Standards of compassion to patients

Exploring how to enable compassionate care in hospital to improve patient experience

Introduction

Care, compassion and respect have always been enshrined in the value statements of the health professions (NMC, 2009; 2008).

However, 'compassion' has recently gained a higher profile with policymakers. The NHS Constitution sets out certain NHS values, including respect, dignity and compassion:

The NHS touches our lives at times of most basic human need, when care and compassion are what matter most

Why does enabling compassionate care matter?

Healthcare staff want to be able to care for patients with humanity and decency and to give to patients the same kind of care that they would want for themselves or their own family and loved ones (Goodrich and Cornwell, 2008).

For many staff, such a desire may have been a motivating factor in their decision to enter the healthcare professions in the first place. Practitioners want to be able to show compassion to the patients under their care.

Compassionate care matters to patients. Anecdotally, it is the presence or absence of compassion that often marks the lasting and vivid memories patients and family members retain about the overall experience of care in hospital and other settings.

Improving patients' satisfaction about their experience of care is an outcome that most patients and families would agree has value in and of itself, and is emphasised in the goals in recent key policy documents (Department of Health, 2008).

Research evidence suggests that compassion affects the effectiveness of treatment. For example, patients who are treated by a compassionate caregiver tend to share more information about their symptoms and concerns, which in turn yields more accurate understanding and diagnoses (Epstein et al, 2005).

In addition, since anxiety and fear delay healing (Cole-King and Harding, 2001), and compassionate behaviour reduces patient anxiety (Gilbert and Procter, 2006), it seems likely that compassionate care can have positive effects on patients' rate of recovery and ability to heal.

The elements of compassion

Compassion, in simple terms, is 'a deep awareness of the suffering of another coupled with the wish to relieve it' (Chochinov, 2007).

Compassion requires that staff give something of themselves. When fatigue, personal factors and organisational circumstances conspire to create workplace stress, it becomes more difficult for staff to feel and show compassion, creating a gap between their intentions and their capabilities.

Sometimes it is easier to identify when compassion is missing than when it is there. In the broadcast and print reports of failures in hospital care – such as, for example, the reports of the Healthcare Commission's (2009) and (2007) investigations into Mid Staffordshire and Maidstone and Tunbridge Wells NHS trusts – it is the apparent lack of compassion that fuels media outrage.

It is important to note that the focus on compassion should not reside merely at the 'sharpest ends' of care – that is, in emergency situations, or when a patient is known to be dying. Lack of compassion in mundane aspects of acute and everyday care also takes its toll on patients and staff. Indeed, it is the 'little things' that patients or carers often recall as having been either present or lacking in their experiences of care

The elements of compassion, as defined in particular relation to health care, are described below:

The elements of compassion

- Compassion starts with good basic care and can be demonstrated in very practical ways – for example, making sure that a patient's feeding needs are addressed, that pain is managed and that the patient is helped to the toilet as needed. It can be equated with providing both dignity and respect.
- Compassion goes beyond essential care, however, to encompass 'empathy, respect, a recognition of the uniqueness of another individual, and the willingness to enter into a relationship in which not only the knowledge but the intuitions, strengths, and emotions of both the patient and the [caregiver] can be fully engaged' (Lowenstein, 2008).
- As such, compassion involves 'real dialogue': communication that is human to human rather than clinician to patient.
- The compassionate caregiver never stereotypes but appreciates difference, recognising the common humanity shared by both patient and caregiver.
- Compassion should not necessarily be seen as being sweet and nice. It includes honesty and may require courage.
- It is not a one-size-fits-all: compassion can mean very different things in different situations and to different people. In recognising the individuality of each patient, compassionate carers will also recognise how best to tailor their behaviour to show compassion based on a particular patient's needs.

- In short, for healthcare professionals, compassion means seeing the person in the patient at all times and at all points of care.

Assessing compassion

How do we assess how good we are at delivering compassionate care? The question is important, but it also presents an immediate, inherent challenge in an NHS reliant on quantified targets and measures.

If we accept that compassion is a felt experience, it follows that the closest we can come to measuring compassion is to ask patients whether or not they experienced it. Measures of compassion must rely to a large degree on patients' own subjective assessments of their experiences of care, which can be obtained in a variety of ways: interviews; questionnaires; frequent feedback mechanisms; and surveys.

There are other types of measure that might also be considered: measures of process and measures of structure. Since compassion can demonstrate itself in very practical ways, there are objective, practical measures that may indicate or point to its presence or absence (the 'feeling for' the patient) in the way care is delivered.

In this way, we can say that many of the physical indicators already assessed, while they might not measure compassion directly, do point towards it. The measures we have in mind are ones such as: how quickly staff respond to call bells; whether patients' feeding needs are attended to; how well pain is managed; and how often and at what times of day or night patients are moved from ward to ward. All of these have an impact on continuity of care and relationships between staff and patients.

These basic indicators of aspects of quality of care may tell us something about attitudes and behaviours that are important with respect to compassion. Poor performance in any of these dimensions may not be caused by a lack of compassion but rather might be taken as indications of environments in which patients are at risk of feeling uncared for, and that therefore merit further investigation.

The structural measures that complete the more rounded attempt to measure compassion would be measures of risk in the physical environment or risk to staff capability to deliver compassionate care. Risk in the physical environment of care would need to be observed and audited. Risks to staff capability would be available from feedback in staff surveys to questions about the quality of leadership and support and team-working. They would also be available in some of the human resource data such as: measures of staff turnover; vacancy rates; and the use of bank and agency staff in different locations.

What stops compassionate care from happening?

Why, when staff may have entered the healthcare profession with high ideals, abundant stores of compassion and a strong motivation to treat patients as they themselves would want to be treated, do lapses in compassionate care sometimes occur?

First and foremost of these reasons, perhaps, is the natural human defences we develop in reaction to trauma. In care settings of all kinds, staff experience regular, frequent or in some cases continuous exposure to their fellow human beings in varying states of pain and distress, to suffering, terminal illness and death. Sometimes the defence takes the form of inappropriate joking; sometimes it manifests itself in numbing, a distancing reaction and withdrawal, as described by an acute care nurse below:

An acute care nurse's view

On staff coping with constant exposure to death and dying:

'I went to work on an elderly ward where patients died daily and there was great pressure on beds. At first, I did all I could to make the lead-up to a death have some meaning and to feel something when one of them died. But, gradually, the number of deaths and the need to strip down beds and get another patient in as fast as you can got to me and I became numb to the patients; it became just about the rate of turnover, nothing else' (Firth-Cozens, 2009).

The key point is that under these conditions, practitioners must develop coping mechanisms – some more effective or appropriate than others.

Staff who do not find effective ways of coping may be more susceptible to stress and burnout. Self-reported stress of health service staff in general is considerably greater than that of the general working population (Wall et al, 1997).

Stress and depression is evidenced by high self-criticism (Brewin and Firth-Cozens, 1997), and a lack of compassion towards oneself is likely to work its way through to a lack of compassion towards patients (Gilbert, 2009).

Stress and burnout have their origins in different sources, some of them individual, some of them situational.

Individual factors:

- Age and experience;
- Self-esteem levels;
- Personal resilience;
- Job satisfaction
- Regular exposure to pain and distress;
- Conflicting information about what the organisation expects from staff or what is valued in the organisation;
- Poor feedback systems or lack of recognition or praise for individual acts of compassion and care;
- Lack of time and simultaneous pressure to meet targets.

Compassion, too, can become problematic for staff in settings where displays of emotion are treated as a failure to maintain an appropriate professional distance or authority. Though not necessarily unique to any one profession or role within the hospital, this is particularly relevant to those in roles that place a high value on professional detachment. Such attitudes are more commonly associated with doctors but perhaps increasingly prevalent in nursing.

The role of education in teaching healthcare staff professional values and standards is also important. In medicine, the psychosocial aspects of caregiving have tended to command secondary status, and workshop participants felt this was increasingly common in nursing training. Training that emphasises professional detachment and positions compassion as 'soft and fluffy' may have a detrimental impact later on the interpersonal relationships between staff and patients – and to the quality of care delivered.

Finally, even where the value of compassion is taught in the syllabus, there is a concern that, without systematic modelling and explicit endorsement and support for striving to be compassionate towards every patient, every time, it will be eroded and more difficult to practise.

Enabling compassion

In the practical circumstances in which staff caring for patients feel under pressure, and experience themselves as having very little time, it is often difficult to do just that one thing for the patient that makes her or him feel cared for. Enabling staff to feel and be compassionate towards patients in their care, at all times, requires action on multiple levels.

At the level of the individual, one of the most powerful resources that healthcare professionals consistently cite is patients' stories.

In cases where professionals themselves, or their loved ones, become patients, the nature of their personal experience of care very often has a profound effect on how they carry out their clinical practice. Where first-hand experiences of care are not available, exercises in which staff are asked to role-play or write a narrative imagining themselves as patients can have a similar usefulness.

Providing practitioners with a forum for open and honest dialogue about their experiences of *delivering* care is similarly important. A safe and recrimination-free environment in which to discuss the everyday challenges, frustrations and pressures of the job – in which sharing stories and feelings about patients and their care is legitimised – is essential.

It helps to remind busy staff that every patient is individual and unique; it provides support to individuals; encourages communication within the team; and it helps to improve team dynamics.

Good team relations make a difference not only to the quality of interactions among team members but also to the quality of care delivered to patients (see Box 3 for the markers of a good team). As such, enabling good team working is important.

Within teams, those in senior positions can enable compassion among staff by modelling compassionate behaviours – towards themselves, other staff and patients – often through relatively simple gestures, for example, by encouraging a junior colleague to take a meal break or by taking one themselves.

We need to focus our attention, too, on the formative stages of the professions, while nurses and doctors are learning their roles within a hospital. If modelling compassionate

behaviour is crucial in the message it sends to all levels of staff, it is especially so when students are in hospital to observe and learn. Mentoring is particularly important in teaching settings and for practitioners at the start of their careers.

None of these suggestions will make much impact, however, if staff remain unaware of what is valued in the organisation or feel undervalued in their jobs. Feeding back regularly to staff on their performance and providing recognition when they deliver compassionate care can help alleviate stress and counter poor organisational morale.

Finally, acute care could learn a lesson from palliative care. With its primary emphasis on patients' experience, on their physical and psychological comfort and quality of life, the palliative care setting can serve as a model of how to better integrate a focus on compassion into care delivery.

- Its task is defined and its objectives are clear
- It has reasonably clear boundaries and is not too large (ideally fewer than 10 people)
- Its members know who leads it and the leadership is good
- There is participation in decision-making by all members, good communication and frequent interaction between them
- It meets regularly to review its objectives, methods and effectiveness
- Its meetings are well conducted
- Its members trust each other and feel safe to speak their minds
- There is a shared commitment to excellence of patient care

Source: Firth-Cozens (2009)

Patients and their families need compassion, support and education along the health-illness continuum from a time of wellness to chronic illness to advancing illness and frailty to death. Those facing serious life-threatening illness and approaching death deserve to be treated with dignity, respect and compassion and receive care that is focused on the individual's goals for care.

Studies show patients need compassion, acceptance, to be treated as a whole person and not to be abandoned. They need clear information that enables identification of the person they trust to make decisions when they are unable to do so and helps in the determination of goals of care.

Further, studies show people want quality end-of-life care that includes:

- Receiving adequate pain and symptom management
- Avoiding inappropriate prolongation of dying
- Achieving a sense of control
- Relieving the burden on loved ones

- Strengthening the relationship with loved ones
- Respecting the uniqueness of individual
- Providing an appropriate environment
- Addressing spiritual issues
- Recognizing cultural diversity
- Effective communication between the dying person, family and professionals

Life is full of personal choices. Education is essential to help us know our choices and share our wishes in conversations around the kitchen table with family and health care professionals.

The compassionandsupport.org website seeks to improve health literacy and help individuals make sound, informed medical decisions. This web site addresses health literacy from a functional standpoint by providing information focused what the individual needs to know and what they need to do. The goal is to improve care for seriously ill patients and those nearing the end-of-life and their families.

Yet, anyone can face sudden and unexpected serious illness or injury. Thus, we all need to become educated and plan ahead for the future. Ultimately it comes down to personal choice but the choices about what works best for an individual are best made with reliable information. What patients and families need and want is delivered by Palliative Care, an interdisciplinary care that aims to relieve suffering and improve quality of life for patients with advanced illness and their families. It is offered simultaneous with all other appropriate medical treatment.

A Nurses personal account

Action, not Emotion: Compassion and Respect in Nursing Care

As a new nurse giving care, I was handed the report on my patient's condition and was warned by seasoned nurses about his anger. "You better watch out for that one, he is a grumpy and angry patient," I was told. After having received this information, and on my way to making my rounds, I approached his room with caution. I knocked on the door and when I heard a somewhat gruff, "come in," I nervously wondered what to expect from this angry man. Getting to Know As I made my assessment, I tried to think of things I could discuss with this grey, whiskered gentleman. While I wrapped the blood pressure cuff around his arm, I made small talk asking if he had any family and what type of job he held. I asked if he would like fresh water in his pitcher, if he would like ice in his water, and I made sure that he had extra drinking straws and Styrofoam cups. I tried to keep lines of communication open and show him that I respected his desires. As I continued communicating with him, he started responding back. He explained that he didn't like the

way people came in and out of his room with no regard for his feelings. He told me that he wanted some privacy and independence, and that he really appreciated that I had knocked before entering his room. After this, throughout my shift, I did my best to service him in ways that showed him respect. Kindness Begets Kindness I knocked before each entrance to his room and I carefully explained each procedure before it was performed, even if it was just a routine procedure. I listened as he talked about his life and, by the end of my nursing shift, he began to open up to me about his true feelings regarding his illness. He was frustrated and frightened that his career might be over due to the development of his illness. His doctor had made a remark that led him to believe this was possible. He further explained that he was a bus driver and loved his job, and that he would miss his playful interactions with the kids. I could tell by the sorrow filled tone in his voice how much this meant to him. I did my best to show compassion while nursing and hope for his situation, and mostly rendered a listening ear while he shared what was on his heart. When I entered his room the next day he was very chipper. "I have something for you," he explained. He riffled through a few papers on his bedside stand and picked up a small piece of newspaper with tattered edges. I could tell it was a small section he had ripped out. This piqued my curiosity. A Small Gift I reached out my hand to receive his gift and he gently handed it over to me. My eyes quickly scanned the paper. It was a clipping of a cartoon character with a caption that read, "Love is...respect." He personalized the message to me by placing my name on the top corner and signing his name at the bottom. That day, I learned a profound personal lesson through this patient. I kept the clipping with its tattered edges and hung it on my bedroom mirror. It stayed there for years and served me as a daily reminder to have compassion and respect for others, especially the patients I was caring for. Respect is not an emotion. It is an action we perform. It is something we do to show others we value them. Showing respect is one way we can show compassion in our nursing care and bring healing to someone during a compromising time of illness and loss.