Doctorate Studies

Cultivating compassion in nursing: A grounded theory study to explore the perceptions of individuals who have experienced nursing care as patients

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ABSTRACT

Although compassion is considered integral to nursing, the ongoing reality of this traditional philosophy has been challenged due to emerging patient reports of care experiences reflecting a lack of compassion. Political and professional guidance reaffirms compassion as an enduring philosophy of contemporary nursing practice, but provides limited insight into what compassion involves. To address this knowledge gap, a constructivist grounded theory study was undertaken with eleven participants who had experienced nursing care as patients across a range of contexts, exploring what they perceived compassion to involve. Theoretical sampling supported data collection via eleven interviews, a focus group discussion and three additional interviews. Data was analysed with initial coding, focused coding and conceptual mapping. Key findings highlighted the importance of cultivating compassion, which involved learning about compassion, role modelling for compassion, leadership for compassion, resources for compassion and systems and processes for compassion. These findings contribute to the ongoing professional dialogue surrounding compassion, specifically in relation to recruitment and selection, nurse education curricula, supervision of student nurses, compassionate organisational cultures, staffing levels and the systems and processes that underpin contemporary ways of working.

1. Introduction

Since the historical influences of Florence Nightingale, compassion has underpinned traditional philosophies of care across the international professional nursing context (Straughair, 2012). However, due to increasing patient reports of care experiences reflecting a lack of compassion (The Mid Staffordshire NHS Foundation Trust Inquiry, 2010; The Parliamentary and Health Care Ombudsman, 2011; The Patients Association, 2011), the withstanding reality of this traditional nursing philosophy has been challenged. Although political and professional guidance reaffirms compassion as an enduring philosophy of contemporary nursing care practice (Department of Health (DH), 2010; Royal College of Nursing, 2010; DH, 2012; Nursing and Midwifery Council (NMC), 2018), this provides limited insight into compassion, particularly in terms of what it involves. Furthermore, evidence informing the concept of compassion predominately arises from professional perceptions, providing limited insight into what individuals' who have experienced nursing care as patients, perceive compassion to involve. A constructivist grounded theory study addressed this knowledge gap, with key findings highlighting the significance of cultivating compassion.

2. Background

Compassion ensues from a recognition of suffering in others, which subsequently initiates helping and alleviatory action (Dewar et al., 2011). Personal attributes and interpersonal skills are antecedents for compassion (Kneafsey et al., 2015; Sinclair et al., 2016; Durkin et al., 2018), supporting nurses to appreciate the person as an individual and attend to the 'little things' that matter to them (Perry, 2009a). Although it is claimed that personal attributes for compassion primarily arise from inherent factors (Kneafsey et al., 2015), the emerging dialogue suggests that compassion can also be cultivated through education (Bond et al., 2018). However, despite education being considered the most traditional method to disseminate and perpetuate customary societal values, there is ongoing professional debate about whether compassion can also be perpetuated this way (Richardson et al., 2015).

Dewar and Mackay (2010) assert that compassion can be taught, through appropriate education to cultivate compassionate care in nursing. A study to explore the impact of education to teach concepts of human caring provides support for this assertion, identifying that nurses developed enhanced compassionate attributes that positively influenced their caring behaviours (Herbst et al., 2010). Other studies to explore the effectiveness of education (Brunero et al., 2010; Curtis et al., 2016) also highlight positive influences, with nurses reporting

they developed enhanced understanding and awareness of the importance of showing compassion towards others. However, whilst this emerging evidence suggests education may positively influence compassion, it provides limited understanding of how this may translate to the reality of practice.

Although education to cultivate compassion is deemed important, emerging evidence suggests this requires nurturing further in the practice context (Bond et al., 2018). Positive experiences of professional socialisation are key to this, guiding the novice to internalise the nursing values, norms and behaviours of professional nursing identity (Curtis et al., 2012). Professional socialisation is thought to be predominately influenced by role modelling, reflected through the behaviours of the exemplary nurse who demonstrates characteristics which are worthy of imitation (Perry, 2009b). Exemplary role models are integral to the professional development of the novice nurse in the care context; considered the most influential environment for professional socialisation in nursing to occur (Goodare, 2015). However, emerging evidence suggests that factors such as time and resources can undermine appropriate professional socialisation in the care context, creating potential to negatively influence patient experiences of compassion in nursing (Tierney et al., 2017).

Effective leadership to disseminate a vision that cultivates compassion, is also thought to be important (Zuleta, 2016). A study to explore the impact of leadership in the general education context supports such a claim. When school teachers experienced compassion focused leadership, motivation, enthusiasm and job satisfaction was enhanced, enabling them to promote positive outcomes for students (Eldor and Shoshani, 2016). Similar findings have also emerged from the nursing context, whereby compassion focused leadership encouraged and supported nurses to sustain compassionate care, despite the need to manage the complexities of contemporary practice (Choi et al., 2016).

The emerging evidence suggests that compassion may involve influences arising from the nurse education and practice context. However, this evidence predominately arises from the professional perspective, highlighting a knowledge gap from the perceptions of individuals who have experienced nursing care as patients.

3. Research aim

To develop a broader understanding of compassion through an exploration of what individuals perceive compassion in nursing to involve, constructed from their personal experiences of care as a patient.

4. Research methods

4.1. Research design

An interpretivist approach addressed the research aim, guided by the ontological assumption that multiple realities of compassion exist due to individual, subjective experiences of nursing care. The theoretical perspectives of symbolic interactionism (Blumer, 1969) and social constructionism (Berger and Luckman, 1966) underpinned the study, acknowledging that individual interpretation of the world is influenced by personal interactions with others and the context or situation in which this occurs. These theoretical perspectives supported a constructivist grounded theory study (Charmaz, 2014), which sought to construct multiple realities into a collective, meaningful account to represent what participants perceived compassion in nursing to involve. The constructivist approach also acknowledged the extensive professional experience the researcher brought to the field, supporting a reflexive approach.

4.2. Sampling

Following ethical approval by the university ethics committee (HCESDS, 13/7/13), participants were recruited from an established

group of thirty-six individuals who had identified themselves as having personal experience of nursing care across a range of contexts. These individuals were involved in sharing personal narratives of care with undergraduate nursing students, and had engaged in extensive reflection to position themselves as experts with experience with potential to provide rich data. Following information outlining the purpose of the study, sixteen individuals consented to participate and were invited to complete a sampling questionnaire. The questionnaire ascertained participant demographics and information about the location and period of time when nursing care experiences had occurred. Participants had experienced care in a range of locations including the hospital, community, care home and their own home. Some were experiencing ongoing care, whilst others had experienced care over time periods ranging from 3 months to ten years previous. This information provided the basis for a matrix, supporting a theoretical sampling strategy (Glaser and Strauss, 1967) to identify initial participants. For example, the first participant was sampled as she was in the 80 plus age range and had experienced nursing care in a range of contexts over a variety of time periods. As the study evolved, theoretical sampling was driven by data analysis to explicate the emerging grounded theory. Theoretical sampling resulted in a final sample of eleven participants, which consisted of nine females from the age ranges of 35–50 (1), 51–65 (4), 65–80 (3) and 80 plus (1), and two males from the 51–65 (1) and 65–80 (1) age range (Table 1).

4.3. Data collection

Semi-structured individual interviews were undertaken with all participants and initiated with an open question. This question invited participants to discuss what they perceived compassion in nursing to involve, drawing on examples from their nursing care experiences. A focus group discussion followed, with three participants who had previously been interviewed. This discussion was more structured, guided by themes constructed from the emerging grounded theory. Three participants were involved in additional interviews, aiming to seek elaboration of key points discussed in previous episodes of data collection.

4.4. Data analysis

Data was analysed using initial and focused coding techniques. This involved fragmenting the data into initial codes and re-assimilating

Table 1
The sample.

Participant	Age range	Gender	Setting of Care Experience
P1	80+	Female	Hospital Community Own home Care home
P2	51–65	Male	Hospital
P3	51–65	Female	Hospital Community Own home
P4	51–65	Female	Hospital Community Own home
P5	65–80	Female	Hospital
P6	51–65	Female	Hospital
P7	36–50	Female	Hospital
P8	51–65	Female	Hospital Care home
P9	51–65	Female	Hospital
P10	65–80	Male	Hospital Community Own home
P11	65–80	Female	Hospital Own home

them into groups to represent the emerging data categories (Charmaz, 2014). Analysis was underpinned by grounded theory procedures, which involved constant comparison (Glaser and Strauss, 1967), theoretical memos and diagrams (Birks and Mills, 2011) and conceptual mapping (Clarke, 2005). This comprehensive analytical process advanced theoretical sensitivity (Glaser, 1978) until theoretical sufficiency was achieved (Dey, 1999).

4.5. Trustworthiness

Trustworthiness in constructivist grounded theory studies is achieved through credibility, originality, resonance and usefulness (Charmaz, 2014). In this study, credibility was reflected through the research methods, which adhered to established constructivist grounded theory principles comprising theoretical sampling, constant comparison, recognised analytical techniques and sustained researcher reflexivity. New insight into the factors that can cultivate compassion was constructed from the perceptions of individuals who had experienced nursing care as patients, represented by an emerging substantive grounded theory that demonstrates originality and contributes to the current dialogue surrounding compassion. The findings present a comprehensive overview of participant data, supporting resonance with, and transferability to, similar individuals and care contexts. This has usefulness to the international context of nursing, in terms of understanding the factors that can influence the cultivation of compassion in nursing.

5. Research findings

Key findings highlighted the importance of cultivating compassion, with participants identifying the potential of this to influence their experience of a humanising approach to nursing care. Humanising approaches involved being treated as a human being, with the ability to contribute to decisions about the care experience. This represented the fundamental embodiment of what participants in this study perceived compassion to involve. Cultivating compassion involved learning about compassion, role modelling for compassion, leadership for compassion, resources for compassion and systems and processes for compassion. These key themes are presented in the following section, supported by verbatim quotes that are attributed to individual participants (Table 1).

5.1. Learning about compassion

Participants perceived that nurses required a fundamental self-propensity for compassion, suggesting that this primarily arose from biological influences:

"I think they've just got a natural application for it [compassion] … they instinctively do it, it's their personality" (P2)

Compassion was exhibited through particular personality traits, such as those associated with caring, kindness, being aware of another's distress and demonstrating effective communication skills:

"Compassion means … really caring, being kind … really showing that you care and … being aware of people's distress and discomfort and anxieties and … and being able to let the person feel that they can speak to you and express any concerns that they have and not be afraid to do so and explain things as clearly as you can" (P5)

However, participants identified that fundamental self-propensity for compassion required nurturing through approaches to facilitate further learning. Experiences in the home and school were an important aspect of this:

"I'm just someone who has a bit of compassion for people because of my own experience in life … it starts at primary school … it needs to be nurtured in the home too" (P9)

Although experiences in the home and school were considered important in laying the foundations for compassion, learning experiences in the nurse education context were identified as significant to nurture this further. The responsibility of the nurse educator to role model for compassion was instrumental to this:

"Well, I think the right training is vital … and if they are not a very compassionate person that's delivering it, you are not going to hand that on really (P11) ….

Yeah, unless it's in-bred and it's there already. But you still need it nurturing, you still need it bringing out (P3)"

Participants perceived that undergraduate nurses should learn about compassion by exploring the care experiences of individuals who had experience of nursing care:

"It's all to do with the training they're being given … they should want to learn from us … that's how the nurses should be taught … that will give them their thinking and their actions" (P1)

However, participants identified that learning about compassion was also essential for postgraduate nurses, as a means to support compassion as an enduring aspect of nursing practice:

"If you have got somebody who is newly trained, newly qualified … and they are wanting to lift the standards on the wards, they are wanting to put things into place. If you have senior staff who haven't had that training, it's extremely difficult for a newly qualified … you need to have more training of qualified staff on the ward so that they have the same approach" (P11)

5.2. Role modelling for compassion

Participants identified role modelling in the care context as significant to cultivating compassion further:

"Nurses must have some inherent caring tendencies … but I think that these need to be nurtured during their training and perpetuated with good role modelling on the wards" (P7)

The notion that compassion was subject to external influence was apparent, with claims that negative experiences within the care context could contribute to nurses' losing their aspirations for compassion:

"I suppose it [compassion] could get knocked out of you too, if you have bad experiences" (P5)

In contrast, positive experiences in the care context were thought to have potential to initiate a cascade effect, with effective role modelling for compassion influencing compassion in others:

"I have got a fabulous nurse at my practice, I mean she is absolutely great … it has a knock on effect" (P6)

Participants were aware that student nurses were likely to observe differing approaches to the ways in which experienced nurses implemented nursing care. In circumstances where nurses failed to demonstrate compassion in their practice, participants perceived there was potential for the novice nurse to assimilate this as the norm and subsequently perpetuate this within their own practice:

"Nurses who are coming through the training and seeing different ways of doing things,.if you have got a nurse who has been qualified for quite a long time and doesn't see the need for somebody to go up and say 'hello, how are you this morning' … if a new nurse had been with her and learning the ropes, she would have thought that was how it should be done (P2) …

They can learn the wrong things … because if that nurse is going to teach other nurses that … then it's just going to spread isn't it? (P3)"

5.3. Leading for compassion

Effective leadership for compassion was also required to cultivate compassion in the care context. Participants identified that this primarily emanated from the very top of the organisation, suggesting this was vital to support a culture for compassion:

"I believe it [compassion]comes from the top" (P9)

The role of the ward manager was identified as important, with participants perceiving that compassion could be influenced by the leadership approach they implemented:

"I think a lot will depend on what the sister in charge of the ward, on what they're like" (P1)

The importance of the ward manager was particularly evident in instances where participants experienced nursing care they perceived to be lacking in compassion:

"I didn't really see a leader there when I had my appointment in that department [outpatients], there was no clear manager and perhaps that's what was needed … they need to have effective leadership … someone who's in support of compassion, who can show them how to act" (P7)

To address the potential for ineffective leadership, a return to old fashioned approaches to nursing was suggested as a means to cultivate compassion. This involved the ward manager assuming a highly visible presence in the clinical area; observing, monitoring and guiding standards for compassion:

"Old fashioned nursing, where the sister was there and you saw everything that was going on … I think that goes for good nursing, and compassion of course" (P11)

The ward manager was instrumental to cultivating compassion. This involved key responsibility for setting expected standards of care, facilitating an effective team approach to compassion and leading by example as a role model for compassion themselves:

"Whoever is in charge of the ward really does need to set the standard for the nurses that are coming in, and listen to new ideas (P11) ….

Or they learn the wrong things (P3) …

Because if that nurse is going to teach other nurses that … then it's just going to spread isn't it? (P11)"

5.4. Resources for compassion

Inadequate staffing levels were a potential factor to influence experiences of compassion, with participants acknowledging the impact of this on nursing workloads:

"There's not enough people on the battlefront … there always seems to be a shortage of staff on the ward … I think their workload is incredible … I knew they were doing their best, but it was just the lack of numbers" (P2)

Although participants conceded that nurses were compassionate human beings in the main, they perceived that the challenges of contemporary practice could influence the levels of compassion that they may feel enabled to demonstrate:

"They might be compassionate and understanding, but I think I have got to give them the benefit that at times, they must be stretched so much that it must be very hard to show compassion" (P4)

Participants identified that they often felt objectified, through nurses having limited time to make interpersonal connections due to low staffing levels and high workload. Consequently, they often perceived they were treated as a task to complete, rather than feel humanised and valued as a person:

"They didn't have the time to be compassionate, all they were interested in was getting the job done, moving me to the next location … like I was just another task to complete" (P7)

Adequate staffing levels and reasonable workloads were considered vital to cultivate compassion. However, rather than attribute blame to individual nurses, the influence of organisational factors were highlighted as significant:

"There's no point in chastising a nurse when that nurse doesn't have the amount of staff that she needs on the ward … you get a very busy nurse and her compassion goes out through the door because she is rushed off her feet. So you've got to have the amount of staffing on the ward to give the excellence of care … with compassion" (P11)

Participants reported that, in most instances, they experienced high quality clinical care. However, despite acknowledging the challenges of the contemporary care context and the potential for this to exert influence on nurses' time to care with compassion, they asserted that nurses needed to adopt a humanising approach, incorporating compassion as an integral aspect of practice:

"Everything was done properly you know, it was very clinical. Very clinical. There was no empathy … a busy day in a clinic, it must be hard … but I think in nursing you have to rise above that … instead of being very matter of fact" (P5)

5.5. Systems and processes for compassion

The systems and processes underpinning contemporary nursing practice were identified as potential factors to influence compassion. This involved advanced roles and responsibilities and in particular, the need to complete increasing amounts of paperwork; all of which could influence nurses' time and capacity for compassion:

"There is so much expected of them now and I know they have to do an awful lot, more paperwork … I don't really think nurses went in to do paperwork, they went in because they have this compassion for nursing and want to help people" (P6)

The increasing use of technology was also considered important. Participants felt that technology created the potential to move nurses away from a person centred focus, in favour of attending to clinical equipment:

"Machinery … with all this technology they know how to work the machine, but they haven't got the time to sit and talk to you for five minutes. I think that's really sad … it's really important because that's where the real compassion comes in" (P3)

There was recognition that the advancing challenges of the nursing role were often impacted further by staffing levels and budgetary constraints, resulting in nurses prioritising technical care over human interaction:

"They've got to get through a certain amount of things and they may have to cut corners that they don't want to cut but they just really can't do anything else. How you deal with that, it's all to do with budgets isn't it?" (P1)

However, this was not the case in care contexts with adequate staffing levels. In these situations, technology was not an issue with the potential to negatively impact compassion:

"I had like sort of four tracheostomies in altogether and different lines, I had lines all over the place, and they would tell me what they were doing, what was going on. You know, it's a scary place. You're like lying there and you can just hear this machinery beep, beep, beeping all the time, so they always kept you, let you know what was happening … they were there all the time, they were just brilliant" (P2)

Ultimately, participants perceived that the person should be at the centre of the care experience. This was exemplified through humanising approaches to nursing care; the fundamental embodiment of what participants in this study perceived compassion to entail:

"They've got to put less emphasis on … targets … key indicators and all the rest of it and think more holistically about people. Get the emphasis back on people … the emphasis has got to be put back on patient care … they need to treat us like human beings" (P3)

6. Discussion

In this study, participants perceived that compassion was embodied by experiences of a humanising approach to nursing care. Key findings identified a range of factors arising from the education and practice environment as vital to facilitate this, particularly in terms of cultivating compassion within the wider context of nursing. In the first instance, participants perceived that nurses required a self-propensity for compassion that could be cultivated further. Although values based recruitment is regarded essential to contemporary nurse recruitment and selection (Health Education England (HEE), 2014), current evidence does not explicitly identify this to be a foundation from which to cultivate compassion in nursing. In this study, the findings built upon the efficacy of values based recruitment further, with participants suggesting that nurses required fundamental self-propensity for compassion to support the cultivation of compassion through appropriate education.

The findings identified that learning about compassion at home and school were important to cultivating compassion in the early years. Although nurses in education and practice cannot exert influence over early years learning, there is evidence to suggest that exposure to compassion in the adult years can positively support its development (McCrae, 2011). Participants concurred with this claim, purporting that learning about compassion in nurse education could cultivate compassion through appropriate pedagogies to promote understanding from the perspectives of individuals with experience of nursing care. This builds upon previous evidence (Brunero et al., 2010; Curtis et al., 2016) to further assert that education can have a positive influence on compassion. Indeed, participants in this study specifically perceived that nurse education curricula could cultivate nurses' understanding of compassion, motivating them to implement compassion as an integral aspect of their nursing care practice.

In order to support learning further, the findings identified that compassion also required cultivating in the care context. Role modelling, whereby students learned about compassion from more experienced nurses, was central to this. Consistent with the claims of Bond et al. (2018), participants suggested that positive experiences in the practice context could influence the replication of compassionate approaches to care. However, in contrast, role modelling behaviours were thought to have potential to cultivate negative approaches. Participants thought this to primarily influence novices lacking competence to discern between good or poor practice. This notion reflected the views of Malouf and West (2010) who suggested that novices may simply imitate observed negative behaviours as they assimilate into the culture of the care context. This suggests that in instances where students or newly qualified nurses are exposed to negative role modelling, compassion may be inhibited and result in a failure to cultivate compassion. Studies to explore the effects of professional socialisation also reflect this assumption, suggesting that repeated exposure to negative experiences can result in nurses experiencing diminishing aspirations for compassion (Maben et al., 2007) due to dissonance between professional ideals and practice realities (Curtis et al., 2012). Participant perceptions also resonated with the notion that the care context is the most influential environment for role modelling (Goodare, 2015), with findings suggesting that novice nurses should only be supported by experienced nurses who effectively role modelled for compassion themselves.

Role modelling was identified as significant for leadership at organisational and ward level. Effective leadership was thought to involve a compassion focused approach, whereby leaders demonstrated compassion themselves, raising standards to create a culture within which compassion could flourish. Participants perceived this to be a vital aspect of motivating others, reflecting the claims of other commentators (Zuleta, 2016; Choi et al., 2016; Eldor and Shoshani, 2016). Participants highlighted that in circumstances where ineffective leaders failed to cultivate a culture for compassion, negative outcomes could ensue for patients. This reflects the claims of NHS England (2016), who identify effective leadership to be essential to positive patient experiences of compassion. Participants suggested that to address this, nurse leaders should be equipped with the skills, knowledge and attributes to cultivate a culture for compassion, perhaps themselves undertaking compassion focused leadership education to support this.

Staffing resources and the contemporary systems and processes that underpin nursing practice were additional factors noted to influence compassion. Participants perceived that environments with adequate staffing levels could enable compassion, whilst environments with inadequate staffing levels could inhibit it. The main influencing factor was time, whereby workload, technical interventions, clinical care and meeting targets took precedence over human interaction. Although contemporary nursing practice seeks to assure quality, some commentators perceive this approach creates potential to move the focus of care away from the person (Bradshaw, 2009). Human resources can influence this further, with reduced nurse-patient ratios resulting in episodes of care left undone due to competing priorities (Duffield et al., 2011). Contemporary systems and processes of nursing practice compound this further, with nurses often focusing on clinical and technological aspects of care to the detriment of human engagement (Ball et al., 2014). Participants agreed that poor staffing levels influenced their experience of compassion, highlighting that adequate nurse-patient ratios were essential to support nurses to balance technical aspects of clinical care with interactions that supported humanising approaches to nursing care.

The findings build upon current evidence, providing insight into cultivating compassion from the perceptions of individuals who have experienced nursing care as patients. These perceptions were constructed from care experiences ranging from exceptionally compassionate, whereby nurses went the extra mile to help, to exceptionally uncompassionate, whereby participants felt dehumanised and treated as a task to complete. This range of experiences suggests that the factors with potential to influence cultivating compassion in nursing, require due consideration.

A substantive grounded theory emerged from the findings, purporting that nurses should be recruited for their self-propensity for compassion, providing a foundation from which to cultivate compassion further. Nurse education, effective role modelling in practice and effective organisational leadership is essential to cultivate a culture for compassion, building upon this further. The care context needs to facilitate enabling conditions for compassion, whereby staffing levels are adequate and care processes support nurses to focus on the individual needs of the person, rather than on technological and clinical care as sole priorities. In summary, addressing key factors at an individual, educational and organisational level can cultivate compassion in nursing, supporting nurses to implement humanising approaches to care; the fundamental embodiment of what participants in this study perceived compassion to involve. The study findings provide additional insight into the dialogue surrounding compassion and are relevant to the international nursing context, particularly in terms of understanding the factors that can enable, or inhibit, cultivating compassion in nursing.

7. Limitations

The participant sample is a potential limitation, due to their position

as experts with experience, which may have influenced their overall perceptions of compassion. However, arguably this provided a strength to the study, due to participants' ability to discuss their personal experiences of such a complex and intangible concept with relative ease, providing rich data to inform the research findings. The demographic profile of participants could also be a potential limitation, due to the majority of the sample being in the over 50 age range. Despite this, the findings provide original insight into compassion from the perceptions of individuals who have experienced care as patients, particularly in terms of the factors which can influence cultivating compassion in nursing, which may have resonance with others in similar contexts.

8. Conclusion

Cultivating compassion in nursing is complex, due to the range of factors with potential to influence this. Despite such complexity, the study findings suggest that compassion can be cultivated more effectively when enabling conditions are in place. This involves recruiting the most appropriate individuals for nursing, who exhibit a fundamental self-propensity for compassion that can be cultivated further with appropriate compassion focused education and role modelling. Compassion focused approaches extend to the realms of nursing leadership, requiring leaders to strive towards cultivating a culture within which compassion can flourish. Care contexts with adequate nurse-patient ratios are important to enable this, supporting nurses to sustain compassion within the complex challenges of contemporary nursing practice. Cultivating compassion is not a straightforward exercise, it requires a compassion focused philosophical approach to nursing care practice, which may require a shift in perspectives. Cultivating a culture for compassion can support nurses to focus on implementing care that humanises the individual, moving them away from potentially objectifying practices that focus primarily on technical aspects of clinical care. Nurses are undoubtedly motivated towards compassion, arguably no more so than at the outset of their career. However, nurses require support to sustain this at an individual, educational and organisational level. This study provides new insight into compassion through the perceptions of individuals who have experienced nursing care as patients, laying the foundations for future research to further explore the factors that can enable the cultivation of compassion in nursing.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.nepr.2019.02.002.

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