. Healthcare professionals need to be flexible and reciprocal when providing patient care, use negotiation and work with patients values, wants, needs and desires (Wolf *et al.*, 2008). This section will review person centred-care from the staffs’ perspective and examine how it affects professional life, whilst reviewing studies that incorporate staff and person-centred care.

3.6.2.1 Understanding and Incorporating Person-Centred Care

One of the most important factors when delivering person-centred care is to have an understanding of what person-centred care is and how it can be achieved. This section will review studies in this area.

Ross *et al.* (2015) conducted a study to view the nurses perspective into the understanding of person-centred care. Individual semi-structured interviews were undertaken with 14 nurses. Results were divided into two sections with the first section reviewing what staff understood as person centred care and second section describing how nurses perceived the facilitation of person-centred care. In section one, understanding person-centred care, all nurses demonstrated a good understanding and identified important aspects including:

attention to detail and knowing the patients personal identity. This links in with what the patients expressed as important in Marshall *et al's*. (2012) study. Section two developed three themes: Characteristics of relationships, personal qualities of staff and principles of person-centred care. Relationships and communication were emphasised as being important for care with not just the patient but the family and the care team and was seen to facilitate person-centred care. Staff felt that being friendly and approachable allowed a relationship to develop and trust to be built and that flexibility was necessary when caring for patients. Staff felt that personal qualities such as values and beliefs, attitude and understanding, listening and recognising what is important for the patient all facilitate person-centred care. Person-centred care was seen as vital for high standards of care but it was acknowledged that it is challenging within an acute setting.

One of the many ways used to incorporate person-centred care into caring is seen in the biographical approach. This allows the patient the opportunity to open up about their life and experiences (Elipoulous, 1997). One of the benefits of using this approach is that it assists practitioners to gain a greater understanding of the person behind the patient (Heliker, 1999). Clarke *et al.* (2003) carried out a study to explore the use of biographical approach by using the method of life stories. The findings revealed that practitioners were encouraged to see the person behind the patient by using a biographical approach. It also identified that it assisted in building and strengthening relationships with patients and their relatives. Practitioners acknowledged the limitations of using such an approach as it would not be suitable for all patients however; it appears to be a very effective tool when used with suitable patients.

McKeown *et al.* (2010) also studied the use of life stories for patients with dementia and how it can impact on person-centred care. A multiple case study design was used with semi-structured interviews, observations and conversation with 4 patients, 3 relatives, 5 nurses, 2 support workers, 2 occupational therapist assistants and 1 student nurse. The findings highlighted that using life work can increase person-centred care for patients with dementia across a range of themes. These included from patient to person (seeing the person behind the dementia patient); can you hear me? (providing a voice for the person with dementia to be heard; and pride and enjoyment (pride was seen from the person with dementia enjoying sharing their story and enjoyment was noted by staff and family having participated in the development of the patients life story work.

3.6.2.2 Work Environment

Person-centred care has been connected with staffs' work environment and has been seen to depend on certain variables. Organisational support, leadership support and a positive psychosocial environment have been identified as enabling person-centred care (McCormack and McCance, 2006; Kitwood, 1997a). This section will review work environment and its impact on person-centred care.

Sjögren *et al.* (2014) carried out a study in a residential care setting to explore the relationship between staff characteristics, perceived work environment and person-centred care. Staff (n =1,169) from 151 residential aged care units completed surveys. What the findings suggested was that higher levels of person-centred care were associated with higher levels of staff satisfaction and supportive psychosocial unit climate and lower levels of job strain and stress of conscience. It was also noted that having completed education in dementia also increased person-centred levels. This study demonstrates that work environment appears to impact on person-centred care and that by staff up-skilling with extra courses within the field they are potentially increasing the ability to provide person-centred care and to increase job satisfaction.

Environmental conditions were also highlighted in a study by Norheim and Vinsnes (2012). Patient involvement and shared decision making were seen to be an integral component of person-centred care for patients. Factors that influence patient involvement in care within the nursing home setting were reviewed from the staff experiences through focus groups with 16 staff members (Norheim and Vinsnes, 2012). Staff identified two main areas that contributed to the involvement of patients, attitudes and environmental conditions. Staff attitudes incorporated values, assessment ability, consciousness raising, knowledge enhancement, role modelling and clarification of responsibilities. Whilst the environmental conditions included team work, continuity, structural conditions, cooperation with next of kin and time pressures when factoring in patient involvement in care within nursing homes. This study demonstrates that staff are aware of the care and the factors that are required to encourage patients to be involved in care.

A study carried out by Balbale *et al.* (2015) with Veteran Affairs health care professionals in the U.S also looks at staff perceptions of person-centred care. Health care professionals completed a photovoice project in which it was required to take photographs of how

person-centred care was present or not present within the care setting, following this the 12 participants were interviewed. The results identified three themes: individual, environmental and systems levels. The theme individual involved the staff recognising the patient as a whole. Health care professionals view person-centred care as going above and beyond the patient's needs and that treatment should be tailored for every patient. Job satisfaction was also highlighted as an important factor in relation to the work experiences and contributions that assist in making the environment person-centred. In general most participants were satisfied with the work environment and indicated that working with other healthcare professionals contributed positively to the working experience. The environment at a physical level was seen to impact on experiences at work and patients experiences in terms of the space and characteristics. Positive space had been created with a relaxing atmosphere, yet certain things for staff like car parking facilities were viewed as a negative as it felt like a struggle to get a space. From a social environment perspective, staff seemed generally happy with interactions with patients and appreciated the importance of communication and being respectful to patients. System level effects were noted to impact on the perspective of person-centred care including having the resources to allow staff to carry out the duties successfully and implement initiatives to assist with the health and well-being of staff. Employee resources were associated with promoting job satisfaction.

From the literature it can be seen that the work environment can have a significant impact on the effects of person-centred care. Certain factors including education, support and team work if present can have a positive impact on person-centred care however, if absent can lead to lower levels of person-centred care.

3.6.2.3 Staff and Person-Centred Care

This section looks at studies surrounding staff and person-centred care. Person-centred care has been indicated to have a positive impact on job satisfaction for staff (Lehluante *et al.*, 2012). Lehluante *et al.* (2012) carried out a study in order to describe nurses' satisfaction with care and work and to examine to what extent a person-centred unit climate influences this satisfaction. A total of 206 Swedish nurses took part in the study which involved the completion of two questionnaires: the Satisfaction with Nursing Care and Work Assessment Scale and the Person-centred Climate Questionnaire-Staff version

(PCQ-S). The results showed that over 60% of the participants were very satisfied or satisfied with care and work. Nurses who worked for more than 9 years were more satisfied than those who had worked less. The PCQ-S score was significantly associated with nurses' satisfaction with care and work as were all three subscales within the questionnaire. This study highlights the link between person-centredness and satisfaction with care and work for nurses in acute care environments.

Satisfaction with care is important for all healthcare professional including healthcare assistants who carry out a high portion of the direct care to residents. Coleman and Medvene (2013) investigated the use of a person-centred intervention for 19 geriatric healthcare assistants within the healthcare setting. Healthcare assistants were trained and interactions were recorded pre and post training. Results demonstrated that residents' perception of relationship closeness increased significantly following training of nursing assistants. Changes were also noted in the nursing assistants' perception of satisfaction and closeness and resident satisfaction indicating that this type of training intervention needs further research. This study suggests that effective training in person-centred care can improve factors for both staff and patients.

As person-centred care is a global phenomenon, Suhonen *et al.* (2011) explored internationally the perceptions of patients' and nurses' on individualised care. Data was collected from five European countries using two questionnaires in the hospital settings. The results showed differences between each country from a nurse and patient viewpoint of individualised care. Nurses, compared to patients, revealed that they supported patient individuality more often. The overall picture highlights the care provided was individualised. From this study one can assume that person-centred care is present and practiced around the world. However, it appears that nurses deem to be providing higher levels of care than what patients identify. This relates to Marshall *et al.* (2012) findings that highlighted patients lack familiarity with the concept of person-centred care. Edvardsson *et al.* (2010a) also conducted a study from the perspective of the patient, relative and staff looking into promoting the continuation of self and normality with person-centred care. A qualitative design was adopted using interviews to gather data. The main findings suggest that the person-centred care was promoting a continuation of self and normality. Within this, five categories emerged including: knowing the person;

welcoming the family; providing meaningful activities; being in a personalised environment; and experiencing flexibility and continuity.

Wilson and Neville (2008) examined the findings of two studies to explore the nature of nurses' practice when caring for vulnerable and marginalised populations. Using a secondary analysis of the studies including 58 participants, the findings highlighted a problem focussed approach to healthcare delivery. Individualised care was not incorporated in care and the social background of a person's life was not incorporated. This leads one to believe that holistic nursing is a rhetorical construct. However much one wants to believe person-centred care is always present in care it seems fair to suggest that this is not a reality at present.

A qualitative study carried out by Train *et al.* (2005) three years earlier to examine the experiences of long-term care for staff, relatives and residents with dementia aimed to assess the positive and negative experiences by conducting semi-structured interviews with 21 residents, 17 relatives and 30 staff. Five main themes were highlighted: Privacy and choice; relationships (abuse and vulnerability); activities; physical environment and expectations of a care environment by carers.

All three groups identified privacy and choice when being interviewed. Residents highlighted a lack of choice and flexibility at times in the little things such as when the residents can have a drink or time spent bathing. From the staffs perspective it was felt that flexibility was present however, certain remarks made suggested staff were not providing choice to residents. It appears there is an understanding for how important privacy and choice are yet, sometimes ward routines and workload or patients' functional ability can affect the realms of this choice.

Relationships appear to be complex within the study; good relationships were mentioned between staff and relatives. Concern was voiced by staff in terms of other staff abusing the position. Staff must use professional judgement when caring for patients, in particular vulnerable patients and codes of conduct must be adhered to, thereby ensuring patient safety.

Activities gained both positive and negative feedback with staff identifying that activities in particular outings need to be suited to individual requirements making it a challenging task. Residents were positive in general about the physical environment, however, the staff were more critical highlighting a lack of space. This study indicates the different viewpoints present from the three different groups. Areas to improve on included communication between all three groups, choice for residents which involves staff being more flexible in caring routines and in the need for activities that can be specific for individuals as opposed to a one size fits all approach.

Choice is seen as an important aspect for patients and staff when caring for patients. Hughes and Goldie (2009) examined to what extent this choice is present for residents in regards to medication when in a nursing home. General practitioners and residents participated in semi-structured interviews while nurses were involved in focus groups. The findings demonstrated that a key theme was control. All healthcare professionals felt that control was required when prescribing and administering medications to ensure resident safety, quality and to provide continuity of care. From the residents' perspective, this control over medications was accepted without asking questions, indicating that shared decision making and choice are lacking. Residents had little say in prescribing or administering of medications. Healthcare professionals acknowledged more involvement by residents would increase resident autonomy and empowerment yet, they were concerned about how it would affect the control within the nursing home environment.

3.7 Conclusion

Person-centred care is seen as a positive relationship between the healthcare professional and the patient. Caring for patients in older adult care settings with a person-centred care approach including patients with dementia, staff must strive to: incorporate positive interactions and communication in order to establish a good relationship, use knowledge of the patient to tailor care to the patient's needs and wants, monitor a patient's behaviour and symptoms from the patient's perspective, give the patient a choice in making decisions and ensure families are aware that their involvement in care is appreciated (Edvardsson *et al.*, 2008b; McCormack, 2004). Results of caring in a person-centred manner have been seen to improve patient outcomes and compliance rates whilst

empowering patients to be an equal partner within their healthcare. By providing individualised person-centred care that incorporates compassion as an integral component, along with dignity and respect, one can assume that by caring in such a manner exhibits compassionate care.

The literature reviewed has identified gaps within the area of compassionate care including a lack of Irish studies surrounding compassion and in particular in the older adult care setting. It also highlights the lack of consensus on how to measure compassionate care and the literature would also suggest that person-centred care could be used as proxy measure of compassion. Studies reviewed demonstrate that compassion is an important aspect of caring for both patients and staff however, there is limited evidence on observed care of patients with healthcare professionals. Likewise there is limited literature on the relationship between person-centred care and professional quality of life. Therefore, there is need to explore compassion in the older adult care setting in Ireland from the patient and healthcare professionals perspectives.

CHAPTER 4: Methodology & Methods

4.0 Introduction

This chapter will outline the research design framework that was utilised to conduct the study in order to achieve a greater understanding of compassionate care and how it is practiced within the older adult care settings. This study is situated within the methodological approach of case study design incorporating multiple data collection methods. The steps involved in devising a case study design will be outlined and an argument justifying the appropriateness of this methodology to meet the research aim and objectives will be presented.

The aim and objectives are identified in section 4.1. The theoretical base of the study will be highlighted and discussed in section 4.2. Section 4.3 will review the research philosophy surrounding the methodology. A detailed explanation of why the research design was adopted is presented in section 4.4 including the phases of the study, with section 4.5 describing the population and discussing the sampling methods used. Recruitment (section 4.6), data collection (section 4.7), reliability and validity of instruments (section 4.8), ethical considerations (section 4.9) and data analysis (section 4.10) will also be addressed in this chapter.

4.1 Research Aim & Objectives

This study aimed to explore compassionate care delivery in the older adult care setting. The aim and objectives for this study emerged from a combination of an initial motivation to explore compassionate care in an older adult setting, and as a result of the key issues and questions emanating from the literature review, which helped to identify how, and in what ways the research investigation may be best approached. The study examined the relationship between observed care delivery, professionals' person centeredness, professional quality of life and patients' satisfaction with person-centred care.

4.1.1 Objectives

The objectives of this study are to:

1. To examine the healthcare professionals – patient/visitor interactions using the Quality of Interaction Scale (QUIS).

2. To assess compassion satisfaction, compassion fatigue and compassion burnout rates of the healthcare professionals using the Professional Quality of Life Scale (ProQOL).
3. To explore healthcare professionals person centeredness using the Person-Centred Climate Questionnaire-Staff version (PCQ-S).
4. To assess patient satisfaction rates using the Person-Centred Climate Questionnaire-Patient version (PCQ-P).
5. To examine for relationships between Professional Quality of Life and Person-Centred Climate.

4.2 Theoretical Base of the Study

Theories are used to describe, predict, explain, and control phenomena (Nieswiadomy, 1998). Following analysis of the literature surrounding compassion, clear components of compassion were identified (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012; Boyatzis *et al.*, 2006), however, significant challenges in terms of how to measure compassion and its components led the researcher to identify alternative ways to assess compassion.

By utilising a triangulated method which incorporates person-centred care from the patients, healthcare staffs and the independent observer a proxy measure of satisfaction with care could be determined which would allow an assessment of each party's views of compassionate care. The theoretical framework underpinning this study is outlined in Figure 4.1.

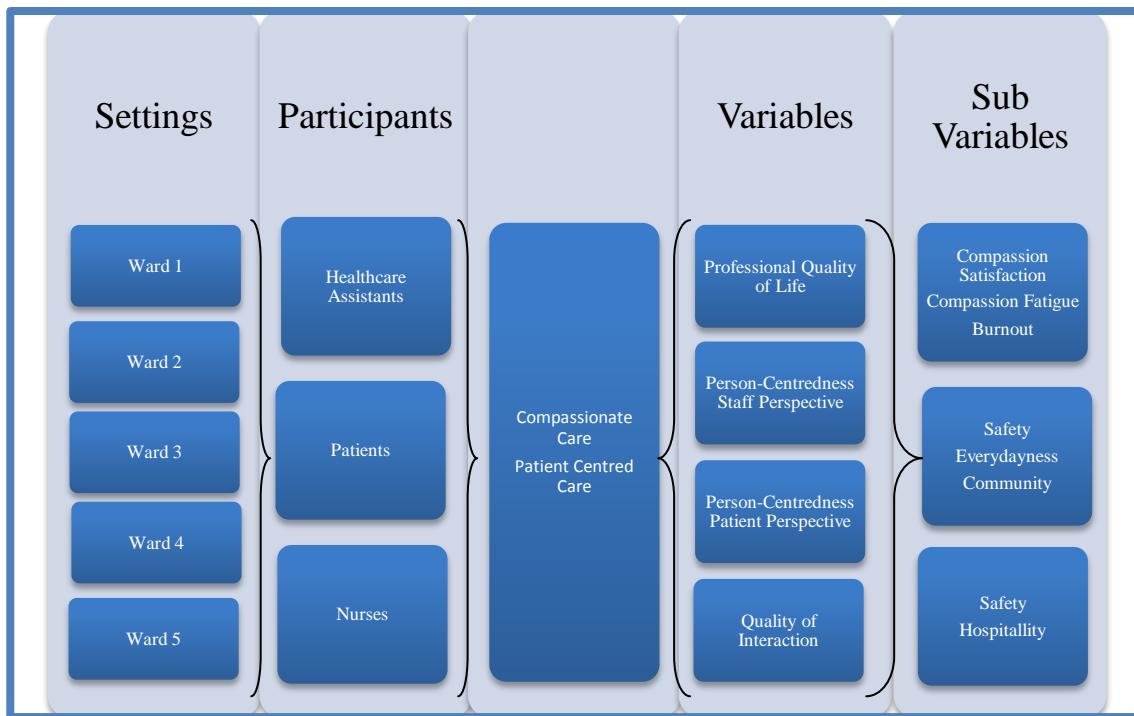


Figure 4.1: Relationship of the Framework to the setting, participants and variables

4.3 Research Philosophy

Research philosophy is a belief that concerns the way in which data about a phenomenon should be collected, analysed and utilised (Levin, 1988). The various philosophies of research approaches are covered within the terms epistemology (what is known to be true) and doxology (what is believed to be true). Galliers (1992) proposes the purpose of science is to be involved in the process of transforming things believed into things known: doxa to episteme. Of the various research philosophies there are two which have been highlighted within the Western tradition of science, positivism and interpretivism, which are reviewed and contrasted in table 4.1 (Solomon *et al.*, 2006). Robert Yin puts forward that the positivist approach incorporates objectives that are tangible. He defines the goals as predication and views the knowledge generations as value-free which is independent of its context. Yin believes this occurs from real causes and requires separation between the researcher and the subject. Whilst Robert Stake view the interpretivist approach as one that is socially constructed and requires understanding. The knowledge base is generated from dependant context and is value-bound. Stake view causality as multiple, simultaneous shaping events that requires the researcher to be interactive with the subjects

being studied. Essentially, both research paradigms offer contrasting views in relation to how reality is viewed.

Table 4.1: Positivist vs. interpretivist approaches to consumer behaviour

	Robert Yin	Robert Stake
Assumptions	Positivist approach	Interpretivist approach
Nature of reality	Objective, tangible Single external reality	Socially constructed No single external reality
Goal	Predication	Understanding
Knowledge generation	Value-free Context-independent	Value-bound Context-dependant
View of causality	Existence of real causes	Multiple, simultaneous shaping events
Research relationship	Separation between researcher and subject	Interactive, co-operative, with researcher being part of the phenomenon under the study

4.3.1 Positivist Paradigm

The positivist paradigm is underpinned by the ‘naïve realism’ in which reality is viewed as an objective viewpoint (Guba and Lincoln, 2005) and as such does not interfere with the phenomena being studied (see table 4.1) It is believed that reality is stable and can be observed (Levin, 1988). Researchers utilising the positivist paradigm will note the objectivity of reality being the independence of peoples’ perceptions. Bryman (2008, p. 18) considers this as being “external to the individuals who inhabit it”, suggesting reality in a singular context. According to Bryman (2008) positivists believe that the ‘real’ reality can be achieved by applying the appropriate research methods. The positivist approach is seen to be “value-free” in such that the researcher’s values are separated from the research findings (Robson, 2011). This is thought to occur as the subjective opinions of the researcher may cause some bias and affect the objective reality. Consequently, data collection and analysis by positivist researchers requires one to be detached during each process. "Positivism has a long and rich historical tradition. It is so embedded in our society that knowledge claims not grounded in positivist thought are simply dismissed as ascientific and therefore invalid" (Hirschheim, 1985, p.33).

4.3.2 Interpretivist Paradigm

Interpretivist paradigm supports the fundamentals of ‘relativism’ and thus, refutes the singular reality of the positivist paradigm (Guba and Lincoln, 2005). It is believed that only through subjective interpretation of and intervention in reality that reality can be fully understood. Cohen *et al.* (2007) discuss relativism and suggests that multiple realities exists and that this can change from each person according to each person’s descriptions. Robson (2011, p. 24) highlights that “there are as many realities as there are participants- as well as that of the researcher” and that knowledge, practice and understanding of people is what form these realities. Table 4.1 identifies Stake’s (1995) explanation of the interpretivist paradigm, recognising reality as being socially constructed as opposed to being objectively determined. Studying the phenomena in their natural environment is key to this philosophy and it is thought to bring about a deeper awareness of the perceptions of each person’s own activities (Hussey and Hussey, 1997), supporting the notion that there is no single external reality. The interpretivists propose that reality is centred on each individual’s perceptions and experiences (Robson, 2011). The subjective nature of the interpretivists’ paradigm is based on the theory that researchers cannot distance or detach themselves from reality (Cohen *et al.*, 2007) which leads to the research being ‘value bound’ as opposed to ‘value free’. Interpretivists acknowledge that there may be many interpretations of reality, yet believe that these interpretations are as a whole part of the scientific knowledge that they pursue.

For the purposes of this study a positivist paradigm guided by Yin’s case study approach will be adopted with the aim of seeking information based on systematic observations in which separation exists between the researcher and the participants with a view to determine if compassion can be determined through person-centred care and professional quality of life.

4.4 Research Design

This study will adopt a 4 phase case study design to explore compassionate care in the older adult care setting using mixed methods of data collection. These phases are observations, staff questionnaires, patient questionnaires and interpretation of results and can be seen in tandem in Figure 4.2. The rationale for this will now be explained.

The process of investigation begins with determining the appropriate research design that is necessary to investigate the research question. The researcher is assigned the task to choose which strategy to utilise, be that quantitative or qualitative or a combination of both. This process requires the researcher to make explicit the research design adopted, including the rationale for the design and the use and the conditions that play a role in the decision making. Myers (1997) views the research methodology as a plan of analysis that carries the philosophical assumptions through to the research design and data collection. Ritchie and Lewis (2003) believe that different methodological approaches are supported by specific philosophical assumptions and that is important for the researcher to ensure consistency from the philosophical starting point and the research approach that is utilised. Morse *et al.* (2001) identifies that by ensuring consistency one can be sure to achieve more valid findings from the research.

4.4.1 Case Study

Given the diverse nature of this study, case study was selected as a rigorous methodological framework to inform and meet the studies aim and objectives. Initially this section will review the case study approach and it will then be discussed in relation to its appropriateness for this study.

Bergen and While (2000) view the case study as a familiar yet elusive approach to research. It is seen as the most flexible of all research designs and it is defined by Robert Yin as ‘an empirical inquiry about a contemporary phenomenon (e.g., a “case”), set within its real-world context- especially when the boundaries between phenomenon and context are not clearly evident (Yin, 2009, p. 18).

One of the leading writers around the topic of case study research, Yin (2003, p. 5), highlights the different strategies that are relevant when aiming to answer ‘how’ and ‘why’ questions (see Table 4.2). These four strategies aim to assist the researcher to find out the ‘how’ and ‘why’ questions including experiment, survey, history and case study. From the four strategies, it is clear that case study is the more favourable option. However, one might suggest that survey could also be chosen given that there is no required control of behavioural events and it focuses on contemporary events but it would

not allow for observations which are an essential component of the research objectives. Ghuari and Gronhaug (2005) view case study design as the preferred method for researchers who have little or no control over events when focusing on a current phenomenon in a real life context, thus, it favours the collection of data in natural settings. Subsequently it was determined that in line with the aims and objectives of the study that the case study strategy put forward by Yin (2003) was the most appropriate method for conducting the research, as the focus was on compassionate care delivery in a real life context. By utilising this method the research objectives including examining how healthcare professionals interact with patients/visitors, how satisfied patients are with the level of person-centredness and how person-centred healthcare professionals believe themselves to be will allow the researcher to answer the why questions.

Table 4.2: Relevant situations for different research strategies

Strategy	Form of Research Question	Requires Control of Behaviours Events	Focuses on Contemporary Event
Experiment	How, why?	Yes	Yes
Survey	Who, what, where, how many, how much?	No	Yes/No
History	How, why?	No	No
Case Study	How, why?	No	Yes

4.4.1.1 Rationale for using Case Study

Yin (2003) discusses the different situations in which case study design can be adopted to heighten knowledge of individual, group and organisational phenomena. The need for case study is derived from the desire to gain a greater understanding for complex social phenomena in which it allows the researcher to maintain the holistic and meaningful characteristics of real-life events. Thus, case study design incorporates the contextual conditions, believing that they may be highly important to the phenomenon of the study. According to Yin (2003), the use of case study in social sciences is one of the many research strategies that can be adopted. What determines the suitability of case study. Yin believes this depends on the research question and whether it falls into one of three categories: explanatory, descriptive and exploratory. The explanatory approach focuses on how and why questions within research. Descriptive case studies are effective when

dealing with who and where questions whereas the exploratory method is based around 'what' questions (Yin, 2003).

The aim of this study is to explore compassionate care in the older adult care setting and thus, it is for this reason that an exploratory case study be conducted. This study needs to explore compassionate care and "what is happening" within the older adult hospital setting. One of its main aims is to "seek new insights, ask questions and assess phenomena in a new light" (Saunders *et al.*, 2000, p. 97). By utilising this method, new ideas and insights can be explored, creating a better understanding of compassion with the aim being to generate an increase in knowledge surrounding compassion (Churchill and Iacobucci, 2002). One of the benefits of using exploratory case study is its defining ability to deconstruct larger problems into more precise achievable issues (Churchill and Iacobucci, 2002), that enhances the progression of the research process from a broader to a narrower path. Scholz and Tietje (2002) believe that the more complex and contextualised the object of the research is, the more valuable the case study method is.

4.4.1.2 Identifying the Case

Once reaching the conclusion to utilise an exploratory case study design, the next step according to Yin (2009) is to define the "case" that is being studied. Robert Stake (1994) highlights that a case can be simple or complex and acknowledges the importance that the case selection offers in terms of maximising learning opportunities within a specific time frame (Stake, 1995).

Generally a case is a bound entity, be that a person, organisation, event, social phenomenon or a behavioural condition. According to Yin (2003) it is imperative to the research that the case is chosen for definite reasons and is not solely hinged on the ease and convenience of the site for data collection.

For the purpose of this study a typical case approach was adopted (Gerring, 2007). The typical case represents a typical set of values and thus, gives a general understanding of the phenomenon being researched. Gerring (2007) notes that some typical cases assist in an exploratory role.

The case identified was the older adult care setting with the subject of compassion being explored. In order to gain access to observe person-centred care and compassionate care it was important to choose a clinical setting that incorporates both into the daily care of the patients. As a result a Health Service Executive (HSE) care of the older adult setting was selected to conduct the research. The facility chosen allowed full access to the staff, patients and nominated relatives who were willing to participate in the study though the different data collection methods. By basing the case around a set of descriptive characteristics it leads to further probing for causal relationships (Gerring, 2007).

4.4.1.3 Case Study Design

This case study follows a four stage process commencing with, the design of the case study, then moving on to conducting the case study, followed by analysing the evidence from the case study and finally developing conclusions, recommendations and implications.

The first stage in this process is determining what a case study design represents within the phenomenon being investigated. Four categories of case study design are highlighted by Yin (1994) including single-case holistic design, single-case embedded design, multiple-case holistic design and the multiple-case embedded design.

The main distinction between each of the case study designs is single or multiple-case design. Single-case study design is seen as the preferred option when the case represents the critical case in testing an existing theory, the case is extreme or rare, to capture the representative or typical case or the case is revelatory in nature (Yin, 1994). On the other hand, the use of multiple-case design is considered by Yin (1994) as a more robust than a single-case study as the multiple-cases facilitate the gathering of more data and evidence. The cases within the multiple-case design are similar and the design involves numerous investigations on a connected topic which utilises replication logic as opposed to sampling logic.

Single-case study design was selected for this study because it is a unique case that requires a representative view point that will allow the researcher to capture the conditions and circumstances of the compassionate interactions. This in association with

the fact that this case is revelatory on the grounds that it is exploring compassionate care delivery from different perspectives, thereby yielding new insights and justifying the use of a single-case study design, as indicated by Yin (1994).

The next section involved in the decision making process when designing a case study is choosing to keep the case holistic or to have embedded subcases within an overall holistic case (Yin, 2003). The holistic design is used to investigate a single unit of analysis and looks at the whole, global or entire picture. Yin (1994) demonstrates that a holistic design can be used if the case study is only examining the global nature of an organisation or program and is beneficial when no subcase is identified. This design allows the researcher to gain a complete view of the case but can lead to potential problems including the avoidance of specific phenomenon which can result due to the nature of the case study shifting during the course of the study and as such the research begins to answer a different research question. One way to prevent this occurrence is to have subcases as are required in the embedded case study.

Some case studies require more than one unit of analysis and thus, within a single case subcase or subcases are investigated. Embedded design involves identifying subcase/subcases which are each explored individually. This allows an overall picture to be achieved by drawing together all the units analysed. However, embedded design is not without its issues. Yin (1994) highlights one such issue which occurs when the subcase becomes the focus of the case study and the researcher fails to return to the case. This study adopts the embedded design and so the case study will be a single embedded case study design. This allows compassion to be studied from different perspectives including the patient, staff and the researcher.

4.4.1.4 Limitations of a Case Study

It would be false to assume that any methodology is not without criticism, and case study is no different. Three arguments have been put forward by Yin (1984) refuting the use of case study for research. To begin with the first issue identified is an expression that case study provides little basis for scientific generalisation (Hall, 2008). Opposing this theory, Yin (2003) believes that the purpose of case studies is to form generalised theories in an analytical manner instead of enumerated frequencies in a statistical manner.

The next issue put forward is that case studies are regularly challenged as lacking rigor. It is felt that the researcher can become inattentive whilst conducting the research process thereby resulting in a biased viewpoint which in turn affects the reliability of the findings (Yin, 1984). It is imperative to work diligently to prevent such inattentiveness and ensure that effective systematic plans are in place during data collection thereby increasing validity and reliability.

The final issue identified by Yin (1984) is that case studies are seen as time consuming and difficult and have the potential to produce large amounts of records from data collection. Yin (2003) recognises this issue and emphasises the importance of being systematic when carrying out and managing case studies. The limitations which have been noted to affect case study research will be addressed with the aim of achieving a high standard of case study research.

4.4.2 Triangulation

Within this case study design which is exploratory in nature, multiple methods of data collection were undertaken in order to obtain a triangulated view of compassion in terms of person-centredness and professional quality of life for patients and healthcare staff. The methods used included questionnaires which demonstrated opinions from the staff and patients'/nominated relatives viewpoint and observations which allow the researcher to identify the interactions that are occurring within the care setting. The four key instruments required to gain a triangulated perspective included the Professional Quality of Life Scale Questionnaire, the Person-Centred Climate Questionnaire-Staff version, the Person-Centred Climate Questionnaire-Patient version and the Quality of Interaction Schedule (Observational Tool).

Triangulation, as defined by Denzin (1970), is the combination of two or more theories, data sources, methods or investigators in a study of a single phenomenon. The rationale behind using triangulation in studies is that, it is thought to enhance confidence in the ensuing findings (Bryman, 2011).

Denzin (1970) identified four forms of triangulation, which included: Firstly, data triangulation, this involves collecting data through several sampling techniques in order to gain data at different times and different social circumstances, from a variety of people. Secondly, investigator triangulation utilises more than one researcher in the field to collect and interpret data. Thirdly, theoretical triangulation, this involves using more than one theory when interpreting data. Finally, methodological triangulation, this involves the use of two or more methods of data collection.

A further distinction is then made by Denzin (1970) between a within-method and a between-method triangulation. The within-method is seen as the use of varieties of the same method to investigate the research question whilst, the between-method triangulation incorporates the contrasting research methods, such as observation and questionnaire.

This study utilised the methodological triangulation approach with the between-method which involved the use of two or more research methods in one study. In doing so one can mix methods such as observations with surveys (Sieber, 1973) thus, potentially reducing bias that may be present in a single method and utilising triangulation of data sources. The data sources within this study included: healthcare professionals (nurses and healthcare assistants); patients; and relatives.

This design allowed for a contemporary phenomenon like compassion to be explored within its context to heighten the knowledge surrounding compassion, person-centred care and professional quality of life. By utilising triangulation of multiple methods within an exploratory case study design data could be collected to assess professional quality of life, person-centred care and examine the relationship between both. It also facilitates the use of observations to provide an independent view on the interactions that occurred within the healthcare setting.

4.4.3 Phases of the Study

In order to achieve the main aim and objectives within the study it was decided that the study would be broken down into four phases. These four phases are detailed below and in Figure 4.2.

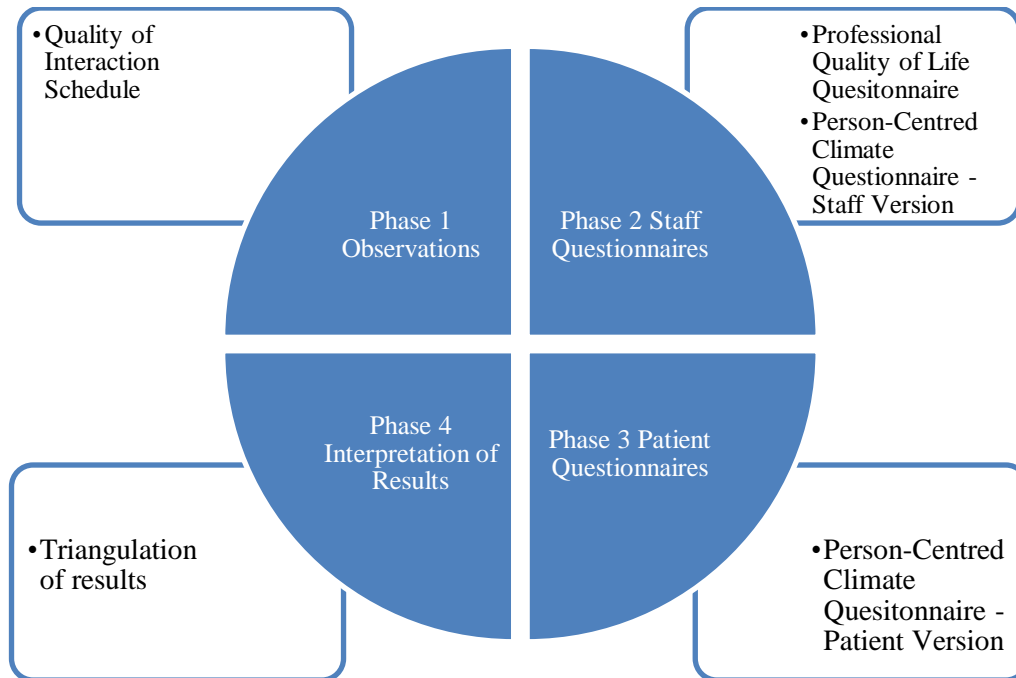


Figure 4.2: Phases of the Study

4.4.3.1 Phase 1 Observations

Phase 1 of the study was the conduction of observations using the Quality of Interaction Schedule Tool. Observations took place within the five wards selected for data collection. All staff that consented to participate were observed in terms of how they interact with patients and relatives.

4.4.3.2 Phase 2 Staff Questionnaires

The next phase of the study involved the distribution of questionnaires to staff. The questionnaires examined the professional quality of life and person-centredness of staff members who completed it within the older adult care setting.

4.4.3.3 Phase 3 Patient Questionnaires

This phase of the study saw the distribution of the patient questionnaires to examine the patients' perspective on person-centredness within the older adult care setting.

4.4.3.4 Phase 4 Interpretation of Results

The final phase of the study was the interpretation and triangulation of results; including comparing person-centredness levels from a staff and patient perspective and examining the relationship between professional quality of life and person-centredness for staff.

4.5 Population & Sample

In this particular study the aim was to explore compassionate care in the older adult care setting so it was essential to enter a healthcare environment so as to identify compassionate and uncompassionate care. The population of the study can incorporate individuals, organisations and events (Brummer, 2005). The population and sampling method will be discussed below.

4.5.1 Target Population

The target population for a study is a distinct set of elements that fits within clear specified properties (Yin, 2003). Bryman (2008) points out that in order to assist the researcher to answer the research question, inclusion and exclusion criteria must exist in order to achieve accuracy of the study and data collected which in turn ensures the findings are more generalisable (LoBiondo-Wood and Haber, 2010). The inclusion criteria for the study (Table 4.3) were older adults over the age of 65 residing in an older adult care setting, healthcare professionals within the healthcare setting and nominated relatives of patients within the care setting. The exclusion criteria were older adults not deemed eligible to participate by the clinical nurse manager and had no nominated family member to participate on their behalf.

Table 4.3: Inclusion criteria and rationale

Inclusion	Rationale
Older adult patients' > 65 years of age.	To be deemed eligible to partake in the study all patients' must be 65 years old or over to comply with the World Health Organisations definition of an older adult which is an individual over 65 years of age (World Health Organisation, 2015).
Healthcare professionals working in the older adult care setting.	All healthcare professionals including all levels of nurses and healthcare assistants who work within the older adult care setting will be asked to participate within the study to allow diverse opinions from all healthcare staff.
Nominated relatives of patients.	Nominated relatives of patients will be given the option to participate in the study on their relative's behalf if the ward sister deems the patient ineligible to participate or give informed consent.

4.5.2 Sampling Method

A multilevel sampling approach will be adopted for this study using purposive sampling technique. The rationale behind choosing this method will be discussed. A multilevel relationship incorporates two or more sets of samples that are identifiable from the different levels within the study including different populations. It allows the research to carry out simultaneous data collection using mixed methods and by utilising the concurrent approach within the multilevel design the data collection facilitates triangulation of the results (Kemper *et al.*, 2003). Onwuegbuzie and Collins (2007) recognise that by using different populations within a study it reflects various hierarchical levels of interaction with the variable of interest. Within this study different populations can be seen within both the patient and staff populations. Staff consisted of nurses and healthcare assistants and the patient population incorporates the patients and the nominated relatives thus, providing different viewpoints within the variables.

Purposive sampling allows the researcher to identify participants who will provide the necessary data surrounding compassion and thus, was included within the sampling method (Miles and Huberman, 2004). Purposive sampling increases the collection of data that is information rich in the area of compassion and facilitates the researcher into

finding out why particular people or groups feel particular ways therefore increasing the likelihood of getting the opinions of the target population (Parahoo, 2006).

4.6 Recruitment

This section will review the procedure utilised to recruit people to participate within the study. It will detail how access was granted to the sample setting and how participants were invited to take part within the study.

4.6.1 Access to the Sample

Gaining access to the research sample is a crucial component of the research process and requires the researcher to negotiate and plan with all the relevant gatekeepers (Woods and Roberts, 2003). The initial phase before being granted ethical approval was to gain access to the older adult care setting. A meeting was set up with the Director of Nursing to allow open communication between the necessary parties. Information leaflets and a plan of how the study would be conducted were presented to the gatekeepers and all concerns and queries were addressed. By opening the lines of communication a good rapport was established with the gatekeepers who proved to be valuable to the researcher. The Director of Nursing appeared in favour of the research study being conducted within the care setting provided it met the ethical approval of the relevant authorities.

The next phase before gaining access to the sample was to seek ethical approval from the appropriate authorities to safeguard all participants within the study (Appendices 4 & 5). Upon receiving ethical approval the director of nursing at the chosen older adult care setting was forwarded a letter requesting permission to conduct the research within the facility (Appendix 6) and agreed access to the care setting in line with the ethical approval (Appendix 7).

The study setting includes five long stay wards within the older adult care setting. All patients, nurses and healthcare assistants on each of the wards were given the opportunity to participate in the study. Information sessions were carried out on each of the five wards with staff, patients, relatives and visitors invited to attend. After each session, information leaflets were distributed to all patients, staff and information leaflets were given to the ward matron to ensure all staff, patients and relatives were informed.

The sample size includes all nurses, healthcare assistants and patients that are based in the five long stay wards. The number of nursing staff is 60, the number of healthcare assistants (HCA) is 64 and the number of patients is 100. Details can be seen in Table 4.4.

Table 4.4: Sample Size

Ward/Unit	Patient Sex		Beds	Staff	
	Male	Female		Nurses	HCA
Ward 1	√ 7	√ 8	20	12	10
Ward 2	√ 16		18	12	11
Ward 3	√ 13		21	11	13
Ward 4		√ 10	11	12	11
Wards 5		√ 17	30	13	19
Totals			100	60	64

4.6.2 Invitation to Participate

This case study was conducted within a specified older adult care setting and thus participants are either residing in the care setting or working within that care setting. Information sessions were held on each of the five wards to reach as many potential participants as possible and information leaflets were also distributed to allow people time to gain a greater understanding of what the study entailed and what participating in the study involved (Appendix 8 & 9). Posters were also displayed in the ward areas and charge nurses agreed to forward on any questions that arose to the researcher. All information leaflets contain a contact number for the researcher should any question arise.

4.7 Data Collection

Data collection is defined as the accurate, systematic approach to gathering information from a variety of sources relevant to the area being researched (Burns and Grove, 2003). According to Scholz and Tietje (2002), a case study should utilise multiple sources of information and methods of data collection. This evidence can be gathered from six

sources as described by Yin (2003). With embedded case study designs allowing the use of both quantitative and qualitative data, the chosen methods for this study were non participant observations and questionnaires (Figure 4.3). Benedicte Meyer (2001) believes that the data collection process is guided by the question being researched and the research design.

4.7.1 Data Collection Instrument

When choosing the instruments required to measure person-centred care and professional quality of life in relation to compassion, it is essential to be conscious of the potential impact on the reliability and validity of the study (Holt, 2009). On top of this, the accuracy of the measurement is paramount to the consistency of replicating results (Topping, 2006). However, one of the issues pertinent to measuring compassion is that there are no clear ways to do so (Firth-Cozens and Cornwell, 2009). As a result and following extensive reviews of possible data collection instruments and after discussions with research supervisors and the steering group committee members, it was decided that in order to gain a whole picture of compassion within the older adult setting that four measuring tools would be utilised (Figure 4.3).

Triangulating evidence within this case study acts to enhance the findings from the study by employing several questionnaires and gaining view points from the patients, nominated relatives and staff as well as incorporating observations from the perspective of the researcher. Yin (2003) identifies using multiple sources of evidence as one of the main strengths of case study data collection with the major advantage being the possibility of converging lines of inquiry within the triangulation. Benedicte Meyer (2001) agrees that triangulation can increase the substantiation of the data collected and produces rigor when different methods are combined.

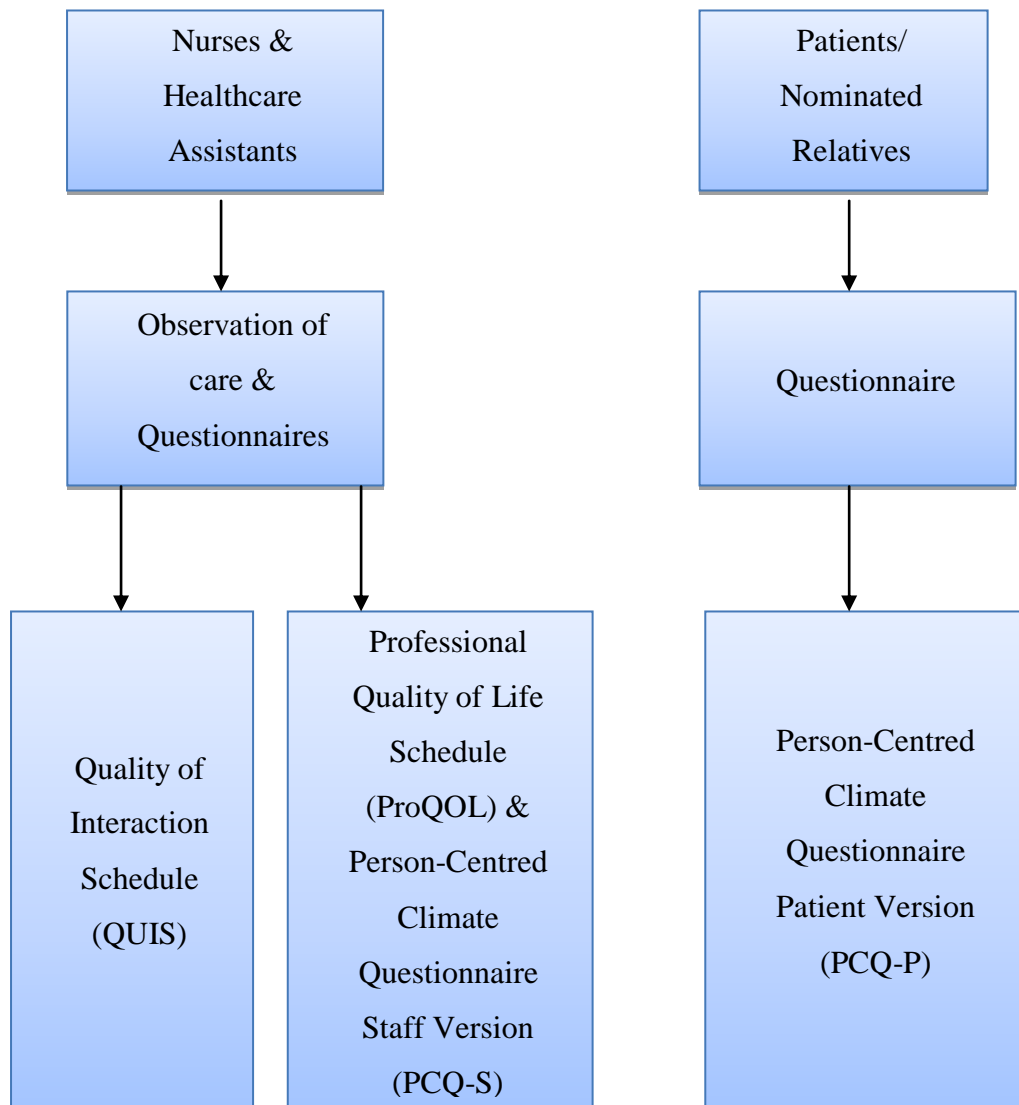


Figure 4.3: Data Collection Methods

4.7.1.1 Observations

The first instrument that was chosen was the Quality of Interaction Schedule (QUIS). This is an observational instrument that allows the researcher to collect data to evaluate the type and quality of the interaction and communication that is taking place within the healthcare setting (Appendix 10). It provided the researcher with a method of systematically observing and recording interactions that occur between nurses and healthcare assistants with patients and visitors. Throughout the observations, the researcher remained a non-participant. Interactions are recorded over 15-20 minute periods throughout the working day for 3 days on each of the five long stay wards.

Interactions were then categorised to determine if they are positive social, basic care, neutral or negative. The QUIS tool was chosen for this study as it provides a simplistic, non-invasive means of recording observations. It allows the researcher to observe care interactions of the healthcare professionals.

The rationale behind using this method is supported by Yin (2003) who acknowledges the benefits of observations including access to the behaviours of participants and the environmental conditions. The use of a formal observational instrument allows the researcher to directly observe and record details in tabular and narrative forms (Yin, 2012). In order to increase the reliability of the observational evidence a pilot study was conducted using a second observer to ensure accuracy in documentation of the interactions which was achieved (Yin, 2003). Another major asset of using observations is the unobtrusive nature of the observation. With direct observations of a group of participants in the clinical area observations have the ability to illuminate the differences between how staff interact with patients (Benedichte Meyer, 2001).

4.7.1.2 Questionnaires

The data collection process involved administering questionnaires to both the nurses, healthcare assistants and patients within the healthcare setting. Two questionnaires were distributed to the nurses and healthcare assistants, the Professional Quality of Life Scale (ProQOL) questionnaire (Stamm, 2009) and the PCQ-S (Edvardsson *et al.*, 2010b; Edvardsson *et al.*, 2009b). Patients/nominated relatives received one questionnaire the PCQ-P (Edvardsson *et al.*, 2008a).

The ProQOL is the instrument and scale used to measure the professional quality of life that a person feels within their working environment (Appendix 11). The decision to choose the ProQOL scale was based on the concise clear nature of the tool and its ability to measure three key factors that may either promote or inhibit the delivery of compassionate care to patients.

The PCQ-S is the third instrument used; its purpose is to measure staff perceptions' of person centeredness within their clinical setting or climate. The tool was originally developed in Sweden by David Edvardsson in 2008 and has since been translated to

English (Appendix 12). The PCQ-S aims to assist in identifying staff perceptions of the levels of person centred care which is an attribute that has been described as an essential component of quality care.

The PCQ-P is the final instrument distributed to patients/nominated relatives to identify if they feel they are being treated as a person and to establish if they feel their needs and expectations have been met. The questionnaire looks at the safety, everydayness and hospitality of the clinical setting (Appendix 13).

4.8 Reliability and Validity of the Instruments

For the purposes of establishing trustworthiness within the research design it is important to assess the rigor of these instruments (Robson, 2011). Reber *et al.* (2011) identifies the integral components necessary for research as being the accuracy and consistency within the measurements of the data collected. This section will review the criteria defined by Yin when evaluating a case study. Each instrument will be assessed in terms of its reliability and validity. By using existing instruments, Coughlan *et al.* (2007) concludes that the reliability and validity will have been calculated and thus, the researcher will summarise these to investigate their trustworthiness.

According to Yin (2003) there are four tests that assist in establishing the quality of a case study. These are construct validity, internal validity, external validity and reliability.

4.8.1 Construct Validity

Construct validity involves ensuring the correct operational measurement is applied for the concept that is being researched (Yin, 2003). It refers to whether there is significant evidence that the theoretical paradigm correctly corresponds to observation (Kirk and Miller, 1986). Benedicte Meyer (2001) recognises that construct validity can be strengthened by incorporating multiple sources of data. Yin (2003) also identifies the importance that triangulations plays when addressing potential issues of construct validity. These multiple sources of data can include multiple viewpoints within and across the data collected once all the information is aimed at proving the same phenomenon and thus, providing a stronger stance of the hypotheses being explored (Yin, 2003;

Benedichte Meyer, 2001). This study fulfils these requirements by including multiple sources of data from observations and questionnaires with multiple viewpoints.

4.8.2 Internal Validity

Internal validity is concerned with the postulated relationships amongst the concepts (Benedichte Meyer, 2001). It is seen as the cause-effect or causal relationship that results from the approximate truth about inferences (Yin, 2003). Yin (2003) believes that internal validity is not a concern with exploratory case studies and therefore internal validity will not be further explored.

4.8.3 External Validity

External validity comprises of dealing with the issue of whether the study's findings are generalisable beyond this immediate case study (Yin, 2003). Generalisability works on the premise that the theories identified within this study can be useful for other persons or situations (Maxwell, 1992). The typical case approach is seen by Gerring (2007) as a representative case. Within a single case study design one could question the generalisability of the research however, given that the research is conducted in an older adult care setting it can be suspected that this research may have relevance for other older adult facilities.

4.8.4 Reliability

Reliability focuses on consistency in terms of measurement (Bryman, 2008). The process that is undertaken within the data collection period needs to be consistent, accurate and stable (Benedichte Meyer, 2001) in order to ensure that if the study was replicated it would extract the same results if the same concepts were measured again (Woods and Roberts, 2003). The main goal of reliability is to decrease errors and bias within a study (Yin, 2003).

Yin (2003) discusses two ways to protect the reliability in a case study, the first being to document all procedures carried out throughout the study, thus allowing replication of the case study protocol and results and the second is to develop a case study database that could again be followed to gain the same results. These recommendations were

implemented within this study. SPSS and Excel were used to record all findings from observations and questionnaires which facilitated a systematic and consistent means of analysing the data which in turn increases the reliability of the data (Yin, 2003).

4.8.5 Quality of Interaction Schedule

The QUIS was developed by Rachel Dean, Roger Proudfoot and James Lindesay in 1993 (Dean *et al.*, 1993). Initially it was developed to evaluate long term residential mental health settings, but since then the tool has undergone substantial revision and has been adapted for general hospital and residential settings (Edinburgh Napier University and NHS Lothian, 2012; QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care). It provides the researcher with a method of systematically observing and recording interactions that occur between nurses and healthcare assistants with patients and visitors. Throughout the observations the researcher remains a non-participant. Interactions are recorded over 15-20 minute periods throughout the working day and will continue for a required number of days to ensure an accurate picture of interactions are recorded. Interactions are then categorised to determine if they are positive social, basic care, neutral or negative.

Dean *et al.* (1993) conducted a study assessing the social interactions between residents and staff. A total of 526 interactions were documented from the observations by one observer. To establish reliability an independent rater initially coded interactions with the observer (Table 4.5). A second reliability test was carried out in which there were two observers who observed a total of 148 interactions (Table 4.5) The findings demonstrated that positive social interactions were the easiest to identify and rate whilst a neutral interaction seem to lack the same clarity.

Table 4.5: Concordance between (a) coding and (b) observation and coding of QUIS interaction categories by independent raters.

QUIS Category	Coding Only		Observations and Coding	
	<i>K</i>	<i>Y</i>	<i>K</i>	<i>Y</i>
Positive Social	0.87	0.91	0.91	0.92
Positive Care	0.77	0.80	0.79	0.81
Neutral	0.77	0.92	0.60	0.84
Negative Protective	0.71	0.87	0.85	0.93
Negative Restrictive	0.79	0.91	0.81	0.84

Proctor's *et al's.* (1998) study noted the Cohen's Kappa as seen in the Table 4.6. The lowest agreement is seen as the negative protective scale but the researcher speculated it may be as a result of not viewing many interactions under that specific category.

The QUIS tool was chosen for this study as it provides a simplistic, non-invasive means of recording observations. It allows the researcher to observe care interactions of the healthcare professionals.

Table 4.6: Cohen's Kappa for QUIS.

Behaviour Code	Inter-observer agreement
Positive Social	0.81
Positive Care	0.64
Neutral	0.76
Negative Protective	0.23
Negative Restrictive	0.80

4.8.6 Professional Quality of Life Scale

The ProQOL questionnaire is a 30-itemed self-report measure that utilises three scales with 10 items in each to measure compassion satisfaction (CS), compassion fatigue (CF) and burnout (BO) using a 5 point Likert scale (1 = never – 5 = very often) but does not provide a composite score combining the three subscales. Originally developed in 1996 by Charles Figley as the Compassion Fatigue Self-Test, the ProQOL has since gone through many revisions in association with Stamm resulting in the addition of compassion satisfaction. Compassion satisfaction is typically skewed towards the positive side whilst the compassion fatigue is skewed towards the absent side. The latest version of the ProQOL addresses the psychometric problems identified in previous editions and has over 200 peer-reviewed articles supporting the test's construct validity (Stamm, 2010). The

Cronbach's alpha was reported at 0.90 for the full scale and 0.88 for CS, 0.75 for CF and 0.81 for BO (Table 4.7). A reliability score of 0.70 is seen as an acceptable for newer instruments (Burns and Grove, 2003).

Table 4.7: Cronbach's Alpha for ProQOL

Variable	Stamm (2009)	Hegney <i>et al.</i> (2014)
Compassion Satisfaction	0.88	0.92
Compassion Fatigue	0.75	0.82
Burnout	0.81	0.74

A 2% shared variance ($r=-.23$; $\text{co-}\sigma=5\%$; $n=1187$) demonstrated the inter-scale correlations with compassion fatigue and 5% shared variance ($r=-.14$; $\text{co-}\sigma=2\%$; $n=1187$) with burnout. A shared variance can be noted between compassion fatigue and burnout scales however, this is likely contributed to by the conditions which require a degree of distress to be felt. The shared variance between these two scales is 34% ($r=.57$; $\text{co-}\sigma=34\%$; $n=1187$). Both scales have a role in measuring negative areas within a person's life but a difference can be clearly identified as compassion fatigue addresses the fear a person experiences whilst burnout does not (Stamm, 2010). Table 4.8 refers to the scale distribution for the ProQOL under each of its subheading compassion satisfaction, compassion fatigue and burnout. It also demonstrates the mean score for each subsection and the bottom and top quartile (25th and 75th Percentile).

Table 4.8: Scale Distribution and Cut off Scores for ProQOL

	CS t score	BO t score	CF t score
N	1187	1187	1187
Mean	50	50	50
Bottom Quartile	44	43	42
Top Quartile	57	56	56
Std. Error of Mean	0.29	0.29	0.29
Median	51	49	49
Mode	53	51	49
St. Deviation	10	10	10
Skewness	-0.92	0.25	0.82
Kurtosis	1.51	-0.31	0.87

4.8.7 Person-Centred Climate Questionnaire – Staff Version

The PCQ-S is a tool used to measure staff perceptions of person centeredness within their clinical setting or climate. The tool was originally developed in Sweden by David Edvardsson in 2008 and has since been translated to English. The questionnaire contains 14 questions which give a representation of the staffs' views of the quality of care provided in the care setting. Again it utilises the Likert scale with 6 points ranging from 1 = No, I disagree completely to 6 = Yes, I agree completely. The questionnaire is sum scored and scores can range from 14 (a climate not very person-centred) to 84 (a climate very person-centred).

The psychometric properties are consistent for the total scale with Cronbach's alpha of 0.88. The subscales also demonstrated consistent Cronbach's alpha with 0.84 for safety, 0.80 for everydayness and 0.77 for community (Edvardsson *et al.*, 2010b). Beck *et al.* (2014) found the total Cronbach's Alpha score to be 0.78 with the three subscales ranging from 0.74 and 0.79 for Cronbach's Alpha. Lehuluante *et al.* (2012) demonstrated a total scale Cronbach's Alpha of 0.85.

The three subscales also demonstrated a high level of internal consistency (Table 4.9). The scale was retested 1 week later to establish the test-retest reliability of the questionnaire and the findings demonstrated that the paired t-test showed >0.05 for all P-values supporting the claim that there is no statistical significant differences between the mean score at test and retest. This implies stability in the test-retest scales and subscales.

Table 4.9: Test-retest reliability of the English Person-centred Climate Questionnaire – Staff Version (PCQ-S)

Scale Dimension	Test Mean ± SD	Retest Mean ± SD	Test-Retest Mean ± SD	P	Pearson's r	Interclass Correlation CI
Safety	5.11± 0.67	5.17± 0.54	0.05± 0.53	0.55	0.64	0.63 (0.40-0.78)
Everydayness	4.71± 0.81	4.65± 0.78	0.06± 0.49	0.47	0.81	0.81 (0.66-0.89)
Community	4.32± 1.00	4.47± 0.82	0.15± 0.88	0.29	0.55	0.54 (0.28-0.73)
Score	4.81± 0.60	4.82±0	-	0.85	0.75	0.75

SD, standard deviation, CI, confidence interval

In order to establish the validity of the PCQ-S principle component analysis with varimax orthogonal rotation was carried out to make sure of the independence of the components. As seen in table 4.9 data analysis leads to the result of four component rotation solution and demonstrated a 71.8% of the total variance indicating that the items measured the same fundamental constructs (Edvardsson *et al.*, 2010b).

A recent paper by Edvardsson *et al.* (2015) established cut-off scores for the PCQ-S. This paper altered the scoring pattern for the questionnaires from 0 – 5 as opposed to 1 – 6 as utilised in this study as per Edvardsson *et al.* (2010b). As a result the cut-off scores will be proportioned to the scores defined by Edvardsson *et al.* (2015). Quartile-based cut-offs were used to interpret the person-centred levels: with <57 being ‘well below average’, 58 – 66 being ‘below average’, 67 – 74 being ‘above average’ and >76 being ‘well above average’.

4.8.8 Person-Centred Climate Questionnaire – Patient Version

The PCQ-P is a 17 itemed questionnaire that was also created by David Edvardsson in conjunction with Per-Olof Sandman & Birgit Rasmussen (Edvardsson *et al.*, 2008a) to identify if the patients feel they are been treated as a person and to establish if they feel their needs and expectations have been met.

The items are rated on a 6-step Likert scale (ranging between 1 = no, I disagree completely to 6 = yes, I agree completely). The questionnaire is sum-scored and scores can range between 17 (a climate not very person-centred) to 102 (a climate very person-centred). This questionnaire looks at the safety, everydayness and hospitality of the clinical setting. The total score for the PCQ-P produced from the Cronbach’s alpha was 0.90 with subscales of safety and hospitality achieving 0.96 and 0.89 respectively, highlighting good internal consistency. Test-retest reliability was noted to be 0.70 with a 95% confidence interval.

Beck *et al.* (2014) also found internal consistency within the scale noting a total Cronbach’s Alpha of 0.90 with a subscale of 0.80-0.84 Cronbach’s Alpha. Likewise Parlour *et al.* (2014) identified good reliability whilst using the scale. These findings suggest that the PCQ-P is a valid and reliable construct for assessing person-centeredness within a healthcare setting from the patient’s viewpoint. No cut off scores have been established for the PCQ-P to date.

4.9 Ethical Considerations

Ethics refers to the rules of conduct that are typically associated with conforming to a code or set of principles (Robson, 2011). For every researcher it is imperative from an early stage within the research process to ensure all the ethical considerations are being well-thought-out. The ethical complexity of carrying out research in a clinical setting involves assessing the considerations of the research design; gaining access and consent; maintaining anonymity and confidentiality for all participants within the study and it also involves addressing the researchers role whilst collecting data (McCosker *et al.*, 2001).

4.9.1 Seeking Ethical Approval

As a nurse researcher one is bound by the codes of professional conduct governed by the Nursing and Midwifery Board of Ireland. The Guidance to Nurses and Midwives regarding ethical conduct of nursing and midwifery research is one such code which is necessary to work within when conducting research (An Bord Altranais, 2007). This code identifies the importance of the nurse researcher gaining ethical approval from the appropriate review boards prior to interacting with any potential participants within the study. By doing this the researcher is safeguarding participants and their rights.

Following the codes of professional practice, ethical approval was sought from the necessary ethics committees and granted by the Ethics Committee of Waterford Institute of Technology (Appendix 4) and by the Health Service Executive Regional Committee (Appendix 5). Detailed research proposals were put forward to both committees and a meeting with each committee took place to discuss all the ethical considerations and potential risks to participants. Each point of concern was discussed with the members of the committees in order to protect participants. Particular concern was noted surrounding the area of working with a vulnerable population like the older adult population. From these discussions it was decided to ensure the protection of all older adults within the healthcare setting that information leaflets would be sent via post to their next of kin. This guaranteed that in the situation where an older adult may not have the capacity to consent to participating in the study that their next of kin was aware of the study and could address any concerns about the study with the researcher. Ethical approval was achieved from both boards in December 2013.

The use of observations was also noted as a possible risk. As a data collection technique, observation can lead to the people being observed feeling like the researcher is invading their privacy. In order to decrease the risk of participants feeling reluctant to be observed the researcher gave the participants a clear rationale for carrying out the observations and had guidelines as to where observations can take place (Appendix 8 & 9). Participants had a full understanding of what the researcher was observing.

The use of questionnaires leading to responder burden was another potential concern. To address this the committee were assured that questionnaires were concise in structure and only questions deemed to be essential to the gathering of necessary data were included in the questionnaire.

4.9.2 Confidentiality

Confidentiality is imperative for participants when partaking in research. Parahoo (2006) identifies that the information collected from participants in a study must be respected. In this study all questionnaires collected were anonymised thus, aiming to reduce the risks of participants being identified. Questionnaires were returned in a sealed envelope and placed into a sealed box to maintain confidentiality. The demographic information on the questionnaires does not make it possible for participants to be identified. Healthcare professionals being observed were guaranteed anonymity (provided there is no poor practice identified, see Appendix 8) in order to reduce any stresses or reluctance felt by staff. The coding of all data during input into the computer further enhanced participants' confidentiality.

4.9.3 Vulnerability

Whilst considering the importance of gathering rich data from the sample population the researcher must also ensure that the welfare of all participants must always take precedence and trumps that of the interests of the study (World Medical Association, 2008). When carrying out research in the area of older adult care the issue of capacity is one that needs to be considered. The older adult care setting where the research is being undertaken cares for older adults who have been diagnosed with a cerebral vascular accident (CVA), dementia, alzheimer's or other disease or disorders that may impact on their capacity.

The older adult population is classified as a vulnerable group. From the literature it suggests that the older adult population are defined as vulnerable due to their health status, cognitive ability and social support systems (Kim and Loren, 2008).

To ensure further protection the nurse managers had to determine the older adult's capacity to participate in the study. If a patient was deemed ineligible to participate the nurse manager nominated a relative to complete the questionnaire on the patient's behalf. It is suggested that the nominated relative be a regular visitor to the patient. An information sheet will be given to the nominated relative to explain the study and the voluntary nature of participating (Appendix 9).

In order to ensure all participants feel secure and confident to take part in the study all potential participants were fully informed about the research and the research methods being used to help ease any anxiety. Information sessions were held and information leaflets were distributed to all potential participants (Appendix 8 & 9).

All older adults who are deemed eligible to participate in the study and wish to do so but were unable to complete the questionnaire were offered assistance by the researcher. This took place in a private room to maintain confidentiality.

4.9.4 Obtaining informed consent

Information sessions were held prior to the research commencing to provide all potential participants with the details of the research. All potential participants were given the appropriate information leaflet explaining the study and how they could participate in the study (Appendix 8 & 9). Inclusion in the study was voluntary. Participants were fully informed and had access to the researcher should any questions arise. The returning of a completed questionnaire implied informed consent.

In order to carry out the observations all staff, patients and visitors were given written information about the use of observations within the research. All healthcare professionals who were willing to partake in the observations had to sign a collective consent form (Appendix 8) in line with best practice as developed by Napier University, leaders in the field of compassionate care research. Any staff member who consented to be observed would be given a red ribbon to wear to allow them to be identified. All participants were informed that they could decline to participate or withdraw from the study at any time and that there would be no repercussions for doing so.

4.10 Data Analysis

Data analysis is seen as the systematic organisation of research data in order to address a research question (Polit and Beck, 2006). The purpose of case study is to gain a greater understanding of the phenomenon being explored. One of the main challenges facing researchers during data analysis is to make sense of large data sets which requires information to be reduced, patterns to be identified and a framework to be utilised to ensure essential data is communicated effectively (Patton, 1990). As a result, Yin (2003) acknowledges the importance of every study adhering to a general guide or process for data analysis. All quantitative data were analysed using the Statistical Package for Social Sciences (SPSS) Version 19. This section will review data entry, missing data values and the tests that were carried out to analyse the data.

4.10.1 Data Entry

Data generated from the Professional Quality of Life questionnaires were scored as previously described (section 4.8.6) and scores were reversed if required and entered into the database systematically. This process was also completed with the scores of the Person-Centred Climate Questionnaires-Staff and Patient versions. All observations were entered into an Excel spreadsheet and the data were imported into SPSS. Data was double checked during the entering process to prevent any errors.

4.10.2 Missing Data

Pallant (2013) acknowledges that when conducting research, specifically with people that it is unique that all data will be complete for every case. The reason behind missing cases can be as a result of refusal on the participant's part to answer all questions, a research error or a skipped pattern within the instruments chosen to collect data (Polit and Beck, 2006).

How to deal with missing data is a priority when doing statistical analysis as missing data has the potential to skew results (Pallant, 2013). By effectively utilising SPSS it is possible to exclude missing data by either choosing to exclude cases listwise, or to exclude cases pairwise. To exclude cases listwise means that all data for that case will be excluded if any variables are missing, the alternative to this is to exclude cases pairwise as this includes all cases and exclusion is only applied if the data is missing from a specific

variable that is being analysed (Pallant, 2013). This study adopted, where possible to exclude cases pairwise to ensure sample size was not affected and to ensure that the participants who did not complete all questions were still included (Pallant, 2013).

4.10.3 Analysis Plan

The initial analysis reviewed the demographic details of the participants of the study. Questionnaires contained closed and open ended questions including categorical and continuous variables. The answers were assigned a numerical value and entered into SPSS. Continuous variables included age, course title and length of time working in older adult care. Job title, qualification and completion of older adult course were seen as categorical variables.

Means and standard deviations (SD) were used to present continuous variables, with categorical data being presented in number form and percentages.

Parametric tests were then conducted including t-tests which are used to compare the mean score of data collected from two groups or two sets of data on continuous variables (Pallant, 2013). The independent-samples t-test was run to compare the means for nurses and healthcare assistants within the ProQOL and the PCQ-S and to compare patient and nominated relatives means for the PCQ-P. It was also utilised to compare shared questions within the PCQ-S and the PCQ-P.

A one-way analysis of variance was conducted for both of the staff questionnaires to establish if there was any connection between the ages of the staff, the ward they worked on or if the number of years working impacted on the levels of compassion satisfaction, compassion fatigue, burnout and person-centredness. Data correlations were conducted using the Pearson product-moment correlation coefficient. This test was run in response to objective 5 to examine for relationships between Professional Quality of Life and Person-Centred Climate.

4.11 Conclusion

This chapter provides a rationale for the research methods applied in this study. Issues in relation to the population and sampling, the choice of instruments, data collection and the

data analysis were critically discussed and justification for the choice of research design has been provided. The chapter argued that a key consideration in selecting and designing the research approach was to ensure that it was driven by the multidimensional and eclectic nature of the study aim and objectives.

The chapter proposed that adopting a single embedded case study design using four study phases supported a more complete multifaceted approach to the study and contributed to the rigour of the research study. A major goal in selecting this design was to illustrate that the relationship between the research aim and objectives, overall research design and data analysis procedures had sequential logic, facilitating the clear reporting of the study findings and in so doing, to ensure an ethically sound and robust research endeavour. Chapter 5 will examine the results obtained from the various phases of the study.

CHAPTER 5: Results

5.0 Introduction

This single embedded case study sought to explore compassion care delivery in the older adult care setting by examining the relationship between observed care delivery, professional person-centredness, professional quality of life and patients' satisfaction with person-centred care. This study involved four key phases, including observations, staff questionnaires, patient questionnaires and interpretation of results. This chapter will present the study findings.

Section 5.1 outlines the study accrual. The socio demographic characteristics of the participants are reported in section 5.2, followed by section 5.3 which considers the reliability of each of the data collection tools and section 5.4 which details how missing data was managed.

Following this, results of the study in relation to each of the study phases and objectives will be explored in Section 5.5. Section 5.5.1 reviews the results from phase 1 of the study with the findings from the observations of the nurses and healthcare assistants interacting with the patients and relatives. Phase 2 looked at the staff questionnaires including the professional quality of life felt by the nurses and healthcare assistants looking at compassion satisfaction, compassion fatigue and burnout in relation to their working lives and person-centredness as perceived by the staff within the older adult care setting (Section 5.5.2). Section 5.5.3 will present the results from phase three and examines the results of the patient questionnaire surrounding person-centredness. The shared questions from the two Person-Centred Climate Questionnaires are then compared (Section 5.5.4). Section 5.5.5 examines for relationships between person-centredness and professional quality of life. Section 5.6 reviews the key findings within the study in relation to the objectives of the study.

5.1 Study Accrual

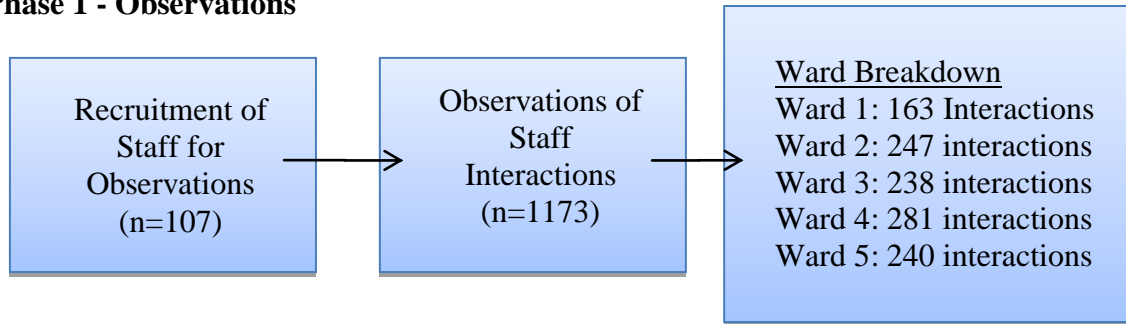
The study was conducted in an older adult care setting that comprised of 6 units, 5 long stay units and 1 rehabilitation unit. For the purpose of this study only staff and patients within the long stay units were included as patients in the rehabilitation unit have a high turnover rate; therefore five units were incorporated in the study. Of these units, two were

female wards, two were male wards and one ward was mixed with male and female patients.

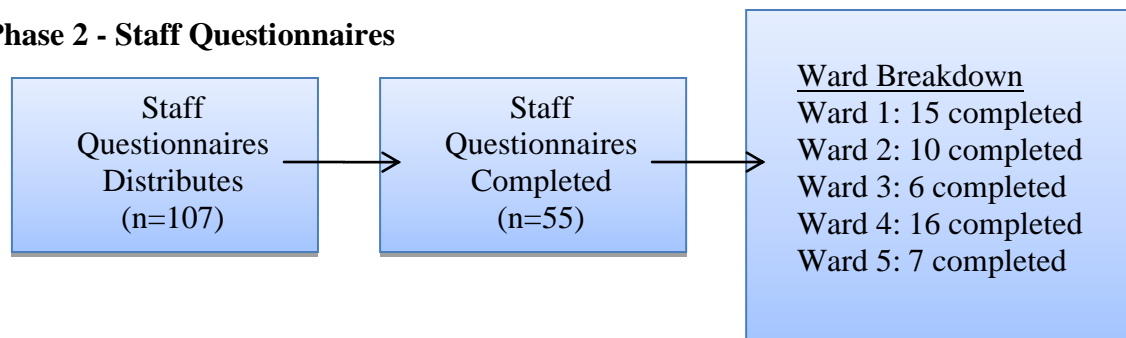
Data collection took place from February 2014 to May 2014 in 5 units. All healthcare staff and patients/nominated relatives were given the opportunity to participate within the study. Figure 5.1 details the recruitment to the study for the three phases, phase 1 the observational element, phase two 2 the staff questionnaires and phases 3 the patient/nominated relatives questionnaires.

All staff present on the wards on observation days consented to be observed. Fifty five staff members out of one hundred and twenty four (response rate= 44%) and seventy patients/nominated relatives out of one hundred (response rate= 70%) completed questionnaires. Figure 5.1 provides an overview of participation in the study from each of wards in the different sections of the study.

Phase 1 - Observations



Phase 2 - Staff Questionnaires



Phase 3 – Patient/Nominated Relatives’ Questionnaire

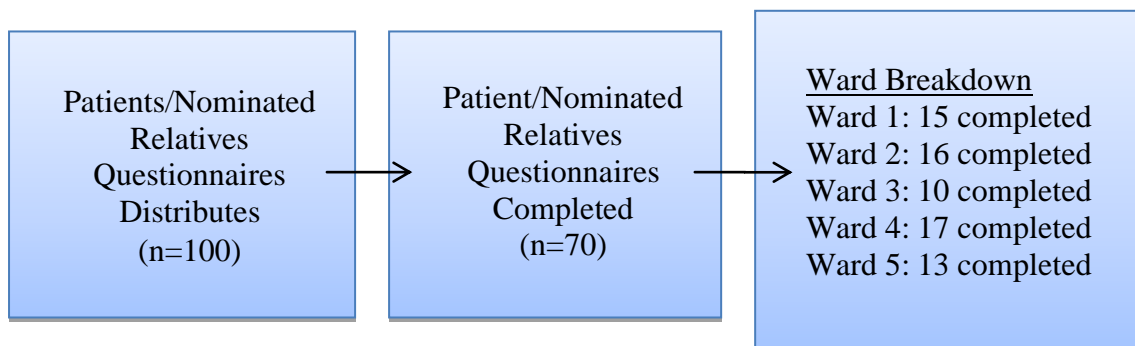


Figure 5.1: Study Participants

5.2 Socio Demographic Characteristics

The socio demographic characteristics can be seen in Table 5.1 and 5.2. These tables illustrate the breakdown of the participant sample incorporating the socio-demographic details of staff and patients. Questionnaires were completed by 125 participants, 43% (n = 55) of whom were staff and 57 % (n = 70) of whom were patients/nominated relatives.

At any given time within the older adult healthcare setting one hundred patient beds were available. Seventy patient questionnaires were returned, 79% (n = 56) were completed by the patients, with 21% (n = 15) completed by the nominated relatives. Patients' ages ranged from 66-100 years of age (mean 83.00, SD 6.88) with their hospital stays varying in length from 1 month to 162 months (13 years) (Table 5.1).

Table 5.1: Socio Demographic Characteristics of Patient

Characteristic	Subgroup	N	%	Range	Mean	SD
Title	Patient	56	79			
	Nominated Relative	15	21			
Gender	Male	28	50%			
	Female	25	45%			
	Question Not Answered	3	5%			
Age in Years	65 – 75	11	15	66-	83.00	(6.88)
	76 – 86	31	44	100		
	85 – 95	22	31			
	96 – 100	2	3			
	Question Not Answered	5	7			
Length of Hospital Stay (Months)				1-162	34.68	(40.23)

The staff ages ranged from 24 - 61 years of age (mean 47.3, SD 10.18), 44% (n = 24) of which were nurses and 43% (n = 23) were healthcare assistants with 20% (n = 11) of staff not answering the question. The number of years that staff members were qualified ranged from 3-40 years (mean 21.59, SD 13.29). Just under half of the staff who participated were registered nurses 41% (n = 22) and 18% (n = 10) of healthcare assistants had completed the Fetac Level 5 course with 13% (n = 7) not answering the

question. With regard to completing an older adult course, less than half 46% (n = 25) had completed such a course. A total of 16 nurses and 9 healthcare assistants answered yes to completing an older adult course. The range of courses completed included a short gerontology course (36%, n = 9), dementia care (24%, n = 6), care of the elderly (8%, n = 2) and a post graduate qualification in gerontology (8%, n = 2) (Table 5.2).

Table 5.2: Socio Demographic Characteristics of Staff

Characteristic	Subgroup	N	%	Range	Mean	SD
Staff		54	43			
Age in years	24-35	6	11	24-61	47.30	(10.18)
	36-48	14	26			
	49-61	23	43			
	Not Answered	11	20			
Job Title	Nurse	24	44			
	HCA	23	43			
	Not Answered	7	13			
Qualifications	RGN	22	41			
	Fetac	10	18			
	Not Answered	22	41			
Number of Years Qualified				3-40	21.59	(13.29)
Older Adult Care Course	Yes	25	46			
	No	7	13			
	Not Answered	22	41			
Other Courses	Gerontology (Short)	9	36			
	Dementia Care	6	28			
	Care of the Elderly	2	8			
	Post-Grad Gerontology	2	8			
	Not Answered	6	24			

5.3 Reliability of the Scales

The reliability of the four scales used was tested using Cronbach's alpha coefficient, which determines the internal consistency of scale items. Internal consistency was reviewed using the Cronbach's alpha coefficient (Pallant, 2013). All questionnaires had subscales that were also examined using Cronbach's alpha coefficient. A value above 0.7 is regarded as being optimal for internal consistency (LoBiondo-Wood and Haber, 2010; Bryman, 2008).

5.3.1 Reliability of ProQOL Scale

The Cronbach's alpha coefficient for each subscale is presented in Table 5.3, which also includes corresponding coefficients for the studies conducted by Stamm (2010) and Burtson and Stichler (2010) (see Table 5.3). All Cronbach's alpha coefficients for the subscales can be seen to be within range of that of Stamm and Burtson and Stichler. Pallant (2013) defines a reliable coefficient as 0.70 or higher as acceptable in social science research.

Table 5.3: Cronbach Alpha Coefficient Scores for ProQOL in Comparison to Other Studies

Scale	No. of Items	Cronbach's Alpha for Current Study	Cronbach's Alpha for Stamm (2009)	Cronbach's Alpha for Burtson and Stichler (2010)
ProQOL	30			
Compassion Satisfaction	10	0.87	0.87	0.88
Compassion Fatigue	10	0.79	0.80	0.81
Burnout	10	0.76	0.72	0.75

5.3.2 Reliability of PCQ-S Scale

According to Edvardsson the Person-Centred Climate Questionnaire-Staff version has good internal consistency, with a Cronbach alpha coefficient reported of 0.89. In the current study, the Cronbach alpha coefficient was 0.91.

Three subscales exist within the PCQ-S and these include 1: safety, 2: everydayness and 3: community. The Cronbach's alpha coefficients for each of these subscales are presented in Table 5.4.

Table 5.4: Cronbach Alpha Coefficient Scores for PCQ-S

Scale	Current Study	Edvardsson <i>et al.</i> (2010b)	Edvardsson <i>et al.</i> (2015)
Total Scale: PCQ-S	0.91	0.89	
Subscale 1: Safety	0.90	0.87	0.82
Subscale 2: Everydayness	0.83	0.79	0.82
Subscale 3: Community	0.89	0.82	0.82

5.3.3 Reliability of PCQ-P Scale

The PCQ-S equally demonstrated high internal consistency with the Cronbach alpha coefficient documented as 0.90 (see Table 5.5).

Table 5.5: Cronbach Alpha Coefficient Scores for PCQ-P

Scale	Current Study	Edvardsson <i>et al.</i> (2009a)
Total Scale: PCQ-P	0.90	0.90
Subscale 1: Safety	0.84	0.96
Subscale 2: Hospitality	0.87	0.89

5.4 Management of Missing Data

When conducting data analysis and examining the findings missing data within questionnaires lead to inconsistency within the numbers included for some of the data findings (see section 4.10.2). Missing data was mainly seen within the staff questionnaires and included socio demographic details and responses to questions.

The Professional Quality of Life Scale (ProQOL) manual provides guidance on coding for missing values in SPSS. It advises that it is nearly impossible to detect why data might be missing, was it a conscious decision, avoidance, or a mistake. The ProQOL manual provide four options or decision rules which were followed to manage missing values. Firstly, for missing data within a scale (when other items have been responded to), a score of 0 (for Never) will be used. Secondly, if an individual begins the scale but then discontinues, the case will be deleted. Thirdly, for ‘occasional missing data’ (less than

10% or 3 items missing), the missing data will be coded as missing. In this case, due to the sum method of scoring, this missing data would not significantly affect the overall averages. Finally, where there is more than 10% missing data, and which do not qualify for options one or two, the case will be omitted. These guides were utilised resulting in one case being removed due to more than 10% of the data being missing. All other missing cases were coded as an occasional missing data.

The other scales used in this study (Person-Centred Climate Questionnaire-Staff version and the Person-Centred Climate Questionnaire-Patient Version) do not include explicit instructions on how to code for missing data. On review of the data sets collected no variables were missing within the patient version and less than five variables were missing from the staff version with no more than one per case. As a result missing variables were left as missing variables as defined within the ProQOL decision rules in order to ensure consistency with missing variables.

In this study, missing data from the patient questionnaire was minimal however; missing data from the staff Professional Quality of Life Questionnaire was more frequent than that of the Person-Centred Climate Questionnaire-Staff version. The two questions that were seen to be the most unanswered or skipped questions were the question surrounding the staff's beliefs and being unable to remember details of work due to working with trauma patients.

5.5 Results

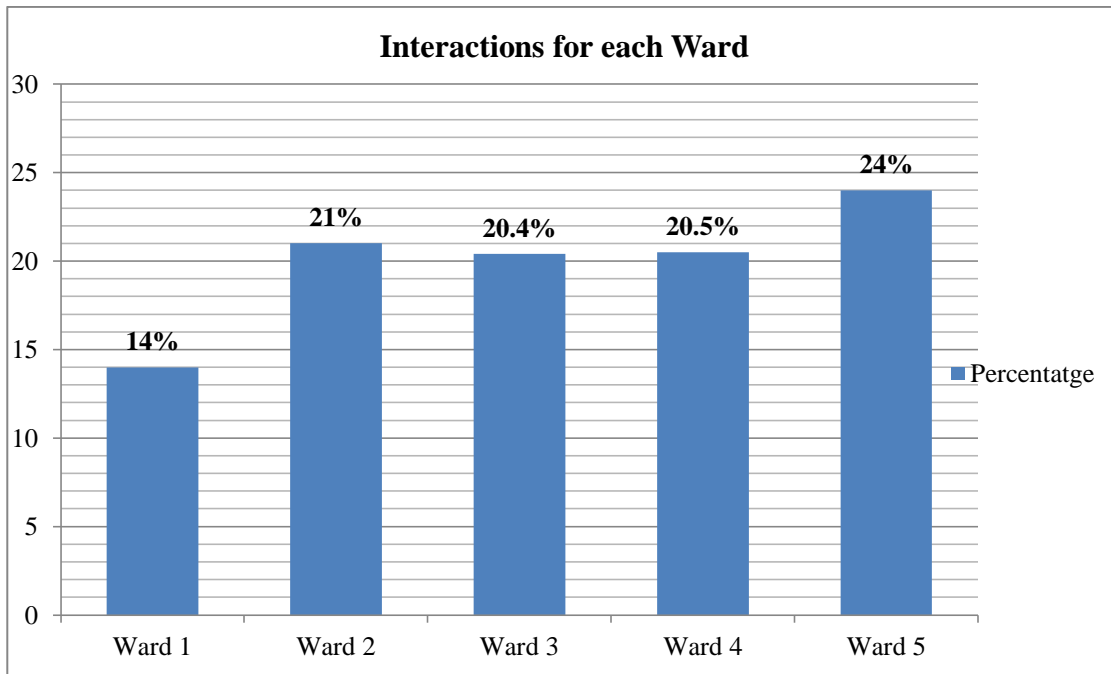
5.5.1 Phase 1 – Observations

Quality of Interaction Schedule

The first objective of the study was to examine the healthcare professionals – patient/visitor interactions. The results of these observations will now be presented. Observations took place over 15 days. Three days of non-participant observations were conducted on each of the five wards during the hours of 08:30 – 20:00. The total hours recorded were 61 hours and 35 minutes with the total number of observations documented reaching 1,173.

The observations took place in a range of settings including the dayrooms, bedrooms and hallways. Analysis of the data collected from the observations can be viewed in Table 5.6 and Figure 5.2. The total number of staff interactions observed was 1126 (Figure 5.2). Table 5.6 presents the percentage of interactions for each of the five wards.

Table 5.6: Interactions for each Ward



The data revealed that a significant proportion, 70% (n = 787) of the interactions that were observed were categorised as positive social, while basic care accounted for 9% (n = 98), neutral care made up 16% (n = 185) and negative care contributed to 5% (56) of the interactions.

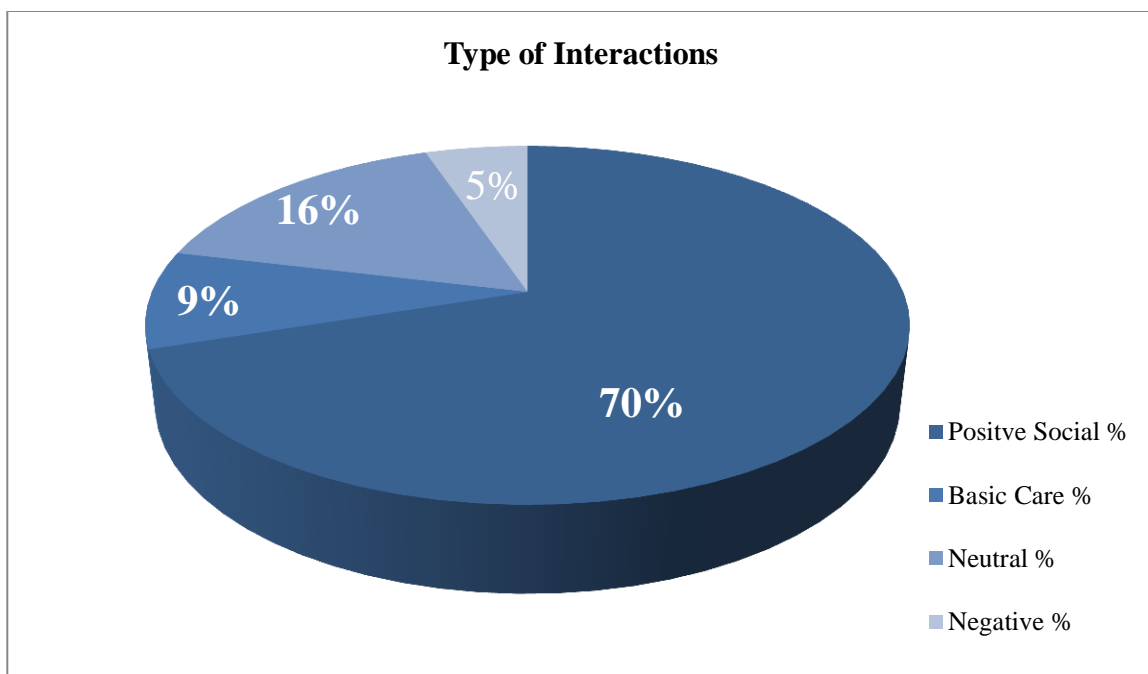


Figure 5.2: Interactions Observed

Documenting the interactions involved identifying who partook in the interactions (Table 5.7). All interactions were based on observing staff and how they interact with patients and relatives. The highest levels of interactions were observed between healthcare assistants with the interactions totalling 60% (n = 565 (Healthcare assistant – Patient) + n = 6 (Healthcare assistant – Patient/Relative) = 571).

Table 5.7: Participants in the interactions

Variable	Number (%)
Healthcare Assistant – Patient	565 (57.4)
Nurse – Patient	372 (37.8)
Nurse – Patient, Healthcare Assistant – Patient	30 (3)
Healthcare Assistant – Patient/Relative	6 (0.6)
Nurse – Patient/Relative	7 (0.7)
Staff	3 (0.4)
Total	984

Additionally all interactions were recorded as being a verbal, nonverbal or verbal and nonverbal interaction. Figure 5.3 highlights the findings of this with verbal interactions accounting for 88% (n = 879) of all interactions. Nonverbal was seen in 8% (n = 75) of the interactions and a mixed for both methods was observed a total of 37 times (4%).

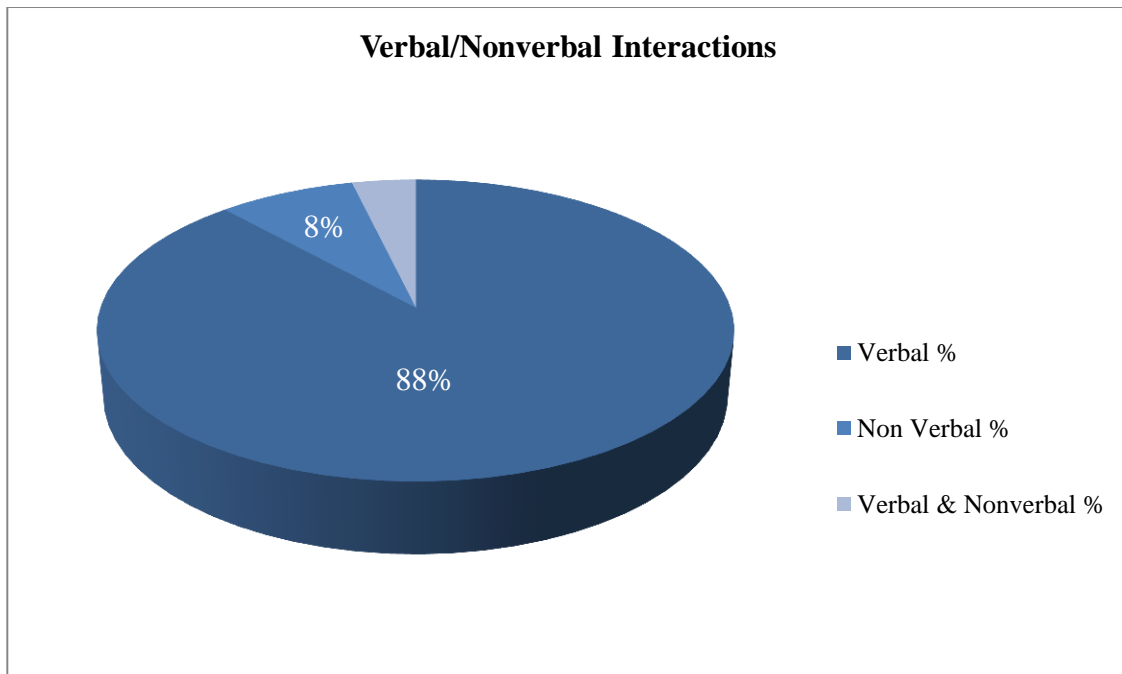


Figure 5.3: Verbal/Nonverbal Interactions

5.5.2 Phase 2 – Staff Questionnaires

This section reviews the findings from phase two of the study, the staff questionnaires.

5.5.2.1 Professional Quality of Life

The next objective of the study was to examine professional quality of life including compassion satisfaction, compassion fatigue and burnout in the nurses and healthcare assistants as measured using the ProQOL questionnaire. This questionnaire consisted of 30 statements. Scoring is performed on a 5-point Likert-type scale, ranging from 1 (never) to 5 (very often). This questionnaire is composed of three subscales that are made up of 10 statements within the questionnaire. Table 5.8 details the mean and range for each of these components.

Compassion satisfaction is the first subscale examined. Stamm (2010) identifies the average score for the compassion satisfaction to be 50 with low range of 43 and a high range of 57. It can be seen from table 5.8 that compassion satisfaction ranged from 30 – 63 with a mean of 50.86 (SD = 7.80). A score of over 57 was achieved 22.6%, with 7.6% scoring below 40.

The mean score for compassion fatigue is 50.24 (SD = 9.94) with a range of 30 – 89. A score above fifty seven was identified in 26.5% of healthcare staff with a score below forty three noted in 8.7% of the staff population. Again Stamm (2010) acknowledges the scoring range with the mean being 50 and with 25% scoring below 43 and 25% scoring over 57.

The average score for burnout was calculated by (Stamm (2010)) as 50 with the higher level being 57 and the lower level being 43. A score below 18 within the burnout subscale is thought to demonstrate a positive feeling towards the work carried out by healthcare professionals. Burnout levels scores ranged from 27 – 67 (mean = 50.46, SD = 9.50). A score of fifty seven or over was recorded by 30% of staff with 21% scoring below forty three. No staff member scored below 18 within the burnout subsection.

An independent-samples t-test was conducted to compare compassion satisfaction scores for both nurses and healthcare assistants. A statistical significant difference was noted between the score for nurses (mean = 49, SD = 8.01) and healthcare assistants (mean = 54, SD = 5.96, $t = -2.61$, $p = 0.01$), whereby a higher score indicated higher levels of compassion satisfaction. Additional independent-samples t-testing was carried out to compare compassion fatigue and burnout scores from the nurses and healthcare assistants. A statistically significant difference was demonstrated for both components (Table 5.8).

On further examination of the ProQOL questionnaire using independent samples t-test, eight questions demonstrated statistical significance between the nurses and healthcare assistants' responses (see Table 5.8). Of the eight questions, four questions were from the burnout subscale with two from each other subscale, compassion satisfaction and compassion fatigue.

Table 5.8: ProQOL Descriptive Statistics & Independent t-test

Variable	Mean (SD)	Range (Min-Max)	
Total Compassion Satisfaction	50.86 (7.80)	30 – 63	
Total Compassion Fatigue	50.24 (9.94)	30 – 89	
Total Burnout	50.46 (9.50)	27 – 67	
Variable	Mean (SD)	t	p
Compassion Satisfaction		2.61	0.01
Nurse (n=24)	48.68 (8.01)		*
Healthcare Assistants (n=22)	54.16 (5.96)		
Compassion Fatigue		2.23	0.03
Nurse (n=24)	51.28 (8.36)		*
Healthcare Assistant (n=22)	46.14 (7.19)		
Burnout		2.69	0.01
Nurse (n=24)	53.23 (7.11)		*
Healthcare Assistants (n=22)	46.39 (10.41)		
I am preoccupied with more than one person I (help) (CF)		2.39	0.02
Nurse (n=24)	3.75 (1.39)		*
Healthcare Assistant (n=22)	2.37 (1.52)		
Because of my [helping], I have felt “on edge” about various things (CF)		2.44	0.02
Nurse (n=24)	2.17 (.963)		*
Healthcare Assistant (n=22)	1.55 (.739)		
I am pleased with how I am able to keep up with [helping] techniques and protocols (CS)		-2.85	0.01
Nurse (n=24)	3.79 (.833)		*
Healthcare Assistant (n=22)	4.45 (.739)		
My work makes me feel satisfied (CS)		-3.89	0.00
Nurse (n=24)	3.54 (.884)		*
Healthcare Assistant (n=22)	4.41 (.590)		
I feel worn out because of my work as a [helper] (BO)		3.47	0.00
Nurse (n=24)	3.29 (.908)		*
Healthcare Assistant (n=22)	2.36 (.902)		
I feel overwhelmed because my case [work] load seems endless (BO)		2.28	0.03
Nurse (n=24)	3.46 (.977)		*
Healthcare Assistant (n=22)	2.77 (1.07)		
I feel “bogged” down by the system (BO)		3.08	0.00
Nurse (n=24)	3.42 (1.02)		*
Healthcare Assistant (n=22)	2.45 (1.10)		
I am a very caring person (BO)		3.18	0.00
Nurse (n=24)	1.58 (.584)		*
Healthcare Assistant (n=22)	1.14 (.351)		

*Significant at $p < 0.05$

A one way between groups analysis of variance (ANOVA) was conducted to examine if there were differences between wards in terms of staff compassion satisfaction, compassion fatigue and burnout. No statistically significant differences were found (Table 5.9).

After conducting a one-way between-groups analysis of variance (ANOVA) across age groups, no statistical significant differences were identified in relation to compassion satisfaction ($p = 0.449$), compassion fatigue ($p = 0.387$) and burnout ($p = 0.391$) and using the same test no difference was identified between the number of years working within the older adult care setting and compassion satisfaction ($p = 0.208$), compassion fatigue ($p = 0.076$) and burnout ($p = 0.422$).

Table 5.9: ProQOL one way between-groups ANOVA

Source	SS	DF	MS	F	p
CS					
Between groups	468.955	4	117.239	2.087	.097
Within groups	2696.405	48	56.175		
Total	3165.360	52			
CF					
Between groups	598.052	4	149.513	1.581	.195
Within groups	4539.911	48	94.581		
Total	5137.963	52			
BO					
Between groups	397.127	4	99.282	1.109	.363
Within groups	4297.955	48	89.541		
Total	4695.081	52			

(SS, Sum of Squares. DF, Degree of Freedom. MS, Mean Square)

The relationship between compassion satisfaction, compassion fatigue and burnout (as measured by the ProQOL) was investigated using the Pearson product-moment correlation coefficient. Preliminary analyses were performed to ensure no violation of the assumption of normality, linearity and homoscedasticity. A strong negative correlation was seen between compassion satisfaction and burnout, $r = -.48$, $n = 53$, $p < .000$. A negative correlation was also noted between compassion satisfaction and compassion fatigue, $r = .07$, $n = 53$, $p < .61$, whilst a strong positive correlation was identified between compassion fatigue and burnout.

5.5.2.2 Person-Centred Climate Questionnaire – Staff version

The next objective of the study was to explore healthcare professionals' levels of person centred climate as measured using the Person-Centred Climate Questionnaire-Staff version. This questionnaire consists of 14 statements aimed at examining the psychosocial environment of the care from the staffs' perspective. Three subscales are measured within the questionnaire including; safety, everydayness and community. The questionnaire is formatted in a 6-point Likert-type scale, ranging from 1 (No, I disagree completely) to 6 (Yes, I agree completely). The minimum level score is 14 which demonstrate low levels of person-centredness whilst a maximum score of 84 indicate high levels of person-centredness. The total scores of the PCQ-S ranged from a minimum of 38 to the maximum of 84 (mean 71.65, SD 9.01) with 94% (n = 48) of participants scoring 60 and above. The maximum score of 84 was achieved twice whilst the minimum of 38 was scored once. The means and SD for each question can be seen in Table 5.10.

Table 5.10: Mean and SD for PCQ-S

Statement	Mean (SD)
1. A place where I feel welcome	5.27 (.750)
2. A place where I feel acknowledged as a person	4.94 (.968)
3. A place where I feel I can be myself	4.92 (.977)
4. A place where patients feel safe	5.47 (.644)
5. A place where staff talk to patients so that they can understand	5.37 (.720)
6. A place which feels homely	5.25 (.891)
7. A place that has something nice to look at	5.06 (1.01)
8. A place that is quiet and peaceful	4.57 (1.14)
9. A place where it is possible to get unpleasant thoughts out of your head	4.25 (1.34)
10. A place which is neat and clean	4.98 (.883)
11. A place where it is easy for patients to keep in contact with their loved ones	5.37 (.937)
12. A place where it is easy for patients to receive visitors	5.51 (.834)
13. A place where it is easy for patients to talk to staff	5.35 (.688)
14. A place where patients have someone to talk to if they so wish	5.31 (.883)

The cut-off scores for the PCQ-S are discussed in Section 4.8.7. Two (4%) staff members scored below 57 which is defined as 'well below average', with nine (18%) falling into the 58 – 66 scoring range which is seen as 'below average'. The largest portion of staff fell into the 67 – 75 and the over 76 scoring range which is known as 'above average' and 'well above average' categories with a total of twenty (39%) staff members in each subsection.

An independent-samples t-test was conducted to compare the scores for person-centredness between nurses and healthcare assistants. There was no significant difference in scores for nurses (mean = 69.13, SD = 10.74) and healthcare assistants (mean = 73.90, SD = 6.58; $t = -1.72$, $p = 0.092$). However, following independent-samples t-test on each of the questions within the questionnaire, statistically significant differences were observed between the nurses and healthcare assistants for three questions. Question 3, 'A place where I feel I can be myself' highlighted the mean for nurses of 4.67 (SD = 1.13) and healthcare assistants mean being 5.30 (SD = .635; $t(45) = -2.39$, $p = 0.02$). Question 10, 'A place which is neat and clean' demonstrated a higher mean (5.30, SD = 0.703) level for healthcare assistants in comparison to nurses (mean = 4.63, SD = .970; $t(45) = -2.74$, $p = 0.01$). Finally, question 12, 'a place where it is easy for patient to receive visitors also revealed a statistical significant difference between the healthcare assistants (mean = 5.78, SD = 0.422) and the nurses scores (mean = 5.25, SD = 1.07; $t(45) = -2.26$, $p = 0.03$).

To establish if age, years working in the older adult care setting or different wards had an impact on the PCQ-S scores, a one-way between-groups analysis of variance was carried out with each variable. No statistical significance was observed between age and PCQ-S ($p = 0.350$) or between years in older adult setting and PCQ-S ($p = 0.045$). A statistically significant difference was however found in relation to the ward and PCQ-S scores: $F(4, 45) = 6.15$, $p = 0.00$. Details of these findings can be seen in Table 5.11. The mean for Ward 3 is considerably lower than that of the other wards with the minimum and maximum range scored being the lowest of the five wards. On further investigation, five questionnaires were completed from this ward out of a possible total of twenty one; four of these questionnaires' scored from 53 – 69 with one questionnaire scoring a total of 38. The effect size was calculated using eta squared and was found to be 3.0 demonstrating a large effect.

Table 5.11: PCQ-S one way between-groups ANOVA

Ward	Mean (SD)	Range (Min – Max)	p
Ward 1	74.27 (6.98)	60 – 84	0.00*
Ward 2	67.56 (9.75)	52 – 84	0.31
Ward 3	58.00 (11.10)	38 – 69	
Ward 4	73.29 (6.13)	59 – 82	0.01*
Ward 5	76.17 (6.62)	67 – 82	0.01*

*Significant at $p < 0.05$

5.5.3 Phase 3 – Patient Questionnaire

Person-Centred Climate Questionnaire – Patient version

The third objective within this study was to assess patients' satisfaction with person-centred care measured utilising the Person-Centred Climate Questionnaire-Patient version. This questionnaire consists of 17 statements investigating the perceived level of person-centredness within a healthcare setting from the patients' perspective. The questionnaire utilises a 6 step Likert-type scale ranging from 1 (No, I disagree completely) to 6 (Yes, I agree completely). The minimum and maximum possible scores are 17 to 102 with a lower score indicating a climate that is not very person-centred and a higher score demonstrating a climate that is very person-centred. The PCQ-P identified the person-centred care scores between 62 and 102 (mean 92.77, SD 9.10) with 71% (43) of the patients recording a score of 90 and over. Table 5.12 identifies the mean values for each question within the PCQ-P.

Table 5.12: Mean and Standard Deviation of PCQ-P

Statement	Mean (SD)
1. A place where staff are knowledgeable	5.67 (.687)
2. A place where I receive the best possible care	5.58 (.880)
3. A place where I feel safe	5.80 (.471)
4. A place where I feel welcome	5.77 (.520)
5. A place where it is easy to talk to staff	5.62 (.762)
6. A place where staff take notice of what I say	5.34 (.966)
7. A place where staff come quickly when I need them	5.52 (.789)
8. A place where staff talk to me so that I can understand	5.54 (.827)
9. A place that is neat and clean	5.90 (.356)
10. A place where staff seem to have time for patients	5.34 (.934)
11. A place that has something nice to look at	5.03 (.992)
12. A place that feels homely	5.55 (1.07)
13. A place where it is possible to get unpleasant thoughts out of your head	4.96 (1.17)
14. A place where people talk about everyday life and not just illness	5.17 (1.05)
15. A place where staff make extra efforts for my comfort	5.49 (.749)
16. A place where I can make choice e.g. what to wear, eat	5.31 (.941)
17. A place where I get that 'little bit extra	5.27 (.978)

An independent-samples t-test was conducted to assess if any differences were present between the person-centred score for patients and nominated relatives. No statistical significance was seen in the overall scores for patients (mean = 92.04, SD = 9.09) and nominated relatives (mean = 95.50, SD = 8.90; $t(64) = -1.27, p = 0.21$).

Each question within the questionnaire was examined in the same manner with statistically significant differences being identified for two of the questions. Nominated relatives scored a higher mean of 5.73 (SD = .458) in comparison to that of the patients (mean = 5.23, SD = 1.01; $t(69) = 2.80, p = 0.01$) in response to question 6, 'a place where staff take notice of what I say'. The same pattern emerged for question 10, 'a place where staff seem to have time for patients'. Nominated relatives had a mean of 5.80 (SD = .561) and patients mean was 5.21 (SD = .967; $t(69) = -3.02, p = 0.00$).

A one-way between-groups analysis of variance was conducted to explore the impact of the number of months in the hospital setting with the patients/nominated relatives perception of patient-centredness. No statistical significance was noted ($F(3, 58) = 1.03, p = 0.388$). Using the same testing strategy, patients' age was also examined to determine

if this affected the patient-centred care scores. Again no statistically significant difference was observed ($F(3, 58) = 1.37, p = 0.262$).

An independent-samples t-test was carried out to establish if gender affected person-centred scores for patients. No statistical significance was noted between males (mean = 90.30, SD = 10.32) and females (mean = 94.08, SD = 7.71). Further independent-samples t-tests were conducted on each question within the questionnaire in the same manner in relation to gender. Statistical significant findings were identified from four of the questions. In all four questions males scored a lower mean in comparison to females. The question 'a place where I feel safe' had a mean of 5.66 (SD = 0.61) for males and 5.96 (SD = 0.19) for females; whilst males had a mean of 5.79 (SD = 0.49) for the question 'a place that is neat and clean' and females scored a mean of 6.00 (SD = 0.00). Statistical significance was also seen for the questions 'a place that has something nice to look at (e.g. views, artwork etc.)' (male mean = 5.29, SD = 1.38, female mean = 5.84 (SD = 0.374) and 'a place where it is possible to get unpleasant thoughts out of your head' (male mean = 4.41 SD = 1.25, female mean = 5.32 SD = 0.852).

5.5.4 Healthcare Professionals and Patient Scores on the PCQ

An independent-samples t-test was conducted to compare staff and patients scores on questions that overlapped within the person centred climate questionnaires. The results of these tests can be seen in Table 5.13. Eight questions from the two questionnaires were shared. It can be seen from Table 5.13 that 5 questions showed statistically significant differences between healthcare professionals and patients. The question 'a place where I feel welcome' was addressed to staff and patients, a mean of 5.26 (SD .763) was recorded for the staff with the mean of 5.77 (SD .513) being documented for the patients.

Table 5.13: Healthcare Professionals and Patient Scores on the PCQ

Variable	Mean (SD)	t	p
A place where I feel welcome Staff (n = 53) Patient (n = 71)	5.26 (.763) 5.77 (.513)	4.21	0.00*
A place where patients feel safe Staff (n = 53) Patient (n = 71)	5.47 (.639) 5.80 (.467)	3.19	0.00*
A place where staff talk to patients so that they can understand Staff (n = 53) Patient (n = 71)	5.40 (.716) 5.54 (.808)	.994	.322
A place which feels homely Staff (n = 53) Patient (n = 71)	5.23 (.933) 5.55 (1.04)	1.79	0.76
A place that has something nice to look at Staff (n = 53) Patient (n = 71)	5.02 (1.04) 5.03 (.985)	.053	.958
A place where it is possible to get unpleasant thoughts out of your head Staff (n = 53) Patient (n = 71)	4.31 (1.31) 4.96 (1.12)	2.94	0.00*
A place which is neat and clean Staff (n = 53) Patient (n = 71)	5.00 (.877) 5.90 (.345)	7.09	0.00*
A place where it is easy for patients to talk to staff Staff (n = 53) Patient (n = 71)	5.34 (.706) 5.62 (.744)	2.12	0.04*

*Significant at $p < 0.05$

A further independent-samples t-test was carried out to examine the healthcare assistant and patient scores between the overlapping eight questions from the two PCQ questionnaires. Of the eight questions, two were seen to have statistical significant differences between healthcare assistants and patient scores (Table 5.14).

Table 5.14: Healthcare Assistants and Patient Scores on PCQ

Variable	Mean (SD)	t	p
A place where I feel welcome Healthcare Assistant (n = 23) Patient (n = 70)	5.26 (.752) 5.77 (.516)	3.03	0.01*
A place which is neat and clean Healthcare Assistant (n = 23) Patient (n = 70)	5.26 (.689) 5.90 (.347)	4.28	0.00*

*Significant at $p < 0.05$

This test was also used to compare nurses and patients scores. The same five questions that were identified as showing statistical significance in Table 5.13 again showed statistically significant differences between nurses and patients (Table 5.15).

Table 5.15: Nurses and Patients Scores on PCQ

Variable	Mean (SD)	t	p
A place where I feel welcome Nurse (n = 24) Patient (n = 70)	5.21 (.833) 5.77 (.516)	3.12	0.00*
A place where patients feel safe Nurse (n = 24) Patient (n = 70)	5.42 (.776) 5.80 (.469)	2.28	0.03*
A place where it is possible to get unpleasant thoughts out of your head Nurse (n = 24) Patient (n = 70)	4.21 (1.38) 4.96 (1.13)	2.63	0.01*
A place which is neat and clean Nurse (n = 24) Patient (n = 70)	4.67 (1.01) 5.90 (.347)	5.88	0.00*
A place where it is easy for patients to talk to staff Nurse (n = 24) Patient (n = 70)	5.25 (.737) 5.61 (.748)	2.07	0.04*

*Significant at $p < 0.05$

5.5.5 Comparison of the ProQOL to the PCQ-S

The relationship between staffs' person-centredness and professional quality of life was investigated using Pearson product-moment correlation coefficient. A preliminary analysis was performed to ensure no violation of the assumptions of normality, linearity and homoscedasticity. Table 5.16 presents the findings. A strong positive correlation was identified between PCQ-S and compassion satisfaction variable, ($r = 0.71$, $n = 49$, $p = 0.00$). No significant correlation was recorded between PCQ-S and compassion fatigue, although it was acknowledged as having a negative correlation ($r = -0.09$, $n = 49$, $p = 0.55$). Burnout and PCQ-S show large negative statistically significant correlation between the variable ($r = -0.54$, $n = 49$, $p = 0.00$).

Table 5.16: Pearson Product-moment Correlations between PCQ-S and Compassion Satisfaction, Compassion Fatigue and Burnout

Scale	1	2	3	4
1. Total Person-Centred Climate Questionnaire-Staff version	-			
2. Total Compassion Satisfaction	.71*	-		
3. Total Compassion Fatigue	-.09	-.07	-	
4. Total Burnout	-.54*	-.48*	.47*	-

*Significant at $p < 0.05$

5.6 Key Findings

Objective 1

Findings from phase 1 of the study, the observational aspect highlighted that a significant portion of the interactions were positive social with 60% of the interactions occurring between healthcare assistants and patients/relatives. Of these interactions the main way to interact was documented as verbal, with 88% of the interactions recorded.

Objective 2

Compassion satisfaction, compassion fatigue and burnout means and standard deviations were analysed in phase 2 of the study and independent-samples t-test was run on the collected data from the ProQOL to examine any differences between the healthcare assistants and nurses. The results identified that healthcare assistants had statistically significantly higher level of compassion satisfaction in comparison to the nurses, whilst the nurses' levels of compassion fatigue and burnout were higher as opposed to the healthcare assistants. No statistical significance were observed following a one way group analysis of variance between ward, age of staff and the number of years working in the older adult care setting.

Objective 3

Phase 2 also examined the totals for the PCQ-S which demonstrated high levels of person-centred care. Further analysis was carried out using independent-samples t-test in order to establish any significant differences between nurses and healthcare assistants' levels for the PCQ-S; no significance was noted. However, upon running the same test on each of the questions within the questionnaire whilst comparing nurses and healthcare assistants three questions were identified as being statistically significant with the

healthcare assistants scoring a higher mean level in all three of the questions. One-way between-groups ANOVA examined the impact of age, years working within the older adult care setting and ward working on. Statistical significance was highlighted between the ward which staff worked on and their PCQ-S, with one ward in particular having lower minimum and maximum levels on their PCQ-S scores.

Objective 4

The PCQ-P levels were totalled and revealed a high mean level of patients' perceptions of person-centred care in phase 3. Following independent-samples t-testing, no significant differences were observed between the patients and nominated relatives total PCQ-P. Continuing with the same testing, all questions were reviewed to examine the patient vs the nominated relatives' viewpoints. Two questions flagged statistical significance identifying that the nominated relatives scored two areas higher than how the patients score it. The number of months within the hospital setting and the age of the patient were also analysed using a one-way between-group ANOVA with no statistical significance being noted.

Gender was also used to test if any differences could be identified in relation to total PCQ-P. No statistical significant differences were noted. However, on testing all the questions to explore male patients in comparison to female patients' perspective, four questions were highlighted as being statistically significant in which females had higher scores than males.

When comparing the PCQ-S and the PCQ-P an independent-sample t-test was run on all eight questions that overlapped. Statistical significance was observed in five of the questions with patients rating the level of person-centredness higher than the staff.

Objective 5

The final objective was to examine the relationship between person-centredness (PCQ-S) and professional quality of life (ProQOL). Pearson product-moment correlation coefficient was utilised to examine this and found that compassion satisfaction and person-centredness showed a strong positive correlation that was statistically significant, as was burnout and person-centredness, showing a negative correlation between the two.

5.7 Conclusion

A critical discussion of these results is provided in the next chapter. The findings with regard to each of the objectives will be discussed further.

CHAPTER 6: Discussion

6.0 Introduction

This study was conducted with the aim of exploring compassionate care delivery in the older adult care setting. The objectives of the study were to examine the observed care delivery by health care professionals; to assess compassion satisfaction, compassion fatigue and burnout rates for healthcare professionals; to explore healthcare professionals' person-centredness; to assess patient satisfaction rates with person-centred care and to examine the relationship between professional quality of life and person-centred care.

The study utilised a case study design which involved triangulation of the data collected. Data was collected through observations (QUIS) and questionnaires (ProQOL, PCQ-S and PCQ-P), with data analysis being carried out with SPSS (Statistical Package for the Social Sciences).

This chapter presents the discussion on, and interpretations of the key findings identified in chapter 5. The findings will be discussed in association with the current literature. This chapter is broken down into 5 sections in which each section will review the findings from each of the objectives defined in chapter 4.

6.1 Observed Care Delivered by Healthcare Professionals

A study objective was to observe care delivery by healthcare professionals within the older adult care setting. To address this, data was collected using the Quality of Interaction Schedule which is a structured observation tool in which interactions are rated as positive social, basic care, neutral or negative.

The results revealed that a significant proportion (70%, $n = 787$) of the interactions that were observed were categorised as positive social, while basic care accounted for 9% ($n = 98$), neutral care made up 16% ($n = 185$) and negative care contributed to 5% ($n = 56$) of the interactions.

Edinburgh Napier University and NHS Lothian (2012) also utilised the Quality of Interaction Schedule but used an adapted version in which interactions were coded as either positive social, neutral or negative. This study incorporated all four coding options

as defined by Dean *et al.* (1993). However similar results were found with the Edinburgh Napier University and NHS Lothian (2012) study identified 76% of interactions to be positive, 14% to be neutral and 10% being negative.

When reviewing the results on who partook in the interactions healthcare assistants had higher rates of interactions with patients (58%) in comparison to nurses (38.5%). Staffing levels were checked for each ward on observation days and the majority of days saw a higher healthcare assistant to nurse ratio. On observations days, ward one had 4 nurses to 3 healthcare assistants, ward two had 3 nurses to 4 healthcare assistants, ward three had 3 nurses to 4/5 healthcare assistants, ward four had 3 nurses to 5 healthcare assistants and finally, ward five had 4 nurses to 6 healthcare assistants.

One finding from the observations is that healthcare assistants within this study were involved in serving all meals to patients, and with meal time being a central point for interactions this might explain the disparity between nurses and healthcare assistants. Healthcare assistants also carried out the domestic duties within the wards which again might add to the increase in interactions between healthcare assistants and patients.

Additionally, all interactions were recorded as being a verbal, nonverbal or verbal and nonverbal interaction. Figure 4.3 highlights the findings of this with verbal interactions accounting for 88% (n = 879) of all interactions. Nonverbal was seen in 8% (n = 75) of the interactions and a mix of both methods was observed a total of 37 times (4%).

Within the interactions, periods of no interactions were identified 168 (14.3%) times out of 1,173 interactions. No interaction was identified as long periods of time where patients had no interaction with healthcare professionals. Given the amount of care that is required within the older adult care setting, there are times when patients may be left unattended in bedrooms, sitting rooms or dining rooms. However, some of the no interaction periods identified within this study were down to patient choice. Certain patients did not want to be involved in the daily activities that occurred on the ward and staff respected this. Other times, particularly in the morning and evening when patients were assisted out of and back into bed by staff, these tasks meant that patients might have spent some time with no interactions. Poole (2009), utilised the QUIS to evaluate the person-centred approach to care of older adult people with cognitive and disturbed behaviour in the acute care setting.

This study found that out of a total 2016 interactions, 1220 (60.52%) interactions were branded as no interaction. This is a significantly higher proportion of interactions in comparison to this study. Poole's study was conducted in the acute care setting and highlighted that patients may need time to rest and recover from procedures, yet felt that levels of 60% would be of particular concern in long-term care settings. From this one can gather that the levels of no interaction within this study appear to be reasonable given that some patients chose not to participate in activities that required interaction.

6.2 Compassion Satisfaction, Compassion Fatigue & Burnout

A study objective was to examine healthcare professionals' quality of life while working in the older adult care setting. Compassion satisfaction, compassion fatigue and burnout measured using the Professional Quality of Life Questionnaire (ProQOL). This 30 itemed questionnaire contained 3 subsections covering the three areas. It was distributed to all healthcare professionals within the older adult care setting. This section is divided into 3 parts in which the findings of each subscale are discussed.

6.2.1 Compassion Satisfaction

Compassion satisfaction for healthcare professionals is seen as a positive attribute within the work setting and, essentially when it is present it has the potential to improve patient satisfaction. The mean score for compassion satisfaction was 50.86 (SD = 7.80). This result is higher than that of Potter *et al.* (2010) who reported an average of 38.3 (SD = 7.2) for compassion satisfaction. Stamm (2009) reported an average score of 37 amongst previous users of the Professional Quality of Life Scale, indicating that staff levels of compassion satisfaction within this study are higher than average. High compassion satisfaction levels demonstrate the pleasure staff derive from being able to carry out their work well (Stamm, 2009).

The results of the independent-samples t-test showed statistical significance between nurses (mean = 48.68, SD = 8.01) and healthcare assistants' (mean = 54.16, SD = 5.96) compassion satisfaction scores. Slocum-Gori *et al.* (2013) found similar findings, although not statistically significant they reported that healthcare assistants had higher compassion satisfaction rates (mean = 44.1) in comparison to nurses (mean = 43.4).

Within this study there is a clear gap between the compassion satisfaction scores highlighting that healthcare assistants appear to have derived more compassion satisfaction when caring for patients.

No statistical significant difference was found between compassion satisfaction and years working within the older adult care setting however, staff that had worked for 31 – 43 years in the care setting had the lowest mean score, with the mean scores reducing with the increase in number of years working within the setting. Potter *et al.* (2010) also identified in their study similar results with compassion satisfaction decreasing with years in service.

Age was also shown to have a comparable pattern with years working in the older adult setting. The older the healthcare professional was the lower the mean level compassion satisfaction score. This difference in compassion levels between age groups was not statistically significant but it was evident staff aged from 49 to 61 had a lower mean score (mean = 49.78, SD = 7.60) than those younger members of staff aged from 24 to 35 (mean = 53.12, SD = 9.62) and aged from 36 to 48 (mean = 53.94, SD = 4.54).

Within the context of this study the levels of compassionate satisfaction were above average for all staff when compared with each other. Albeit limited studies are available and it also appears that healthcare assistants demonstrated higher levels of compassion satisfaction than nurses. No other studies measuring compassion satisfaction were identified where the sample included both nurses and health care assistants.

6.2.2 Compassion Fatigue

Compassion fatigue occurs from the negative effects related to witnessing trauma, pain and suffering of patients (Flarity *et al.*, 2013). The results of compassion fatigue being present within the healthcare setting generally leads to decrease in compassionate care as the healthcare worker is unable to provide such care.

The compassion fatigue for healthcare professionals within the study scored a mean of 50.24 (SD = 9.94). This is seen as the mean rate when using cut off points identified by Stamm (2009). This section of the ProQOL questionnaire also reported statistical

significant differences between the rates of compassion fatigue for nurses (mean = 51.28, SD = 8.36) and healthcare assistants (mean = 46.14, SD = 7.19), with healthcare assistants having a statistically significant lower compassion fatigue rate. Slocum-Gori *et al's* (2013) study also identified a difference between the member of staff and compassion fatigue rates with nurses (mean = 20.1) scoring higher levels of compassion fatigue in comparison to healthcare assistants (mean = 18.8).

In relation to years of service in the older adult care setting, this study's results demonstrated that healthcare professionals within the 11 – 20 years category had the lowest levels of compassion fatigue and that healthcare professionals within the 21 – 30 years category had the highest levels of compassion fatigue. This does not concur however, with Potter *et al.* (2010) findings which found that staff working between 11 – 20 years had the highest levels of compassion fatigue. Older staff in Potter *et al's* (2010) study were seen to experience less compassion fatigue than all younger groups within the study.

While there are not many studies against which to compare and this is a small scale study, it may be that an increase in time in practice may be a factor in creating increased compassion fatigue. However, this would require further research.

6.2.3 Burnout

Healthcare professionals who experience burnout tend to have a reduction in work performance which ultimately leads them to distance themselves from the patient due to exhaustion. The fall out of this is it can ultimately lead to a reduction in compassionate care for patients.

The results from the burnout subscale presented similar findings as the previous two subscales. The mean score for all healthcare professionals was 50.46 (SD = 9.50) with healthcare assistants scoring statistically significant differences (mean = 46.39, SD = 10.41) than nurses (mean = 53.23, SD = 7.11). This result suggests that healthcare assistants in this study were at less risk of experiencing burnout. These results are again comparable to Slocum-Gori *et al's* (2013) as the study indicted higher levels of burnout for nurses (mean = 22.3) than healthcare assistants (mean = 18.8). As both this study and

Slocum-Gori *et al's* (2013) study were correlation and cross sectional it is not possible to draw definitive rationale for these results. However, it could be related to the higher level of responsibility held by the nurses.

Burnout was also reported in a study examining what contributes to burnout (Glasberg *et al.*, 2007). In Glasberg's study, burnout was measured using the Maslach Burnout Inventory Scale, but despite the differences in the data collection tools, the exhaustion and depersonalisation that are associated with burnout were found to differ between nurses and healthcare assistants with healthcare assistants yet again having lower rates. While burnout in nurses has been extensively researched, there are again few papers that compare burnout in nurses and health care assistants which limits the comparisons that can be made with this study.

Furthermore, the results of this study identify that compassion satisfaction, compassion fatigue and burnout are interrelated. Specifically, compassion satisfaction is negatively correlated with both compassion fatigue and burnout, whilst a positive correlation was seen between compassion fatigue and burnout. Slocum-Gori *et al's* (2013) findings corroborate these findings. Therefore it seems that the nurses in this study have increased levels of compassion fatigue and reduced compassion satisfaction, which impacts on their professional quality of life. However it also needs to be acknowledged that the mean that was displayed lies within the average and high parameters as defined by Stamm (2010), and hence while compassion fatigue and burnout were high, they could in fact be much higher.

6.2.4 Review of the ProQOL Findings

Healthcare assistants' results within this study for the ProQOL demonstrate above average levels of compassion satisfaction, with moderate to lower levels of compassion fatigue and burnout. Stamm (2010) highlights that this is the most positive result that can be achieved from the ProQOL indicating that healthcare assistants within this study should have a good professional quality of life. It would appear from this result that healthcare assistants receive positive reinforcements from their work within the older adult care setting and feel no significant concerns about how they carry out their work and appear not to be feeling bogged down. Stamm (2010) suggests that persons who are at this level

may benefit from engagement and educational opportunities to allow them to grow. It is also recognised these healthcare professionals are most likely to be good role models within the healthcare setting for colleagues and the organisation. One of the other factors that may be considered when reviewing healthcare assistants' results is that healthcare assistants rotate between caring duties and domestic duties. This could contribute to their results as their daily routines change regularly. However, it could also relate to factors such as carrying lesser responsibilities than the nurses in the setting. Indeed the results could also suggest that due to the health care assistants' increased interactions with patients, that the opportunities for positive reinforcement of their caring role arise more for them than for the nurses and may go some way to explaining the differences between the two groups.

The ProQOL results for nurses identified that nurses seem to experience higher than average burnout rates, with moderate levels of compassion fatigue and compassion satisfaction rates. Stamm (2010) discusses the average burnout rates to be 50 with the top quartile being 56. In this study nurses scored a mean of 53.23 (SD = 7.11) putting them at a higher risk of burnout. Stamm (2010) identifies that persons who score higher on burnout are at risk as individuals and may be also putting their organisations at risk. The causes of burnout may be person or organisational factors and can be associated with high workloads and poor system function. Healthcare professionals who suffer from burnout are usually disengaged from their patients, yet they do not associate the fear experienced as a result of the engagement with their patients. People who suffer from burnout from Stamm's (2010) perspective could benefit from changing their routines within the organisation for example by working different shift patterns or rotating to a different ward with different colleagues. As nurses appear to be under the higher levels for burnout perhaps a rotation system within the wards of the organisation could assist in reducing the levels of burnout for nurses.

The ProQOL identified the levels of compassion satisfaction, compassion fatigue and burnout for healthcare professionals within this study. One major finding was the differences between each of the subscales between the nurses and healthcare assistants, with healthcare assistants scoring better levels on each scale. It is clear within this study that some staff have a better quality of life than others, factors that influenced this included age and years in service.

6.3 Person-Centredness of Healthcare Professionals

Person-centred care aims to place the patient at the centre of all care that is carried out, thus, healthcare professionals work in collaboration with the patients. The Person-Centred Climate Questionnaire – Staff version (PCQ-S), a 14 itemed questionnaire was used to gather healthcare professionals' opinions of how person-centred the climate of the organisation they work in was as part of one of the study objectives.

The total mean scores of the PCQ-S was 71.65 (SD = 9.01), which according to Edvardsson *et al.* (2010b) demonstrates a climate that is very person-centred. There was no statistical significance noted between healthcare professionals. Beck *et al.* (2014) calculated the mean for an intervention and control group at baseline and found the mean to be 5.25 for the intervention group and 4.99 for the control group. Within this study the mean of 5.12 fell above the control group and below the intervention group demonstrating a high level of person-centredness.

Within the questionnaire, 3 subscales existed including safety (mean = 5.20, SD = 0.69), everydayness (mean = 4.82, SD = 0.78) and community (mean = 5.38, SD = 0.73). Beck *et al.* (2014) found similar means between an intervention and control group with baseline mean scores for the three subscales as follows: safety (intervention group mean = 5.28, SD = 0.60 and control group mean = 5.00, SD = 0.63); everydayness (intervention group mean = 4.95, SD = 0.73 and control group mean = 4.65, SD = 0.75) and community (intervention group mean = 5.59, (0.50) and control group mean = 5.41, SD = 0.66). This result suggests that in this study safety and community appear to be present in higher levels than that of everydayness. Staff felt the environment was less conducive to everydayness when caring for patients. Reasons for this may include that staff do not believe that the care setting is what their everyday lives are like, but one must remember that as people get older their lifestyle changes.

An independent-samples t-test was conducted to compare the scores for person-centredness between nurses and healthcare assistants. There was no significant difference in scores for nurses and healthcare assistants. However, on further investigation using independent-samples t-test on each of the questions and the association between being a nurse or healthcare assistant, 3 questions were found to show statistical significant differences with healthcare assistants having higher means than that of nurses (Section

5.5.2.2). This highlights the different perspectives that nurses and healthcare assistants have within the care setting on personal factors and on environmental factors that were associated with these questions.

No statistically significant differences were found between the level of PCQ-S and the years within the older adult care setting. Yet, on further inspection of the mean level for staff working for 31 to 43 years (mean = 58.00, 17.35) was seen to be considerable lower than that of staff working for less years, with staff within the bracket of a 11 - 20 years scoring the highest mean of 74.16 (SD = 6.44). A study conducted by Edvardsson *et al.* (2011) found similar findings using a different tool, which highlighted that staff with more experiences had lower levels of person-centredness. This may suggest that the longer staff are within the caring profession the less person-centredness appears to be present. Alternatively, it may be an outcome of the new focus on person-centred care that has resulted in long-term serving staff being unable to adapt to the newer model of care. Whatever the cause, it is imperative that it is addressed within all healthcare setting organisations as older staff exert a major influence on the working environment and are essentially the role models within the caring culture.

A further finding in relation to person-centredness was that the ward in which staff worked on had a statistical significant difference on PCQ-S scores. One ward demonstrated a significantly lower mean score of 58.00 (11.10) in comparison to the highest mean score of 76.17 (6.62) (Section 5.5.2.2). One of the findings from the observations on this particular ward was at the time of the observations there was no clinical nurse manager assigned to the ward. All of the 4 other wards had clinical nurse managers and perhaps this may be the cause of the lack of person-centredness on this ward, as staff may have felt under pressure as a result of the lack of management. From the 12 nurses and 11 healthcare assistants that worked on the ward, 5 questionnaires were completed with low levels of person-centredness. Following the cut off points set out by Edvardsson *et al.* (2015) as seen in section 4.8.7 the five score for this ward demonstrated 1 score 'well below average', 3 scores 'below average' and 1 score 'above average'. The low response rate may also be due to a lack of management or the absence of a clinical manager on the ward. The older adult care setting within this study appears overall to be very person-centred climate organisation with high levels of person-centredness scored by staff.

6.4 Patient Satisfaction with Person-Centredness

Person-centred care is seen to benefit patients by involving patients within the decision making process and making the process a shared decision (Abrahamsen *et al.*, 2014). Patient satisfaction was assessed using the Person-Centred Climate Questionnaire – Patient version (PCQ-P). This 17 itemed questionnaire allowed the patients to demonstrate the levels of person-centred climate care within the care setting.

The mean for the total level for the PCQ-P was 92.77 (SD = 9.10), which demonstrates very high levels of person-centredness. No statistical significant differences were identified between patients and nominated relatives total PCQ-P scores. The total mean level (5.46) is comparable to that of Parlour *et al.* (2013) study who utilised the PCQ-P at two time points within the study and found the mean to be 5.3 at first time point and 5.4 at the second time point.

A total of 2 subscales were incorporated into the PCQ-P including safety (mean = 5.61) and hospitality (mean = 5.25), with safety scoring higher than hospitality in this study. Parlour *et al.* (2013) found similar findings for the means at two different time points which included: safety: (time point 1, mean = 5.46 and time point 2, mean = 5.63) and hospitality (time point 1, mean = 5.00 and time point 2, mean = 5.14).

The findings demonstrate that patients felt safe within the care setting environment but felt that in comparison to the safety aspect of the environment that the hospitality factor was rated lower. The scores within the current study suggest higher levels of safety and hospitality within the environment in comparison to that of Parlour *et al.* (2013). However, both studies revealed that hospitality is scored lower than safety which may need to be addressed. The scores within Parlour *et al.* (2013) study are seen to improve at the second time point which is an important factor as it highlights that the rates of person-centredness can be increased.

Although, no statistical significant differences were identified between patients and nominated relatives, further analysis using independent-samples t-test highlighted statistically significant differences for two of the questions in the PCQ-P (Section 5.5.3). Both questions followed a pattern of nominated relatives having a higher mean score in comparison to the patients' mean scores. This indicated that the nominated relatives may

have a different perspective of the pattern of person-centredness within the care setting environment in contrast to that of patients. Generally, relatives visit patients in care settings for a certain period of time and thus, might only be obtaining a snap shot of the care within the environment (section 5.5.3).

The gender of a patient had no statistically significant difference on the PCQ-P, yet, when all questions were compared using an independent-samples t-test four questions were highlighted as showing statistical significant differences. Within these 4 questions males had a significantly lower mean than females which may suggest that female patients were more satisfied with certain levels of person-centredness (Section 5.5.3). However, one must acknowledge that the mean scores for the males were very satisfactory in terms of person-centredness.

The final analysis of the PCQ-P was carried out against the PCQ-S in which eight of the shared questions from the staff and patient questionnaires were analysed. The results identified that of the 8 questions patients had higher means for each question when compared to healthcare professionals, with 5 questions demonstrated statistically significant differences between healthcare professionals and patients. Additional analysis was conducted using independent-samples t-test to examine whether being a nurse or a healthcare assistant had implications on the shared questions when compared to patients (Section 5.5.4). Healthcare assistants showed statistical significance for 2 out of the 8 questions whilst nurses had statistical significance for 5 of the 8 questions. Nurses' scores for the two comparable statistically significant questions when compared to healthcare assistants showed that they had lower levels in both. One can only speculate that nurses are more critical of the care that they provide than the care perceived by patients.

The findings from this highlighted that patients within this study had a more positive opinion on the level of person-centredness within the care setting with all staff (nurses and HCA's) appearing to be more judgemental on the level of person-centredness. Poghosyan *et al.* (2010) carried out a study using different tools which refutes this study. The study found that patients had lower mean level scores than nurses. However, that study was conducted within the acute hospital setting.

Another finding identified when comparing the two questionnaires was concerned with the question of feeling welcome. The levels indicate that staff felt lower levels of being welcome within their work place as opposed to the patients feeling welcome within the care setting. A mean score of 4.92 was also calculated for the question a place where staff feel they can be themselves. This might address why staff feel less welcome as some struggle to believe that they can be themselves within the work place and thus believe they are not accepted.

It is clear from the findings of the PCQ-P that the patients within this study appear satisfied with levels of person-centredness. This view is also held by the healthcare assistants whilst the nurses are more critical of the level of person-centred care that they deliver.

6.5 Relationships between Professional Quality of Life and Person-Centred Climate

The final objective within this study was to examine if a relationship existed between professionals quality of life (ProQOL) and person-centred climate (PCQ-S). From the subscale of the ProQOL compassion satisfaction was identified as having a strong statistically significant positive correlation on the PCQ-S scores. This indicates that staff that have high levels of compassion satisfaction are more likely to have high levels of person-centredness. Within this study as healthcare assistants had higher levels of compassion satisfaction one would assume that they then should have the highest levels of person-centredness, which was the case within this study (section 5.5.2.2).

The PCQ-S was negatively correlated with compassion fatigue and burnout; however it was not at a statistically significant level with compassion fatigue ($p = 0.55$). This means that with an increase in compassion fatigue or burnout levels one may expect to see a reduction in person-centredness. As nurses had the higher level of compassion fatigue and burnout in this study, the presumption could be that their levels of person-centredness would be decreased. It is important to consider the affect that burnout has on staff and why it may have a knock on effect on the person-centredness of the environment, particularly if not addressed.

6.6 Conclusion

This chapter discusses the key findings of the study and critically compares to those within the literature. The findings were comparable to the literature when available and demonstrated an overall agreement with the results in the study. However, as a result of the limited literature some of the results have no comparable findings. Yet, this is not surprising considering the exploratory nature of the study and the ambiguity of the topic which is being addressed.

The observations of care identified high levels of positive interactions. Professional quality of life was determined to be higher for healthcare assistants in comparison to nurses, with healthcare assistants having higher levels of compassion satisfaction and nurses having higher levels of compassion fatigue and burnout.

High levels of person-centredness were acknowledged by both patients and staff and person-centredness was positively correlated with compassion satisfaction and negatively correlated with compassion fatigue and burnout within staff.

The overall findings from this study indicate that healthcare professionals require further support in order to enhance professional quality of life and thus, improve compassionate person-centred care.

CHAPTER 7: Conclusion and Recommendations

7.0 Introduction

This chapter considers the relevance and implication of the study findings. Section 7.1 discusses the limitations of the study. Following this in section 7.2 highlights the recommendations for practice that result from the study.

7.1 Limitations of the Study

The main limitations identified in this study are issues related to the research design and the observation tool. Section 7.1.1 will review the limitations of the research design, whilst section 7.1.2 will discuss the limitations of the observational tool.

7.1.1 Research Design

This study adopted an exploratory case study design, the limitations of which were previously discussed in section 4.4.1.4. The biggest concerns with using the case study design are in relation to rigor and generalisability.

The issue of rigor is one that frequently appears surrounding case study design. Yin (1994) considers one of the practical difficulties with case studies being the amount of data that is collected. In order to increase construct validity (section 4.8.1) within this study, multiple sources of data were collected including observations and questionnaires. One of the problems that may arise according to Zainal (2007), is poor management of the data that is generated. In order to prevent such occurrences a systematic structure was put in place in which all data was entered into SPSS, allowing for more in-depth analysis, which thereby increased the rigor and reliability. By utilising SPSS, the additional problematic label given to case studies as being time consuming and difficult was eased. SPSS was critical in organising large quantities of data from both observations and questionnaires.

The second issue is concerned with the case study design is the lack of scientific generalisation which in turn affects external validity (Hall, 2008; Yin, 2003). Yet, Yin (2003) contests this on the basis that a case study design forms analytical general theories as opposed to statistical general theories. Hence, the findings from this study could reflect to other older adult care settings, however taking into account the degree to which the

findings can be generalised to persons outside of this study. It is clear that the findings cannot be generalised to the whole population due to purposive sampling. However, the sample is reflective of the older adult care setting specifically in Ireland.

7.1.2 Observation Tool

The observational tool that was utilised in this study was the Quality of Interaction Schedule which was developed by Dean *et al.* (1993). This tool has been adapted over the years from its initial form which was set up to evaluate long term residential mental health settings and is now used in general hospital settings and residential settings (Edinburgh Napier University and NHS Lothian, 2012; QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care). However, one limitation of this tool is the lack of a Cronbach's alpha coefficient. The purpose of the Cronbach's alpha is to measure the internal consistency in terms of how closely related a set of items are as a group, thus increasing the reliability. Despite the lack of a Cronbach's alpha this tool has been utilised by the leaders in compassionate care research Edinburgh Napier University and NHS Lothian (2012), thus was seen to have significant reliability and hence, was utilised within this study.

7.2 Recommendations

The findings of this study have highlighted a number of recommendations for both clinical practice and future research.

7.2.1 Recommendations for Clinical Practice

- Rotation of nursing staff between wards. A rotation system of one nurse per unit rotating every 6 months would allow patient care to be maintained at the high levels.
- The presence of an effective nurse manager on each ward, who would lead the compassionate and person-centred care agenda and would also have good support from the management is imperative to improving compassionate person-centred care.

- Education levels of all staff (managers, nurses and healthcare assistants) to be monitored and encouraged. Staff should be informed about up and coming study days/seminars within the area of care of the elderly to increase the skill set of staff. Specific training on compassionate person-centred care could be helpful.

7.2.2 Recommendations for Future Research

- Replication of this research in other settings including hospital settings, using the same methodology and methods, to establish if the findings can be generalised to a wider population.
- Further research, particularly qualitative focus, to explore healthcare assistants and the quality of life in comparison to hospital and residential care settings.
- Intervention research to address professional quality of life and person-centred care is necessary. A specific educational tool designed to increase person-centred care knowledge could be developed and evaluated in practice.

7.3 Study Conclusion

This study explored compassionate care delivery in the older adult care setting through professional quality of life and person-centredness. The study was an exploratory case study design with purposive sampling technique to examine staff and patient/nominated relatives' perceptions of person-centredness within the older adult care setting whilst looking at staffs professional quality of life and if this impacted on person-centredness. It also sought to explain not only what person-centred care is but also how it was manifested and perceived by staff and patients.

Relationships were identified between professional quality of life and person-centredness with high levels of person-centredness being associated with a better quality of life. Differences were found between nurses and healthcare assistants, indicating that healthcare assistant had a higher professional quality of life.

The study findings allowed a triangulated view of compassionate and person-centred care. The observations identified high levels of positive care, patients identified a high level of person-centredness yet, it was the staff that rated their levels of person-centredness as

lower than that of the observations and the patients/nominated relatives. Further studies should focus on the nurses and healthcare assistants quality of life and the effect on person-centredness within hospital and residential settings.

The study highlights the disparity between the quality of life for healthcare professionals within the care setting. Findings demonstrated that healthcare assistants scored higher on the positive aspects of work related quality of life and lower on the negative aspects when compared to nurses. Given that the results of this study showed that levels of perceived person-centredness is related to professional quality of life, it would appear that it is essential to assist all staff (nurses and healthcare assistants) to gain a high quality of life within the work place. It could then be the case that person-centred care and compassionate care delivery would be increased.

Overall, therefore, this study identified high levels of compassionate interactions between staff and patients in the older adult setting. This was also demonstrated through the high level of patient perceived person-centred care. Likewise, healthcare and nurses perceived they delivered person-centred care. A key finding from the study highlighted the differences in the perceptions between nurses and healthcare assistants, with nurses being more critical of their care and having reduced work related quality of life.

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Appendices

Appendix 1: Literature Search Strategy

Databases Searched & Results

Initial results from the search strategy employed can be seen in there raw state. The next step was to continue combining keywords to ensure saturation of literature.

Multisearch WIT Database Including: Academic Search Complete, British Index Nursing, JSTOR, Ovid SP, PsychArticles , The Cochrane Library, Wiley Online Library	Cinahl	Science Direct	PubMed	Health Service Executive Library Athens login to Full Text Search Peer Reviewed
Compassion + care + any content type = 84,466	Compassion + care + full text + academic journal = 81	Compassion + care = 10,697	Compassion + care = 6,646	Compassion = 1,406
Compassionate + care + full text = 50,278	Compassionate + care + full text = 162	Compassionate + care + journal = 8,643	Compassionate + care + free full text = 199	Compassionate + care + full text = 221
Compassionate care + nursing + journal + full text + limit to articles from Scholarly Publications = 7,632	Compassionate care + nursing + academic journals = 20	Compassionate care + nursing = 3,296	Compassionate care + nursing + free full text = 277	Compassionate care + nursing = 115
Compassionate care + older	Compassionate care + older	Compassionate care + older	Compassionate care + older	Compassionate care +

adult nursing + journal + full text + limit to articles from Scholarly Publications = 1,317	adult nursing = 0	adult nursing = 1,276	adult nursing + free full text = 70	older adult nursing = 0
Measuring + compassion + full text = 16,710	Measuring + compassion = 3	Measuring + compassion + journal = 2,162	Measuring + compassion + free full text = 34	Measuring + compassion = 5
Measuring + compassion + older adult care + full text = 9,281	Measuring + compassion + older adult care = 0	Measuring + compassion + older adult care + journal = 614	Measuring + compassion + older adult care + free full text = 6	Measuring + compassion + older adult care = 0
Person-centred care = 35,447	Person-centred care = 493	Person-centred care = 49,241	Person-centred care = 859	Person-centred care = 8,826
Person-centred care + full text = 30,142	Person-centred care + full text = 247	Person-centred care + full text = 49,241	Person-centred care + full text =	Person-centred care + full text = 5,148
Person-centred care + caring = 8,571	Person-centred care + caring = 41	Person-centred care + caring = 10,110	Person-centred care + caring = 115	Person-centred care + caring = 73
Person-centred care + older adult care + full text + + limit to articles from Scholarly Publications = 2,795	Person-centred care + older adult care + full text = 139	Person-centred care + older adult care + journal + full text + health care = 362	Person-centred care + older adult care + free full text = 40	Person-centred care + older adult care = 1

<u>National and International Organisations Searched</u>				
World Health Organisation	Department of Health and Children (Ireland)	Department of Health (UK) National Health Services	Parliamentary and Health Service Ombudsman (UK)	Health Information and Quality Authority (Ireland)
National Institute for Health and Care Excellence	Age Action Ireland	Health Research Board	Nursing Homes Ireland	

<u>Keywords used to Further Refine the Search</u>				
Compassion fatigue	Burnout	Definition	Nurse-patient relations	Empathy
Quality of life	Advocacy	Self-compassion	Sympathy	Patients over 65
Hospital setting	Nursing home	Nurses	Relatives	Family
Emotion	Suffering	Motives for compassion	Framework	Identifying compassion
Conditions for compassion	Individualised care	Patient-centred care	Patient perspective	Staff perspective
Observed compassion	Measuring patient-centredness	Patient centredness	Measuring Quality of Life	Challenges

Appendix 2: Studies on Compassion

Study	Design	Purpose	Sample	Setting	Data Collection	Key Findings
Apker <i>et al.</i> 2006 United States of America	Grounded theory	The aim of this study was to highlight effective nursing communication skills within team care interactions	25 nurses 3 clinical nurse specialists 7 physicians 6 patient care assistants 4 unit clerks 5 charge nurses	Hospital setting	One to one interviews Focus group Observations	Four skills were recognised for effective communication: collaboration, credibility, compassion and coordination
Arman <i>et al.</i> 2004 Sweden & Finland	Phenomenological approach	To interpret and gain an understanding of the meaning of patient's experiences of suffering related to health care from ethical, existential and ontological perspectives	16 women	Health care centres	Interviews	Three levels of interpretation were themed. Ethical: Caring relationship that fails to materialise and the carer's choice. Existential: not being treated as a whole human being with experiences and needs. Ontological: an imperceptible call for help in disintegrating, incomprehensible life
Armstrong <i>et al.</i> 2000 UK	3 round Delphi study	To inquiry into the moral virtue, especially compassion in psychiatric nurses	26 nurses: Round 1 22 nurses: Round 2 14 nurses: Round 3	Psychiatric nurses areas of employment in Newcastle	Semi-structured questionnaires were distributed at each round	8 themes emerged and the paper focused on 2 of those themes: the nature and role of moral virtues in psychiatric nursing and the meaning and the importance of compassion in psychiatric nursing. Nurses were asked what does it mean in your view "to behave and act compassionately". 16

						different meanings were noted: give time & listen; show understanding about how they feel; compassion is caring & showing it; assists other to make decisions; not denying any rights to clients and always act in their best interests
Beckett, 2013 United Kingdom	Qualitative embedded study	Exploring relationships with patients	12 Nurses 11 Physiotherapists	4 NHS hospitals	Semi-structured interviews	Findings demonstrated that nurses find their role is not conducive to caring. Both nurses and patients feel uncared for. Nurses felt that care and compassion have been devalued
Berg & Danielson, 2007 Sweden	Interpretive phenomenological method	Aim to examine patients with long-term illness and nurses' experiences of a caring relationship	6 nurses 7 patients	Hospital setting	Interviews were conducted.	Findings were divided into the patients' and nurses' views. Patients': Maintaining dignity, feeling vulnerable. Nurses': A purposeful striving, an arduous compassion
Bray <i>et al.</i> 2014 UK	Mixed method design	Explore qualified and pre-registered healthcare professionals understanding of compassion and the role of education in promoting	155 qualified healthcare professionals 197 pre-registered students.	University	Survey and interviews	Participants' understanding of compassion in healthcare was questioned. There was a high consensus between all participants' that compassion was 'acting with warmth and empathy, individualised care and act in a way you

		compassion				would like to be treated. Identifying compassion was seen as actively listening, respecting patients' dignity and privacy and being attentive to needs. Compassion was deemed hard to define but was evident if it was present or not in practice. Training was necessary to provide compassionate care however, many felt that compassion could not be learnt or taught that it was innate. Contradictions were evident within the discussion of the role of education for compassion.
Burtson & Stichler, 2010 United States of America	Correlational study	Examine the relations of compassion satisfaction, nurse job satisfaction, stress, burnout and compassion fatigue to nurse caring. Hypotheses 1 & 2 tested compassion satisfaction (H1) and nurse	126 nurses	Academic medical centre	4 questionnaires were distributed to each participant. 1. The Mueller McCloskey Satisfaction Scale. 2. The Professional Quality of Life Scale. 3. The Stress in General Scale. 4. The Caring Behaviours Inventory.	Hypotheses 1, 2, 3 and 4 were supported with statistical significance. Compassion satisfaction shows a positive correlation between general happiness and working meaningfulness and patient satisfaction. Compassion was seen as important in nursing care. Compassion fatigue was noted to be prevalent in acute care settings especially amongst

		<p>job satisfaction (H2) are positively correlated with nursing caring. Hypotheses 3, 4 & 5 looked at stress (H3), burnout (H4) and compassion fatigue (H5) are negatively correlated to nursing care. Hypotheses 6 tested all 5 hypotheses are related to nurse caring.</p>				<p>younger, less experienced nurses. Compassion satisfaction and opportunities for social contact with colleagues at, and outside of, work may influence nurse caring.</p>
<p>Christiansen, 2009 Norway</p>	<p>Longitudinal, micro ethnographic study of actions</p>	<p>To explore how nursing students cultivate authentic concern for patients.</p>	<p>4 second year student nurses</p>	<p>Hospital setting</p>	<p>Observations were conducted and videotaped. Semi-structured interviews were carried out before and after the observations.</p>	<p>Concern was expressed through body movement, voice and style. Attentiveness and commitment were present</p>
<p>Cosley <i>et al.</i> 2010 United States of America</p>	<p>Experimental design</p>	<p>The role of compassion for others and social support in physiological stress reactivity</p>	<p>59 women</p>	<p>Community setting</p>	<p>Prior to the experiment an online questionnaire was completed assessing compassion with the dispositional positive emotion scales. A laboratory</p>	<p>This study found that compassion may influence physiological wellbeing. Participants that were socially supported showed higher compassion levels with lower blood pressure and cortisol levels.</p>

					session was attended at least 1 week later during which participants were connected to physiological equipment and asked to complete social stress test	
Curtis <i>et al.</i> 2012 United Kingdom	Grounded Theory informed by Symbolic Interactionism	Explore student nurses experience of socialisation in compassionate care. The concerns they highlighted and how they managed their concerns about compassion	19 student nurses 5 nurse teachers	University	In-depth interviews were carried out with the students. Interviews were also conducted with the nurse teachers. Nurse teacher data and NHS survey data were collected and analysed	The study found that socialisation in compassionate practices for students appear to be compromised. The study identified dissonance between the students' ideals of compassionate practices and the reality of practice
Dean <i>et al.</i> 1993 UK	Prospective evaluation study	To evaluate two residential units for the elderly mentally ill in the first year of operation	12 residents from Domus A. 12 residents from Domus B. Nursing staff and domestic staff	Residential units	Assessments of each resident were undertaken at each follow up appointment: 1. Organic Brain Syndrome. 2. Depressive Signs Scale. 3. The Adaptive Behaviour Rating Scale. Nursing staff and domestic staff were interviewed once. Observational data was collected using	The findings identified that the care was superior in comparison to the long-stay mental health hospital in which they are replacing

					the Short Observation Method. Policies were monitored using the Policy and Program Information section of the Multiphasic Environmental Assessment Procedure.	
Dewar & Cook, 2014 Scotland	Leadership programme utilising appreciative relationship centred leadership	To support staff to work together to develop a culture of inquiry to promote compassionate care	86 nurses from one acute hospital participated. 405 nurses completed the staff culture questionnaire 65 nurses were interviewed	Hospital setting	Questionnaire Reflections Case studies Interviews	Key themes identifies were: enhanced self-awareness, better relationships, improved reflection of practice, changes to conversations incorporating compassion and being respectful and the desire to continue learning and improving oneself and practices on the wards
Dewar & Mackay, 2010 Edinburgh	Appreciative inquiry and action research	To explore, develop and articulate strategies that enhanced compassionate relationship centred care for older people	Four wards defined as Beacon wards were incorporated due to their know excellence of caring compassionately . Staff, students, patients and family were included	Hospital setting	4 phases were used to collect data. Phase 1the Discovery phase included observations (structured and informal), story sharing & photo elicitation. Phase 2 saw feedback session and group interviews with	Data identified special and often hidden acts that make up compassion. This study emphasised what worked best and developed a dream phase about what might be. From here they developed strategies to initiate new the dream and complete the process by applying and re-evaluating the actions, whist all the time working with the staff.

					staff. In phase 3 group discussion were utilised with development of actions. Finally phase 4 incorporated one to one interviews with staff.	
Dewar & Nolan, 2013 Edinburgh	Appreciative inquiry, participant observation, interviews, storytelling and group discussion	To actively involve older people, staff and relatives in agreeing a definition of compassionate relationship-centred care and how to promote such care in an acute hospital setting	35 staff members 10 patients 12 family members	Hospital setting	Structured observations. Collection of stories using emotional touch points (the storyteller explains how they feel during their experience). Group discussions. Informal observations. Discussions captured as field notes	The study found two ways of assisting staff, patients and families to work together. Informed compassionate relationship-centred care took place by: 1. Knowing who I am and what matters to me 2. Understanding how I feel
Dunn, 2012 Northern Arizona	Interpretive phenomenology	This study explored what kept nurses in nursing	8 students who were practising registered nurses		Open ended interviews were conducted and taped	Key findings reported included: practicing from inner core beliefs, understanding the other from within, making a difference and nursing as an evolving process. What linked the themes was intentional compassion energy.
Edwards, 1998	Anthropological interpretation	To establish the interpretation of	7 staff members 6 patients	Hospital setting	Participant observation	The findings demonstrated the

England		nurses' and patients' perceptions of the use of space and touch			Semi-structured interviews	importance of body language and positioning when conversing with patients. The study acknowledges that as a result of professional socialisation many nurses tend to keep a distance from the patient
Eisenberg <i>et al.</i> 1994 Arizona	Multi method approach	Examine prediction of adults' situational and dispositional empathy-related responses from measures of emotionality and regulation	164 participants' 82 of each sex	College setting	Questionnaires	Generally, dispositional sympathy, personal distress and perspective taking exhibited different, conceptually logical patterns of association with indexes of emotionality and regulation. Facial and heart rate (men) measure were more evocative empathy induced stimulus
Fogarty <i>et al.</i> 1999	Randomised pre-test/post-test control group design with standardised videotape intervention	The use of videotape stimulus to assess the effect of physician compassion on viewers' anxiety	210 participants 123 breast cancer survivors. 87 women without breast cancer	2 Hospital settings	State-Trait Anxiety Inventory (STAI) assessed anxiety. An information recall test. A compassion rating. Physicians attribute rating scale	The results identified that women who viewed the enhanced compassion videotape identified the physician as warmer, more caring and sensitive and compassionate than the women who saw the standard videotape. Anxiety levels were also reduced after the enhanced compassion videotape
Fry <i>et al.</i> 2013	Ethnographic multicentre study in part of a larger	Explore the extended role of emergency	16 non-participant observations	3 emergency departments	Non-participant observations	Six main themes were identified that focused on compassionate care and

New South Wales, Australia	qualitative exploratory study	nurses. Specifically focusing on their role as a compassionate carer	were conducted in 3 emergency departments			interpersonal relationships: 1. Positive body language & emotions; 2. Calming strategies for patients; 3. Negative body language. 4. Professional and personal conflict. 5. The emergency doctor and the CIN (nurse). 6. Nursing mentors and teamwork. Interpersonal relations and communication were essential to practice with compassion
Hudacek 2008 Pennsylvania	Giorgi's methodology for existential phenomenology was utilised allowing everyday experiences to be described by participants	The aim of this study was to describe the caring practices of nurses through their stories	200 nurses completed narratives from around the world including: United States, Slovakia, Tokyo, Tekrit, Argentina, Australia and Cuba	Community based care	Data was collected from nurses by asking them to describe about "one caring practice that made a difference in your life and the life process of a patient you cared for in your nursing career".	Nurses are unique care givers whose work goes beyond that of technical skill. Seven dimensions of caring in nursing were identified. 1. Caring, 2. Compassion, 3. Spirituality, 4. Community Outreach, 5. Providing Comfort, 6. Crisis Intervention and 7. Going the Extra Distance
Kret, 2011 Mineola, USA	Descriptive study	To explore the complexities of compassion, the historical roots and its effect on patient care. To allow patients' to evaluate their nurses level of compassion.	100 nurses 100 patients	Medical/surgical units in hospital	Compassion scale survey. Demographic information was also collected. Patients were asked to describe how their nurse demonstrated compassion	Patients' rated their nurse as compassionate. Compassionate qualities were deemed to be: caring, attentive, dedicated, approachable, professional and keeping the patient informed.

Lown <i>et al.</i> 2010 United States of America	Evaluation design and survey	To evaluate the impact of Schwartz Centre Rounds. This is an interdisciplinary forum that allows attendees discuss psychosocial and emotional aspects of patient care	510 physicians 800 patients	Hospital setting	Telephone surveys were utilised to investigate 3 areas: 1. The insights into psychosocial and emotional aspects of clinical care on patient interaction. 2. Teamwork. 3. Support for providers.	The majority of patients and physicians agreed that health care outcomes were dependant on effective communication and emotional support and that compassion and the elements that make up compassion were very important in care. Just over half of patients and physicians said that compassion was provided.
Olusina <i>et al.</i> 2002 Nigeria	Descriptive study	Assess the both patient and staffs perceptions in the quality of care provided in psychiatric unit	118 patients 35 staff	Hospital setting	Observations using Quality of Interaction Schedule. Questionnaires included Brief Psychiatric Rating Scale; the Patient Care Assessment Questionnaire; the Staff Assessment Questionnaire and the World Health Organisation's Quality of Life Assessment Instrument	Opinions differed between staff and patients. Patients were pleased with relationship with staff however, they felt the patients' freedom was curtailed. While staff were not satisfied with facilities (patients rated the facilities higher than staff). Patients emphasised the importance of staff empathetic qualities. The study highlights that patients were more favourable towards the hospital than the staff (staff judging hospital as professional with ideals in mind)
Perry, 2009 Canada	Descriptive phenomenology	Discover the means nurses' use to demonstrate to	7 nurses 7 students	Long-term care setting	Unstructured interviews Participant observation	The main theme nurses' recognised the need to care for the essential ordinary of older people.

		older people they are aware of their suffering and are willing to relieve or reduce it				Sub themes included attention to the little things and keeping the promise to never abandon
Proctor <i>et al.</i> 2010 UK	Observational study	To assess the applicability of a training and support programme for care staff in nursing and residential homes and to measure the effects of this programme on the quality of staff- resident interaction	12 residents 51 staff	Residential homes	Data was collected using the Quality of Interaction Tool, a non-participant observation tool. Data was collected initially to assess the baseline. At 3 months and at 6 months post the completion of the intervention.	The results of this study suggest that changes in the quality of interaction between staff and residents can be obtained by providing regular advice and support in individual care planning. Increases in resident activity suggest that a positive interpersonal relationship with staff reinforced and stimulated the residents. Increases in the frequency of positive interactions at the levels of both social and direct care indicate that the intervention was successful in helping staff to actively evaluate the skills that they bring to the care process at both these levels
Shaltout <i>et al.</i> 2012		To explore the impact of exposure to nonverbal communication of compassion	20 people		BIOPAC, electrocardiography and BIOPAC arterial pressure system measured the subject and the	The interventions were seen to significantly reduce the heart rate in the subjects

		using different time lengths and tactile versus non-tactile interventions			practitioner's heart rate, heart rate variability, respiratory rate and blood pressure	
Skea, 2007 UK		2 hypotheses were tested: The first hypothesis was that service users in the smaller day centre would receive a higher rate of interaction from staff that those in the larger centre. The second hypothesis was testing is the proportion of interaction in the smaller day centre which is of a Positive type, as opposed to the negative to neutral, will be higher in than in the larger day centre.	2 Day centres: Day centre 1 had a capacity for 50 service users. Day centre 2 had a capacity for 250 service users.	Day centres	Observation data was collected using the Quality of Interaction Tool. 20 minute observational episodes were carried out over an 8 month period in both day centres. 16 visits to each day centre occurred in the 8 months.	Findings noted an overall difference of interactions between service users and staff with higher rate of interaction in the smaller day centre
Svanstrom <i>et al.</i> 2013	Lifeworld hermeneutical approach	Clarify and gain an understanding	25 people participated. This was made	Community care setting	Interviews and conversations were used to collect data	Four themes were found: 1. An absence of the other in care.

Sweden		of elderly patients' experiences of suffering in community care. Establish the meaning of suffering caused by care	up of older adults or the spouse of a person with dementia.			2. An absence of dialogues. 3. A sense of alienation. 4. A sense of insecurity.
Torjuul <i>et al.</i> 2007 Norway	Phenomenological-hermeneutics approach	The study aimed to investigate the ethically difficult situations within surgical units for nurses'	10 female nurses	Surgical unit within the hospital	Interviews were conducted on a one-to-one bases	The main theme to emerge was being close to patients and being moved by their suffering thus experiencing compassion for patients.
Van der Cingel, 2011 Netherlands	Qualitative analysis of in-depth interviews	To gain knowledge about the benefits of compassion in relation to caring for patients in long-term care settings	30 nurses 31 older adult patients.	Residential care setting	Semi-structured interviews were conducted in 3 settings	The study found compassion to be a process of intuition and communication. 7 dimensions of compassion were identified: attentiveness, listening, confronting, involvement, helping attitude, presence and understanding. Theoretical framework has six issues: compassion & suffering, compassion & identification, the emotion of compassion, motives for compassion, conditions for compassion and moral

						significance of compassion
Wiklund Gustin & Wagner, 2013	Clinical application research Experimental and reflective	To explore participants understanding of self-compassion as a source to compassionate care	4 clinical nurse teachers	University	Hermeneutic reflection, pre-understanding, interpretation and formation of new understanding were used to generate data	The study revealed that in order to be compassionate to others one must develop a compassionate self. A compassionate self includes being sensitive, non-judgemental and respectful towards oneself
Wilkes <i>et al.</i> 2014 Australia	Descriptive method	To ascertain undergraduate nurses' perception of the essential attributes required as a professional nurse		University	Survey were utilised for data collection	Undergraduates identified six concepts Caring was the most common followed by knowledge/understanding , empathy, work, communication and skills
You <i>et al.</i> 2013 China		The purpose of this study is to evaluate the nurses resources within hospital in China and assess the link between resources and nurse and patient outcomes	9688 nurses and 5786 patient participated from 181 hospitals in China	Hospital setting	Nurses completed the Multi-State Nursing Care and Patient Safety Study questionnaire. While the Consumer Assessment of Healthcare Providers and Systems was completed by patients	

Appendix 3: Studies on Person-Centredness

Study	Design	Purpose	Sample	Setting	Data Collection	Key Findings
Abrahamse <i>n et al.</i> 2014 Denmark	A cross-sectional cohort design	To assess the patient perspective on the importance of, preference for and experience of participation	1173 patients	Inpatients and outpatients in a hospital setting	Questionnaire with 117 items concerned with patient care pathways including: the perceived adequacy of information; preference for participation; attitude to importance of participation and the perceived participation	A large number of patients wished to be consulted in the decision making process with more than half then leaving the decision to the staff. Just less than three quarters of participants experienced participation. Of the patients who received the required information to make a decision themselves over half did not want to make that decision themselves. A mismatch was noted in patients who did not want to participate in decision and yet were still induced by staff
Balbale <i>et al.</i> 2014 USA	Qualitative design using photovoice	To use photovoice to examine health care employees perceptions and experiences of person-centred care	12 staff	2 Healthcare facilities	Semi-structured interviews and photographs	Three themes were identified including: individual, environmental and system levels. Staffs in general were satisfied with the work environment and experiences but identified areas for improvement. Staff felt there was a great need for more health and wellness care for employees and a need for further training and professional growth
Bastiaens <i>et al.</i> 2007 EU	Qualitative design	To explore the preferences of older people on the involvement	406 patients	General practices	Semi-structured interviews	Four categories were identified 1. The doctor-patient interaction. This was seen

		in their own care in 11 EU countries				<p>as an important aspect of patient involvement. Three themes emerged:</p> <p>1. communication/information, the relationship and decision making.</p> <p>2. GP related issues. It was felt that GP's need to facilitate patient involvement through positive attitude and enabling.</p> <p>3. Patient related issues. Age related issues including forgetfulness, poor sight, hearing and mobility can complicate patient involvement. Low education was also seen to inhibit certain patients. With some patients choosing not to be involved in care.</p> <p>4. Contextual factors. Time spent with patients was an important factor and was seen to help older people gain a better understanding. Shorter times with the GP were seen as a barrier to actively participate in care.</p>
<p>Bruus <i>et al.</i> 2011</p> <p>Estonia</p>	A cross-sectional design	To describe the assessment of older adult about patient-centredness in long-term care units and to	111 patients	Long-term care units in hospitals	Structured interview using the Client-Centred Care Questionnaire	<p>Patients' assessment: Patients felt on a whole that they were given the opportunities to do the activities they were capable of doing themselves. Two thirds of patients felt they</p>

		determine the correlations between the patients' assessment and their socio-demographic details				had not been sufficiently consulted on who would provide their care. Most patients felt their personal wishes were addressed, that they were listened to, and their emotional needs were understood. Just under half the patients felt they did not have the opportunity to decide what kind of care they need and how it would be received. The more assistance the patient required from staff the less they considered their care person-centred
Clarke <i>et al.</i> 2003 UK	Collaborative approach using practice development	To explore if a biographical approach using story telling can encourage person-centred practice		A unit within an NHS hospital	Focus groups were carried out with staff. Interviews were conducted with patient and relatives pre and post the project	The findings revealed that practitioners were encouraged to see the person behind the patient by using a biographical approach. It also identified that it assisted to build and strengthen relationships with patient and their relatives. Practitioners acknowledged the limitations of using such an approach
Coleman and Medvene 2013 USA	A wait-list control design	To increase certified nursing assistants' awareness of person-centred care using	19 nursing assistants' 19 residents	Nursing homes	Data was observed and recorded using a videotape. All staff observations were coded	Results demonstrated that residents' perception of relationship closeness increased significantly following training from nursing assistants'. Changes were also noted in

		training			using one of two tools the Person-centred Behaviour Inventory and the Global Behavioural Scale. Residents completed a subscale of the Residents Satisfaction Index (Relationships with staff), a subscale of the Maslach Burnout Inventory (Personal Accomplishment) and the Mutuality Scale	the nursing assistants' perception of satisfaction and closeness and resident satisfaction indicating that this type of training intervention needs further research
Dilley & Geboy 2010	Qualitative narrative design	To explore staffs perception on the implementation of person-centred care in an adult dementia day centre and to examine if any changes have affected the staff experiences	21 staff	Adult dementia day centre	Semi-structured/open ended interviews	Staff view person-centred care positively and believe it supports participants' well-being. Three stages were noted 1. Changes in external/professional perspectives. 2. Process perspectives. 3. Pattern of internal/personal perspectives. External/professional perspectives revealed Three themes "It's not about efficiency", "Every day is different" and

						<p>working together looks at staff relationships.</p> <p>The process perspective found three themes also “A leader vs a boss”, “We’re in this together” and “The reason why I’m here today”.</p> <p>Overall it demonstrates that person-centred care replaces the traditional model of care.</p>
<p>Edvardsson <i>et al.</i> 2010</p> <p>Australia</p>	<p>Qualitative explorative design</p>	<p>To describe the content of person-centred care from the perspectives of people with dementia, family members and staff in residential care settings</p>	<p>37 staff 11 people with dementia 19 family members</p>	<p>Residential care settings Respite facility Café connected with a support group for Alzheimer’s</p>	<p>Interviews and focus groups were used to collect data</p>	<p>The main findings suggest that the person-centred care was promoting a continuation of self and normality. Within this five categories emerged including: knowing the person; welcoming the family; providing meaningful activities; being in a personalised environment; and experiencing flexibility and continuity</p>
<p>Epstein <i>et al.</i> 2005</p> <p>New York</p>	<p>An observational cross-sectional design</p>	<p>To examine the relationship between patient-centred communication and diagnostic expenditures</p>	<p>100 primary care physicians</p>	<p>Physician practices</p>	<p>Audio recordings of clinical encounters were rated with the Measure of Patient-Centred Communication (MPCC) Patient surveys</p>	<p>Physicians were compared in terms of their Measure of Patient-Centred Communication and those who scored in the lowest section had greater standardised testing expenditures. In comparison to lower scores on the rating system which was associated with shorter visits, adjustment for visit</p>

						length and standardised patient detection did not affect the relationship with expenditures. Total expenditures were also higher for physicians who scored lower on the rating scale Patient-centred communication is associated with fewer diagnostic testing expenditures but also with increased visit length
Ferguson <i>et al.</i> 2013 Canada	Interpretive descriptive qualitative study design	To explore the patients experience of person-centred care and their role in interprofessional teams	18 patients	Acute medical ward within a hospital	Interviews with patients. At times family members were present for the interview and participated	Patient expectation of care varied. Five themes emerged surrounding patient expectations, satisfaction with the quality and patients involvement in care. 1. Patients wished to feel valued and respected. 2. Trust between patients and healthcare professionals was vital for a positive relationship. 3. Effective communication of necessary information. 4. Patients perceived the team relationship existed primarily with the physician (although other professionals were acknowledged. 5. Around half of the patients expressed

						satisfaction with care. Issue surrounding communication with and amongst healthcare professionals were identified. Younger patients indicated they were more assertive in attaining information and decision making with healthcare professionals.
Fiscella <i>et al.</i> 2004 New York		To assess if patient trust is associated to patient-centred behaviour of primary care physicians	100 physicians 4746 patients	Physician practices	The Measure of Patient-Centred Communication (MCP) scale was used to assess physicians' behaviours. The Primary Care Assessment Survey was distributed to patients	The section of the MCP scale surrounding patient experience of disease and illness was independently associated with patient's rating of trust for their physician. For every additional minute spent with the physician patients' trust was seen to increase. Physician verbal behaviour during an encounter is associated with trust reported by patients
Gnaedinger 2003 Canada	An exploratory, qualitative design	To explore front line workers experience of implementing resident-centred dementia care	8 practice leaders 30 staff	Residential care setting	In-depth interviews were held with practice leaders. Focus groups were conducted with staff from four long-term care units	Five key barrier were identified on the full implementation of resident-centred dementia care: workload , resistance to change at all levels, operational realities, resident characteristics and the design and scale of the built environment Success identified from this study include: higher staff-to-resident ratios,

						effective leadership, formal involvement of front line staff in decision making, continuous education and training for staff and more flexibility in staff scheduling
Holmström & Röing 2010	Concept analysis approach	To explore the relation between patient-centredness and patient empowerment				Patient-centredness can be the goal of encounters between patients and healthcare professionals. It facilitates patient empowerment.
Hughes & Goldie 2009 Northern Ireland	Qualitative study design	To assess adherence to medication and residents involvement in prescribing and decision making with regards to medicines in nursing home setting	9 nurses 8 GP's 17 residents	Nursing homes	Semi-structured interviews with GP's and residents. Focus groups with nurses	The key theme was control. Control was required to ensure resident safety, quality and continuity of care. Residents accepted this control without asking questions. Residents had little say in prescribing or administering their own medications. Healthcare professionals acknowledged more involvement by residents would increase resident autonomy and empower they were concern about how it would affect the control within the nursing home
Jackson <i>et al.</i> 2001	Quantitative design	To determine predictors of patient	500 adult patients	General medicine walk in clinics	Patients completed 3 surveys at 3	Results demonstrated that over half the patients were completed satisfied with

US		satisfaction			<p>times points. Pre visit patients completed: patient symptom characteristics, symptom-related expectations and Health Survey [SF-6]), mental disorders (PRIME-MD). Immediately post visit patients completed: functional status (Medical Outcomes Study Short-Form Two week and three months later patients completed: symptom resolution, unmet expectations, satisfaction (RAND 9-item survey), visit costs and health utilization. Prior to study participation, physicians completed the Physician Belief Scale. After</p>	<p>their care immediately post visit. That number increased at 2 weeks and 3 months. Older patient (over 65) who has better functional status were most likely to be satisfied. Unmet expectations were seen to decrease satisfaction throughout. Information given to patients was seen to increase satisfaction. Communication was seen as important</p>
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					each patient visit, physicians completed the Difficult Doctor Patient Relationship Questionnaire	
Kvåle & Bondevik 2008 Norway	Giorgio's scientific approach to phenomenology	To gain an insight of the perceptions of patients' with cancer of the importance of being respected as a partner in care and shared control decisions of their health problems and their reasoning behind their wishes	20 patients	Hospital setting	Interview	Three themes were identified from the data, 1. Empowerment, patients' wished to be respected, listened to, given honest information and be valued. 2. Shared decision making about treatment, patients' wished to be asked for their opinion, have information about the treatment but the majority of patients opted to let the doctor make the final decision as they were the professional with the expertise. 3. Partnership in nursing care, patients' wished to partake in decision regarding their daily life and care. Patients' revealed they felt closer to nurses than doctors and saw the nurse as more of a partner
Lehuluante <i>et al.</i> 2012 Sweden	Cross-sectional explorative study	To describe nurses satisfaction with care and work and explore the extent to which	206 nurses	Hospital setting	Two questionnaires were distributed: Satisfaction with Nursing Care and Work Assessment	It was found that 62% of the respondents agreed that they were either very satisfied or satisfied with care and work. However, as indicated in Table 2, there was a

		a person-centred unit climate influenced this satisfaction.			Scale; The Person-Centred Climate Questionnaire-Staff version	statistically significant difference in job satisfaction depending on length of work experience. Participants reporting more than 9 years of experience as nurses were more satisfied than those who had 9 years or less. It was also found that the total PCQ-S score was significantly associated with nurses' satisfaction with care and work. Furthermore, all three subscales of the PCQ-S were significantly associated with nurses satisfaction with care and work
Little <i>et al.</i> 2001 UK	Quantitative design	To assess patient preference for patient-centred consultations in general practice	865 patients	General medical practices	Pre and post questionnaires	Three domains were highlighted as important: communication, partnership and health promotion
Marshall <i>et al.</i> 2012 Australia	Qualitative research study grounded in phenomenology	To explore patients' experiences of the care they receive and their opinion on what person-centred care means to them in hospital setting	10 patients	Surgical ward within a hospital	Interpersonal interviews were conducted with patients	Data revealed that patients can assign meaning to PCC although they lacked familiarity with the term. Two key themes emerged 1. Staff and 2. Systems. The theme staff had 3 subthemes: being attentive; making an effort and connectedness. It also identified that patients generally did not

						<p>distinguish between different professions within the hospital.</p> <p>The theme systems highlighted a negatively view with issues impacting on the patients' experience and the staff. The 3 subthemes were:</p> <p>Resources; culture and waiting.</p> <p>When asked what patients want they looked to be involved, for staff to be attentive and for connection with staff that is based on them being a person as opposed to a patient</p>
<p>McKeown <i>et al.</i> 2010</p> <p>UK</p>	<p>Multiple case study design within a constructivist approach</p>	<p>To investigate how life story work is: understood and developed in practice; experienced by participants and how it affects the delivery and outcomes of care for patients with dementia</p>	<p>4 patients 3 relatives 5 nurses 2 support workers 2 OT assistants 1 student nurse</p>	<p>NHS hospital</p>	<p>Semi-structured interviews were conducted with key stakeholders. Observations and conversations took place with the patients'.</p>	<p>The findings highlighted that using life work can increase person-centred care for patients with dementia across a range of themes. These included from patient to person (seeing the person behind the dementia patient); can you hear me? (providing a voice for the person with dementia to be heard; and pride and enjoyment (pride was seen from the person with dementia enjoying sharing their story and enjoyment was noted by staff and family having participated in the</p>

						development of the patients life story work
Norheim & Guttormsen 2012 Norway	Qualitative focus group design	Identifying staff's experience with factors that influence patient involvement in nursing homes	16 participants including nurses, nursing assistants, physiotherapists and an occupational therapist.	Nursing homes	3 focus groups were established and focus group interviews were conducted lasting from for up to one and half hours	Two main areas were acknowledged as factors including: Attitudes and environmental conditions. Staff attitudes incorporated values, assessment ability, consciousness raising, knowledge enhancement, role modelling and clarification of responsibilities. The environment conditions included, team work, continuity, structural conditions, cooperation with next of kin and time pressures when factoring in patient involvement in care within nursing homes
Olusina <i>et al.</i> 2002 Nigeria	Descriptive study design	To explore how patient and staff satisfaction within an acute admission psychiatric unit	35 staff 118 patients	Acute admission psychiatric unit	Items used to collect data included: The Brief Psychiatric Rating Scale The Patient Care Assessment Questionnaire The Staff Care Assessment Questionnaire The WHO's Quality of Life Assessment Instrument (short version)	Patients were unhappy with items that involved restricting their freedom, whilst, staff were not happy with the physical facilities for care. The relationship between the staff and patient was rated highest satisfaction. Other issues identified included time spent with doctors by patients. Patients also rated the care facilities higher than staff

					Quality of Interaction Schedule	
Parlour <i>et al.</i> 2014 Ireland	A cross-sectional survey design	To examine the relationship between patients' perceptions of person-centredness and their experiences of care.	354 patients	Acute hospital setting	Two questions were used to collect data from patients: The Picker Patient Experience Questionnaire The Person-Centred Climate Questionnaire-patient version	A significant portion of patients felt they were treated with dignity and respect during their admission. A moderate positive and significant relationship was identified between patients' perceptions of person-centred climate and patient experiences. A higher score of person-centredness was seen to have indicated a more positive patient experience. Yet, almost half of the patients surveyed expressed a wish to be more involved in decisions about their care and treatment.
Poochikian-Sarkissian <i>et al.</i> 2010 Canada	Descriptive correlation design with repeated measures	To examine the degree to which staff nurses provide person-centred care from a staff and patient perspective. And to review the relationship between the implementation of PCC and patient	63 nurses 44 patients	Cardiology, neurology/neurosurgery and orthopaedic units	Nurses completed an adapted version of the Patient-Centred Comprehensive Care subscale for Individualised Care Index (individualised care) and 5 questions surrounding patient	The result of staff engagement in PCC was seen to be a moderate extent by both staff and patients. Different aspects of PCC are moderately associated with patient outcomes including self-care and satisfaction with care. Patients viewed individualised care as important and identified that participation in their

		outcomes in acute hospital setting			participation in care. Patients answered a subscale of the Medical Outcome Study-Short Form 36 (functional status), the Therapeutic Self-Care scale (self-care) and the a subscale of the Patient Judgment of Hospital Quality Questionnaire (satisfaction with care).	care was limited. Overall this paper acknowledges that the implementation of PCC can be expected to improve patient outcomes (by increasing self-caring ability, improving satisfaction and quality of life)
Rademaker <i>et al.</i> 2012 Netherlands		To explore education inequalities on person-centred care, and what patients' preferences and experiences are	1009 patients		Consumer-quality Index questionnaires	Education level was directly related to how important person-centred care was perceived. All patients rated PCC as important and related it to positive experiences. Less educated may receive too much PCC in comparison to higher educated patients in terms of communication, information and shared decision making
Ross <i>et al.</i> 2014 UK	Action research approach	To understand and achieve person-centred care from the nurses	14 nurses	Acute medical ward in hospital	Semi-structured interviews were conducted individually and in groups	Section 1 reviewed what staff understood as PCC. A good understanding was demonstrated identifying important aspects

		perspective in an acute care setting				including: Attention to detail and knowing the patients person identity. Section 2 developed three themes: Characteristics of relationships, personal qualities of staff and principles of PCC. Relationships and communication were emphasised as being important. Staff felt that being friendly and approachable allowed a relationship to develop and that flexibility was necessary. PCC was seen as vital for high standards of care but it was acknowledged that it is challenging within an acute setting
Sidani 2008 Canada	A non-experimental repeated measure design	To examine patients' perception of on the effects of patient-centred care on patient outcomes	320 patients	Acute medical and surgical wards within the hospital setting	The Medical Outcomes Study Short-Form (SF-36) subscale was used to assess functional status. Self-care ability was assessed with the Therapeutic Self-Care scale. The Satisfaction with Hospital subscale of the Patient Judgement	Patient perceived that acute care nurse practitioners provided PCC. Patients felt they were encouraged to participate in their own care and the decision involved in their care to a moderate extent. They reported individualised care to a moderate level. The use of PCC was seen to be associated positively with self-caring abilities and satisfaction with care

					Hospital Quality Questionnaire was used to measure satisfaction with care	
Simmons <i>et al.</i> 2014 USA	Mixed method design	To examine how staff and family value and recognise residents choice during daily care for residents	17 nurse aides 15 family	Residential setting	Video vignettes were played in pairs each highlighting a certain active within the average day. One video demonstrated choice whilst the second video did not. A Forced-choice questionnaire was then completed asking participants which interaction they preferred. Focus groups were held with each group	Staff and family rated the video footage with choice as “strongly” preferred over the video without choice. Resident well-being, sense of control and the respondents’ own personal values were highlighted as the reasoning for choosing the choice option
Sjögren <i>et al.</i> 2014 Sweden	Cross-sectional quantitative design	Explore the relationship between staff characteristics, perceived work environment and person-centred care in residential aged	1169 staff	Residential aged care settings	3 Surveys were distributed with 151 residential units being included. The Person-centred Care Assessment Tool,	Higher levels of person-centred care were associated with higher levels of staff satisfaction and supportive psychosocial unit climate and lower levels of job strain and stress of conscience. Having

		care units			the Person-centred Climate Questionnaire-Staff version and the Satisfaction with Nursing Care and Work questionnaire were utilised within the study	completed education in dementia also increased person-centred levels. Work environment appears to impact on PCC
Sjögren <i>et al.</i> 2013 Sweden	Cross-sectional design	Aims to explore the relationship between person-centred care and several factors including: ability to perform activities of daily living; quality of life; levels of pain; depressive symptoms and agitated behaviours with residents diagnosed with dementia within a residential care setting	1169 staff 1261 residents with dementia	Residential care setting	The following tools were used to gather data: Person-centred Care Assessment Tool Quality of Life in Late Stage Dementia The Pain Assessment in Advanced Dementia Scale of Depression in Dementia Cohen-Mansfield Agitation Inventory Multi-Dimensional Dementia Assessment Scale Geriatric Rating Scale	Correlations were noted with higher person-centred care and abilities to perform activities of daily living. Furthermore residents with higher PCC also rated having a higher quality of life in comparison to residents with lower levels.
Steinberg <i>et</i>	Qualitative	To assess and	5 students	Residential care	Interviews	Both students and lectures

<i>al.</i> 2013	design	compare student and lectures perspectives on person-centred care in Edinburgh and the Netherlands	3 lectures	facilities		believed that person-centred care should be incorporated within pre-registration nurse education
Suhonen <i>et al.</i> 2005 Finland	Cross-sectional, descriptive, correlation survey design	To describe individualised care from the patient viewpoint and to examine the association between individualised care and satisfaction with nursing care and health-related quality of life	279 patient	Surgical wards within the hospital setting	Questionnaires used included: Individualised Care Scale, Patient Satisfaction Scale, Nottingham Health Profile, EuroQol 5D	Findings showed that individuality was supported through certain nursing activities. They also show that the more individualised the patient care was the higher the level of patient satisfaction with the care. Patients were least satisfied with their information needs.
Suhonen <i>et al.</i> 2011 Europe	A cross-sectional comparative survey design	Compare patients' and nurses' perceptions of individualised care in five EU countries (Czech Republic, Cyprus, Finland, Greece and Hungary)	960 nurses 1315 patients	Surgical wards within the hospital	The question Individualised Care Scales for Nurse and for Patient were distributed to nurses and patients	Differences were noted between each country from a nurse and patient viewpoint of individualised care. Nurses, compared to patients, revealed that they supported patient individuality more often. The overall picture highlights the care provided was individualised.
Train <i>et al.</i> 2005	Qualitative design	To examine the experiences of	30 staff 21 residents	Long stay psychiatric hospital wards and	Open semi-structured	Five main themes were highlighted: Privacy and

UK		long-term care for residents with dementia, their relatives and staff	17 relatives	nursing homes	interviews	choice; relationships (abuse and vulnerability); activities; physical environment and expectations of a care environment by carers.
Whittington & McLaughlin 2007 Northern Ireland		To assess the portion of time that psychiatric nurses spend in one-to-one communication with patients	20 nurses	Psychiatric hospital	Observations using Nurses' Daily Active Recording System	Less than half of the working day for nurses was spent with patient contact. Psychotherapeutic interactions were only occurred for a very small few patients
Wilson & Neville 2008 New Zealand	A secondary analysis of two studies	To explore the nature of nursing practice working with vulnerable and marginalised populations from the findings of two studies whilst considering holism and individualised care	Study 1: 20 data sources Study 2: 38 data sources			The findings highlighted that healthcare is delivered in a problem focussed approach. Individualised care was not incorporated in care and the social background of a person's life was not incorporated. Thus leading one to believe that holistic nursing is a rhetorical construct
Wolf <i>et al.</i> 2008 USA	A clinical randomised study (post-test design)	To examine whether patient-centred care impacts on patient satisfaction, perception of nursing care and quality of care	36 patients	Surgical (Gastro bypass) ward within the hospital	Control group of 18 patients and an intervention group of 18 patients were defined. Instruments used to collected data included: The Baker and Taylor	The person-centred care group rated satisfaction and quality of services higher than controls. PCC can potentially impact on patients perception of care received

					Measurement Scale (patient satisfaction); Quality of care was defined as a hospital admittance that lacked the occurrence of infections or falls and that was over 3 days. The Schmidt Perception of Nursing Care Survey was utilised for the perception of nursing care. Structured interviews were conducted pre and post discharge interviews	
Woolhead <i>et al.</i> 2004 UK	Qualitative design	To explore the concept of dignity from the older adults perspective	72 participants		Focus groups Interviews	Findings demonstrated strong evidence that dignity was salient to the concerns of older adults. Data collected found it was a multifaceted with three major themes. 1. Dignity of identity (self-respect/esteem, integrity, trust). 2. Human rights (equality, choice). 3. Autonomy

						(independence, control). Participants acknowledged that dignity may be in jeopardy rather than being enhanced.
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Appendix 4: WIT Ethical Approval Letter

Port Láirge, Éire.
T: +353-51-302000
info@wit.ie

Waterford, Ireland.
T: +353-51-302000
www.wit.ie



Ref: 13/NUR/04

18th November, 2013.

Ms. Fiona Kelly,
Gaulsmills,
Kilmacow,
Co. Kilkenny.

Dear Fiona,

Thank you for bringing your project '*An exploration of compassion in care in the older adult care setting using case study design*' to the attention of the WIT Research Ethics Committee.

I am pleased to inform you that we fully approve WIT's participation in this project and we will convey this to Academic Council.

We wish you well in the work ahead.

Yours sincerely,

Prof. John Wells,
Chairperson,
Research Ethics Committee

cc: Dr. Suzanne Denieffe
Ms. Miriam Cass

Appendix 5: HSE Ethical Approval Letter



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE South
Waterford Regional Hospital
Dunmore Road
Waterford
Ireland

Telephone 051 848611
Fax 051 848612

RESEARCH ETHICS COMMITTEE.
HEALTH SERVICE EXECUTIVE, SOUTH EASTERN AREA

8th January 2014

Ms. Fiona Kelly, R.G.N.
Room G03, Department of Nursing
O'Connell Bianconi Building
Waterford Institute of Technology
Cork Road
Waterford

Re: An exploration of compassion in care in the older adult care setting using case study design

STUDY STATUS: APPROVED

Dear Ms. Kelly

The Research Ethics Committee, HSE, South East reviewed the above study at their meeting on 9th December 2013.

The following documents were reviewed and approved:

1. Standard R.E.C. Application Form
2. Research Proposal Form
3. Interview Schedule Form
4. Quality of Interaction Schedule Observation Sheet
5. Participant Information Sheet (For Advocates, Patients/Relatives, Patients/Visitors, Staff)
6. Consent Form for Observations, Advocates.
7. Letter to Director of Nursing requesting permission to access the staff/site.
8. Letter requesting use of QUIS tool.
9. Letter granting use of QUIS tool
10. Patient Centered Climate Questionnaire – Patient Version

The following documents were received:

1. C.V. of Principal Investigator – Ms. Fiona Kelly
2. Signed hard copy of Declaration
3. C.I.S.

Please notify the Research Ethics Committee Office, Old School of Nursing, Waterford Regional Hospital on completion of Research.

Yours sincerely,



Ms Caroline Lamb
A/Research Ethics Committee Coordinator
Health Service Executive, South Eastern Area

The Research Ethics Committee, HSE, South East is a recognized Ethics Committee under Regulation 7 of the European Communities (Clinical Trials on Medicinal Products for Human use) Regulations 2004 and as such is authorized to undertake ethical review of clinical trials of all descriptions and classes for the Republic of Ireland.

The Research Ethics Committee, HSE South East issues ethical approval on the basis of information provided. It is the responsibility of the researcher to notify the Research Ethics Office of any changes to a study to ensure that the approval is still relevant.

Appendix 6: Letter Seeking Permission to the Director of Nursing

Dear

XX,

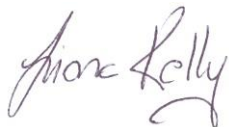
I am writing to you to request permission to carry out a research project titled “An exploration of compassion in care in the older adult care setting” in XXXX Hospital as previously discussed.

I am currently carrying out a Masters by research in the Waterford Institute of Technology, Ireland in the area of compassionate care and would be extremely interested in using your facility to conduct my research. The research would look at the observed care delivery, professionals’ quality of life and person centeredness from both the staff and patients perspectives.

I would really appreciate your hospitals involvement in this project. Please contact me if you have any questions or concerns.

I look forward to your response.

Yours sincerely,

A handwritten signature in cursive script that reads "Fiona Kelly". The ink is dark and the signature is fluid and legible.

Fiona Kelly,
Postgraduate Research Student,
Department of Nursing,
Waterford Institute of Technology.

Appendix 7: Letter Granting Access from Director of Nursing



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

16th October 2013

Dear Miss Kelly,

Thank you for your letter received today.

I am pleased you are undertaking such a beneficial research project I am happy to confirm access to the hospital. I am delighted for the research to take place at XXXX Hospital and wish to extend hospital managers consent. This consent is given provided it complies with ethical regulations for research with patients and staff in XXXX Hospital as previously discussed.

I welcome you and hope to support your work in the area of compassionate care. I understand the research would look at the observed care delivery, professionals' quality of life and person centeredness from both the staff and patients perspectives. I acknowledge fully the access required to the hospital and it alignment in progression of the project.

Sincerely

XXXXXX

Director of Nursing

Appendix 8: Information Sheets for Staff

Information Sheet for Observations

Study: An Exploration of Compassionate Care in the Older Adult Care Setting.

This study is being carried out to explore compassionate care in an older adult care setting. It will look at the interactions between healthcare professionals and the patients and visitors (if applicable). The findings of the research may have the potential to help identify ways to improve the delivery of compassionate care in older adult care settings.

This study is funded by the HSE and is supported by hospital management in XXXX Hospital.

Observation will be used to collect information for this study. Observations undertaken will be carried out by Fiona Kelly. I will be observing the nurses and healthcare assistants' interactions with patients and visitors (if applicable) for short periods of time (15-20 minutes) throughout the day. Observations will take place in common areas. Activities being observed include: Meal times (breakfast, lunch & dinner); Report; Personal care of patients; Activities times. At no point will the observer enter into an area where the patient's privacy will be invaded.

Signs will be displayed in the ward to make people aware that observations are in progress.

At no point will the observer be allowed into an area that will invade the, patients or visitors privacy.

Your participation in this study is voluntary. If at any stage you want to withdraw your consent from the study you are free to do so.

If you have any further questions, please contact us on the details below.

Fiona Kelly

Dr Suzanne Denieffe

Poor Practice Guidelines

HSE Protecting Older People from Abuse (Health Service Executives, 2013)

Elder abuse is defined as -"a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person or violates their human and civil rights." (Protecting our Future, 2002, p. 25)(p. 25). 65 years of age is taken as the point beyond which abuse may be considered to be elder abuse.

There are several forms of abuse, any or all of which may be carried out as the result of deliberate intent, negligence or ignorance. Physical abuse, including hitting, slapping, pushing, kicking, misuse of medication, restraint or inappropriate sanctions.

Sexual abuse, including rape and sexual assault, or sexual acts to which the older adult has not consented, or could not consent, or into which he or she was compelled to consent.

Psychological abuse, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.

Financial or material abuse, including theft, fraud, exploitation, pressure in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Neglect and acts of omission, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life such as medication, adequate nutrition and heating.

Discriminatory abuse, including ageism, racism, sexism, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

If any of the above are noted during the study the researcher will report directly to the Director of Nursing in XXXX Hospital.

Information Sheet for Questionnaires

Study: An Exploration of Compassionate Care in the Older Adult Care Setting.

This study is being carried out to explore compassionate care in an older adult care setting. It will look at nurses and healthcare assistants' quality of life and person-centeredness. The findings of the research may have the potential to help identify ways to improve the delivery of compassionate care in older adult care settings.

This study is funded by the HSE and is supported by hospital management in XXXX Hospital.

If you wish to take part in this study you will be asked to complete two anonymous questionnaires, the Person-Centred Climate questionnaire and the Professional Quality of Life Scale questionnaire. All questionnaires completed will be anonymous.

You can return the questionnaire in the sealed envelope provided into the sealed box that will be located on each ward.

Your participation in this study is voluntary. If at any stage you want to withdraw your consent from the study you are free to do so.

If you have any further questions, please contact us on the details below.

Fiona Kelly

Dr Suzanne Denieffe

Appendix 9: Information Sheets for Patients/Nominated Relatives

Information Sheet for Observations

Study: An Exploration of Compassionate Care in the Older Adult Care Setting.

This study is being carried out to explore compassionate care in an older adult care setting. It will look at the interactions between healthcare professionals with the patients and visitors (if applicable). The findings of the research may have the potential to help identify ways to improve the compassionate care in all older adult care settings.

This study is funded by the HSE and is supported by hospital management in XXXX Hospital.

Observation will also be used to collect information for this study. Observations will only be carried out by Fiona Kelly. I will be observing nurses and healthcare assistant's interactions with patients and visitors (if applicable) for short periods of time (15-20 minutes) throughout the day. Observations will take place in common areas. For example: the dining area, the general room, the staff meeting room and main wards. At no point will the observer be allowed into an area where the patient's privacy will be invaded. Signs will be displayed in the ward to make people aware that observations are in progress.

If you have any further questions, please contact us on the details below.

Fiona Kelly

Dr Suzanne Denieffe

Information sheet for Questionnaire

Study: An Exploration of Compassionate Care in the Older Adult Care Setting.

This study is being carried out to explore compassionate care in an older adult care setting. It is funded by the HSE and is supported by hospital management in XXXX Hospital. The findings of the research may have the potential to help identify ways to improve the delivery of care in older adult care settings.

If you wish to take part in this study you will be asked to complete a Person-Centred Climate questionnaire. All questionnaires completed will be anonymous.

You can return the questionnaire in the sealed envelope provided into the sealed box that will be located on each ward.

Your participation in this study is voluntary. If at any stage you want to withdraw your consent from the study you are free to do so.

If you have any further questions, please contact us on the details below.

Fiona Kelly

Dr Suzanne Denieffe

Appendix 10: Quality of Interaction Schedule

The Quality of Interaction Schedule (QUIS) Observation Sheet (developed by Dean, R. et al., 1993)

Time	Interaction	Code	Verbal/Non Verbal	Between	Events

Reference: Dean, R., Proudfoot, R., & Lindsay, J. 1993, "The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units", *International Journal of Geriatric Psychiatry*, vol. 8, pp. 819-826.

Appendix 11: Professional Quality of Life Scale

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009)

Instructions for use:

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper].

Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

How frequently I experience these feelings in the last 30 days.		Ne ver	Rarel y	Someti mes	Oft en	Very Often
		1	2	3	4	5
1.	I am happy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	I am preoccupied with more than one person I [help].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	I get satisfaction from being able to [help] people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	I feel connected to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	I jump or am startled by unexpected sounds.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	I feel invigorated after working with those I [help].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	I find it difficult to separate my personal life from my life as a [helper].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	I think I might have been affected by the traumatic stress of those I [help].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	I feel trapped by my job as a [helper].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How frequently I experience these feelings in the last 30days.	Ne ver 1	Rarely 2	Someti mes 3	Oft en 4	Very Often 5
11. Because of my [helping], I have felt “on edge” about various things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I like my work as a [helper].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I feel depressed because of the traumatic experiences of the people I [help].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I feel as though I am experiencing the trauma of someone I have [helped].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I have beliefs that sustain me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I am pleased with how I am able to keep up with [helping] techniques and protocols.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I am the person I always wanted to be.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. My work makes me feel satisfied.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I feel worn out because of my work as a [helper].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I have happy thoughts and feelings about those I [help] and how I could help them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I feel overwhelmed because my case [work] load seems endless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How frequently I experience these feelings in the last 30 days.	Never 1	Rarely 2	Sometimes 3	Often 4	Very Often 5
22. I believe I can make a difference through my work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. I avoid certain activates or situations because they remind me of frightening experiences of the people I [help].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. I am proud of what I can do to [help].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. As a result of my [helping], I have intrusive, frightening thoughts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. I feel “bogged down” by the system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. I have thoughts that I am a “success” as a [helper].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. I can’t recall important parts of my work with trauma victims.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. I am a very caring person.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. I am happy that I chose to do this work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

© B. Hudnall Stamm, 2009. *Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL)*. /www.isu.edu/~bhstamm or www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.

Appendix 12: Person-Centred Climate Questionnaire-Staff version

The Person-centred Climate Questionnaire – Staff version (PCQ-S)

Instructions for use:

This questionnaire aims to measure the extent to which the psychosocial environment of a health care setting is perceived as being person-centred. The questionnaire provides 14 statements for which you are asked to agree or disagree by ticking the most appropriate box. Please respond to all statements.

I experience this ward as:	No, I disagree completely	No, I disagree	No, I partly disagree	Yes, I partly agree	Yes, I agree	Yes, I agree completely
	0	1	2	3	4	5
1. A place where I feel welcome.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. A place where I feel acknowledged as a person.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. A place where I feel I can be myself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. A place where patients feel safe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. A place where staff talk to patients so that they can understand.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. A place which feels homely.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. A place that has something nice to look at (e.g. views, artwork etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. A place where it is quiet and peaceful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I experience this ward as:	No, I disagree completely 0	No, I disagree 1	No, I partly disagree 2	Yes, I partly agree 3	Yes, I agree 4	Yes, I agree completely 5
9. A place where it is possible to get unpleasant thoughts out of your head.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. A place which is neat and clean.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. A place where it is easy for patients to keep in contact with their loved ones.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. A place where it is easy for patients to receive visitors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. A place where it is easy for patients to talk to staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. A place where patients have someone to talk to if they so wish.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Appendix 13: Person-Centred Climate Questionnaire-Patient version

The Person-centred Climate Questionnaire – Patient version (PCQ-P)

Instructions for use:

This questionnaire aims to measure the extent to which the psychosocial environment of a health care setting is perceived as being person-centred. The questionnaire provides 17 statements for which you are asked to agree or disagree by ticking the most appropriate box. Please respond to all statements.

I experience this ward as:	No, I disagree completely	No, I disagree	No, I partly disagree	Yes, I partly agree	Yes, I agree	Yes, I completely agree
1. A place where staff are knowledgeable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. A place where I receive the best possible care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. A place where I feel safe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. A place where I feel welcome.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. A place where it is easy to talk to staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. A place where staff takes notice of what I say.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. A place where staff come quickly when I need them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. A place where staff talk to me so that I can understand.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. A place that is neat and clean.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. A place where staff seem to have time for patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I experience this ward as:	No, I disagree completely	No, I disagree 1	No, I partly disagree 2	Yes, I partly agree 3	Yes, I agree 4	Yes, I agree completely 5
11. A place that has something nice to look at (e.g. views, artwork etc).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. A place that feels homely.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. A place where it is possible to get unpleasant thoughts out of your head.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. A place where people talk about everyday life and not just illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. A place where staff make extra efforts for my comfort.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. A place where I can make choices (e.g. what to wear, eat etc).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. A place where I can get that 'little bit extra'.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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