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Teaching Compassionate Care: Nurse Educators' Perspectives

Jane Defazio
jane.defazio@shu.edu

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Submitted in partial fulfillment of the

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in the world every day." This was for you! Compassionate care is truly a wonderful feeling, both giving and receiving. I pray your lives and successes overflow with Compassionate Care!

DEDICATION

This work is dedicated to my mother Marie

and in loving memory of my father Mario.

Their ongoing encouragement and emphasis for learning and reading

provided the foundation for this work

which has shaped me in my practice

as a nurse, nurse educator, and nurse researcher.

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Chapter I

INTRODUCTION

Aim of the Study

The aim of this study was to explore and describe the ways in which nursing faculty educate baccalaureate nursing students on how to provide compassionate care. Both registered nurses and students are expected to practice nursing with compassion, yet the ways in which this can be facilitated within a rapidly changing healthcare environment or within the scope of nursing education are not understood (Curtis, 2013). The delivery of compassionate care benefits both patients and healthcare institutions by improving the quality of patient care and developing a sense of professionalism in the workers of healthcare institutions (Dewar, Adamson, Smith, Surfleet, & King, 2014). Possessing the ability to provide compassionate care allows nurses to build effective relationships with their patients and to address and manage the different challenges and difficulties encountered when taking care of patients (Adam & Taylor, 2014; van der Cingel, 2014).

The ability to provide compassionate care to patients is one of the core competencies expected of nurses, underscoring the importance of developing the skills needed to provide compassionate care in the education of nursing students (Adam & Taylor, 2014; Drumm & Chase, 2010; Murphy, Jones, Edwards, James, & Mayer, 2009; van der Cingel, 2014). Nurse educators face the challenge of preparing

student nurses for the realities of healthcare delivery, while continuing to foster a meaningful understanding of what constitutes compassionate care in professional practice. Nurse educators have the potential to influence and teach their students about compassionate care through clinical interaction with patients and/or through the nursing curriculum (Adam & Taylor, 2014; Drumm & Chase, 2010; Newton, 2010). Given their important role in teaching nursing students the various skills and competencies needed to be effective healthcare workers (Adam & Taylor, 2014; Drumm & Chase, 2010; Livsey, 2009; Newton, 2010; Tanner, 1990), it could be surmised that nurse educators would be an excellent source of rich descriptive data about the ways in which nursing students are taught to provide compassionate care.

In this study, nurse educators were asked to define compassionate care and describe how they taught compassionate care in baccalaureate nursing programs. Descriptions of experiences as well as the facilitators and barriers to teaching compassionate care were also explored. Understanding the personal and first-hand experiences of nurse educators can add valuable, practical knowledge of which behaviors, methods, and resources they have found useful in helping students to develop the competencies needed to provide compassionate care to patients. Moreover, this understanding can provide insight into any barriers they have encountered in teaching compassionate care in baccalaureate nursing programs.

Definition of Compassionate Care

Compassionate care is a difficult term to define. Researchers have noted that it is an individual and subjective term, making it challenging to articulate and measure

(Adamson & Dewar, 2011; Crawford, Brown, Kvangarsnes, & Gilbert, 2014; van der Cingel, 2014).

Chochinov (2007) defined *compassion* as "a deep awareness of the suffering of another coupled with a wish to relieve it and speaks to feelings that are evoked by contact with the patient and how those feelings shape our approach to care" (p. 186). The provision of *compassionate care* as defined by Dewar et al. (2014) is:

> A relational activity that is about the way in which we relate to other human beings when they are vulnerable. It can be nurtured and supported. It involves noticing another person's vulnerability, experiencing an emotional reaction to this, and acting in some way with the person, in a way that is meaningful for people. (p. 49)

The literature discusses caring and caring behaviors as acts of compassion (Burnell & Agan, 2013; Dewar & Nolan, 2013). It is therefore reasonable to say that compassionate care is the result of someone demonstrating caring behaviors toward others in the provision of healthcare services.

Phenomenon of Interest

Nurses are expected to demonstrate compassionate care while simultaneously providing a high level of technical expertise. This can be especially challenging when the skills involved in providing compassionate care are not directly included as a curricular element in nursing education and may contribute to some of the challenges educators face in specifying how compassionate care as a competency is to be taught (Badger & Royse, 2012; Lown, Rosen, & Marttila, 2011; van der Cingel, 2014). "Compassion, if positioned as the main competence for nurses and acknowledged as

an integral part of Evidence-Based Practice, has great potential to become a powerful support in the realization of excellent nursing care" (van der Cingel, 2014, p. 1257).

Being able to provide patients with compassionate care is one of the goals of effective healthcare (Badger & Royse, 2012; Lown et al., 2011; van der Cingel, 2014) and of nursing education (American Association of Colleges of Nursing [AACN], 2015; American Nurses Association [ANA], 2015; National League of Nursing [NLN], 2003, 2005). Given that the delivery of compassionate care is a prominent goal for nursing education and because there is evidence that patients value the delivery of compassionate care (Badger & Royse, 2012; Lown et al., 2011; Smith, Dewar, Pullin, & Tocher, 2010), it is important to know more about how nurse educators help students develop the knowledge, skills, and attitudes that are necessary to deliver compassionate care to patients (Adam & Taylor, 2014; Adamson & Dewar, 2011).

Educators play a significant role in shaping the competencies required for students planning to work in health-related fields when they graduate (Lown et al., 2011). One of the ways in which compassionate care can be developed in students is through direct interactions with teachers who model compassionate care and caring behaviors in the classroom and clinical settings (Drumm & Chase, 2010; Newton, 2010). However, only a few clear strategies or methods have been identified as especially effective for teaching students how to provide compassionate care (Adam & Taylor, 2014; Knight, Pokorná, & Hampshire, 2013; Lown et al., 2011). Moreover, only a scant amount of published research has shed light on the ways in which

nursing students learn about how to provide compassionate care (van der Cingel, 2014). Therefore, a qualitative research design was a fitting choice, with its potential to uncover rich descriptions of this phenomenon. This new knowledge has the potential to shape 21st-century nursing curricula and guide nurse educators in the development of useful compassionate care teaching practices.

Research Questions

This research was designed to answer the overarching research question: How do nurse educators describe their experiences with teaching compassionate care in a baccalaureate-nursing program?

The following sub-questions served as a guide to explore the main research question:

a. How do nurse educators define compassionate care?
b. What are nurse educators' beliefs concerning the value of teaching compassionate care in nursing education?
c. What are some of the approaches nurse educators use when teaching nursing students how to provide compassionate care?
d. How do nurse educators evaluate whether a nursing student is able to provide compassionate care?
e. What are the barriers to teaching compassionate care in baccalaureate nursing programs? (See Individual and Focus Group Interview Guide Questions, Appendices F and G.)

Justification for Studying the Phenomenon

The delivery of compassionate care is associated with positive outcomes for both the patient and the nurse. Patients have reported that they felt they received compassionate care when nurses took time to explain important medical information that pertained to their care, while nurses have reported that imparting compassion and compassionate behaviors during interactions with patients and families enhanced their professional relationship (Badger & Royse, 2012; Griffiths, Speed, Horne, & Keeley, 2012; Smith et al., 2010).

A patient care survey conducted in the United States by Lown et al. (2011) and studies completed in the United Kingdom (Bramley & Matiti, 2014; Griffiths et al., 2012; Price, 2013) have indicated that compassionate care is lacking in healthcare systems and, in some cases, nurses are being criticized for not being able to provide compassionate care. Specifically, Lown et al. (2011) conducted a survey of 800 hospitalized patients. The findings indicated that only 53% of patients felt they were provided compassionate care during their healthcare experience. In addition, patients provided examples of what they felt constituted the delivery of compassionate care. These included instances when healthcare workers and professionals: acted respectfully toward them and their families, provided timely and sensitive communication of medical information, demonstrated understanding of their emotional needs, offered the experience of being attentively listened to, and were sensitive to cultural and religious beliefs. Unfortunately, almost half of the patients reported they did not receive such care.

In response to this concern, Price (2013) identified challenges for nursing education. He reported that one chief concern is that nurses have lost sight of basic compassionate care. One reason may be due to modern changes in nursing education that may be de-emphasizing the importance of compassionate care during the education of nursing students. This calls attention to the importance of ensuring that the core principle of delivering care with compassion is made central in all aspects of nursing education and practice.

The justification for studying this phenomenon is that although a considerable amount of research has been published on the value of providing compassionate nursing care, there is only minimal research on how this particular capacity can be taught and developed in nursing students. Nursing faculty carry the responsibility for teaching nursing students to provide compassionate care to their patients. While this has been addressed by nursing curricula as important, research that clarifies how this might be accomplished is lacking. Additionally, by exploring the ways in which compassionate care is taught, researchers have posited that new knowledge may lead to the actual delivery of compassionate care by nurses and other professionals currently working in healthcare (Curtis, 2013; Lown et al., 2011; van der Cingel, 2014).

van der Cingel (2014) discussed perspectives about what constitutes good quality healthcare. The use of evidence-based practice, which primarily focuses on the use of research to support the choice of technical skills and protocols contributing to effective nursing practice, is widely accepted in healthcare practice. Establishing a

trusting relationship and bond that develop between nurses and their patients is also a critical element in delivering good quality healthcare. van der Cingel stated that compassion is the missing link in providing quality care and suggested there is a need to focus on the development of the nurse-patient relationship, the encounter in which compassionate care is experienced. The researcher further noted that a focus on the development of the nurse-patient relationship is worthy of emphasis during the education of nursing students. Curtis (2013) shared the same position as van der Cingel (2014) and, in a phenomenological study with nurse educators, identified that the way in which one teaches nursing students to practice with compassion remains a complex concept requiring more development in nursing academia (Cornwell, Donaldson, & Smith, 2014; Curtis, 2013; van der Cingel, 2014). The behaviors or resources that are needed to provide compassionate care are difficult to reduce to a key set of measureable attributes; however, it is important to explore the ways in which nurse educators teach nursing students how to provide compassionate care in the classroom and clinical setting. In their findings from a cross-sectional survey of both first- and third-year nursing students, Murphy et al. (2009) reported that the mean scores of caring behaviors were significantly lower in Year 3 than Year 1. Murphy et al. measured caring behaviors using the Caring Behaviors Inventory I, which was created by Wolf, Giardino, Osborne, and Ambrose (1994). In the first year of nursing school, students' caring behavior mean scores measured 3.57, but in the third year, the mean score went down to 3.46. The implication of this finding is that

by the time nursing students graduate and become practicing nurses, caring behaviors may be perceived as less important, thus influencing practice (Murphy et al., 2009).

The findings of Murphy et al. (2009) are consistent with the arguments of Curtis, Horton, and Smith (2012) that sometimes nurses experience dissonance between upholding the professional ideals and values of compassionate practice while also striving to meet the real-life demands of acquiring a nursing degree or being a competent skilled nurse in the workforce. Curtis et al. conducted a grounded theory study and interviewed nursing students to explore their experiences in compassionate practice. The students reported feeling vulnerable and unprepared to deliver compassionate care. As such, Curtis et al. concluded that this area of nursing education requires further development.

Authors in the United Kingdom have published a few different strategies to develop the skills needed to provide compassionate care. These include reflective discussions, reflective diaries, simulation exercises, web-enhanced assignments, and faculty role modeling (Adam & Taylor, 2014; Adamson & Dewar, 2011; Knight et al., 2013; Newton, 2010). Despite these strategies, however, greater attention to compassionate care is needed in nursing education. Given the paucity of studies in the United States that provide details about how compassionate care is taught in schools of nursing, much remains unknown about the ways nursing students are helped to understand how they can provide compassionate care as well as what value is placed on this in nursing education.

Relevance for Nursing

Developing relationships and expressing compassion are components of the daily activities of nurses (Halifax, 2014). In the current healthcare environment of increasing technological advancements and short hospital stays, it has become progressively difficult for nurses to develop close compassionate relationships with their patients (Youngson, 2010). Providing compassionate care is important for nurses to build effective relationships with their patients and address the challenges nurses encounter when taking care of patients (Adam & Taylor, 2014). Many patients believe that healthcare providers are unable to provide compassionate care (Lown et al., 2011), and patients and their family members have identified compassionate care to be an important quality that is missing in the practice of some nurses and healthcare professionals (Crowther, Wilson, Horton, & Lloyd-Williams, 2013; Price, 2013; van der Cingel, 2014; Youngson, 2010).

Examining and exploring how educators teach students compassionate care in baccalaureate programs is important because compassionate care is essential in providing patient-focused comprehensive healthcare (Lown et al., 2011; Murphy et al., 2009; van der Cingel, 2014). Given the perception among patients that compassionate care is not practiced widely in healthcare, it becomes relevant and important to focus on the ways that nurse educators can develop the various skills that nursing students will need in the provision of compassionate care (Lown et al., 2011; Price, 2013; van der Cingel, 2014). By discovering the beliefs that nursing faculty members have about compassionate care and the ways they teach and develop this

capacity in students, I hope that an understanding of what is being done, what is novel, and what is still missing in nursing education curricula will be uncovered.

Researcher's Perspective

I became interested in conducting research on the ways in which nurse educators teach students in baccalaureate programs to provide compassionate care through my own teaching experiences as a nurse educator. I noticed significant differences in the ways nurses and nursing students do or do not provide compassionate care. Working with student nurses has taught me that many enter the field because they genuinely want to provide compassionate care, but this does not mean they know how to do this or what this looks like in practice. This observation prompted me to learn more about compassionate care and explore how nurse educators define and teach nursing students to deliver compassionate care to their patients.

In my role as a nurse educator and while attending research conferences that focused on nursing education, I engaged in discussions about the need to develop this capacity in students. Faculty express different views about how they believe this should be done, some of which appear to be intuitive or at least very individualized. By exploring the particular ways in which compassionate care is being taught, I sought to uncover rich descriptions of this process.

My 30-year experience as a practicing registered nurse has included Oncologic, Psychiatric, Gerontologic, and Critical Care Nursing. I have also worked in various leadership roles and have taught while practicing for the past 20 years.

My teaching experience (didactic and clinical) has included all levels of nursing education: Diploma, Associate Degree, Baccalaureate, and Graduate nursing courses. My personal bias is that while I do believe compassion is an inherent characteristic in some nurses, I also believe the delivery of compassionate care can be taught to nursing students. Nurse educators are faced with the challenge of balancing all aspects of learning and I believe one way they can teach compassionate care is by being excellent role models. The importance and value of compassionate care are found in nursing models that describe caring and compassion (Roach, 1984; Watson, 2008) and emphasized in the principles that guide our professional behaviors, such as the Nursing Code of Ethics (ANA, 2015). However, patient reports continue to suggest that compassionate care is missing at times from nursing care delivery. These reports are concerning because I believe that providing compassionate care to patients is one of the most important attributes of the nursing profession. Thus, even though the importance and value of compassionate care are noted in the literature, a lack of specific knowledge remains about the value of compassionate care and how it is addressed through nursing education. I also believe that high-stakes testing and competency exams have created a challenging situation for nurse educators, who are expected to gear educational practices toward passing competency and licensure exams, while still helping students understand how to provide quality in human care, such as through compassionate care practices.

Based on my teaching experience, clinical practice, and review of the literature, I have concluded that nursing research has yet to establish how nurses can

be taught to connect and care for patients in a compassionate way. Nurse educators carry the responsibility to teach nursing students how to provide compassionate care, yet little research is available to guide nursing faculty on how this can be done. It is my perspective that in order to maintain caring as the moral center of the nursing profession, it is necessary to apply both art and science through theoretical concepts, scientific research, and a conscious commitment to include caring behaviors during each nurse-patient interaction. For this study, I have made every effort to remain aware of these stated perspectives and take the methodological steps that will maintain the study's trustworthiness, as described in detail in Chapter III, Methods. This new knowledge will add to what is currently missing in nursing pedagogy and have the potential to influence the delivery of compassionate care in practice.

Chapter II

LITERATURE REVIEW

Compassionate Care

There is much debate over the definition of the term *compassionate care* and its implications for being supported, taught, and assessed in practice. While generating a precise definition of compassionate care is often difficult, the literature has described compassionate care as a complex and multifaceted concept that involves various skills and competencies such as: being respectful, employing excellent communication skills, extending empathy, and demonstrating overall professionalism (Badger & Royse, 2012; Lown et al., 2011; van der Cingel, 2014). Yet, what compassionate care means in a given context and how it can be learned and achieved in everyday practice are far from clear.

The origins of the term *compassion* were "derived in the 14th century from the Latin term *com* (together with) *pati* (to suffer), literally [meaning] *to suffer with*" (Von Dietze & Orb, 2000, p. 168). According to the *Merriam-Webster Dictionary*, *compassion* is defined as "a sympathetic consciousness of others' distress together with a desire to alleviate it" (Compassion, n.d.). In addition to these definitions, the concept of compassion is frequently used in religious, moral, and ethical disciplines. One example is stipulated in Provision One of the ANA (2015) Code of Ethics, which

states that nurses are to "practice with compassion and respect for the inherent dignity, worth and unique attributes of every person" (p. 7).

As a unified profession, nurses assert that their primary responsibility is dedicated to human care, which includes the element of compassionate care; however, it remains difficult to identify what the term *compassionate care* is comprised of (Von Dietze & Orb, 2000). Nurse theorists have discussed compassion or compassionate care as an element of "*caring*" in the theoretical nursing literature (Benner & Wrubel, 1989; Dunlop, 1986; Leininger, 1984; Watson, 1979) as well as the relationship of *compassion* to *caring* when dealing with human lives (Benner & Wrubel, 1989; Leininger, 1984). Watson (2008) further developed the 10 Caritas Processes and defined each process as it relates to the nurse within the context of caring. She referred to this as the "*Caritas Consciousness*," which states the nurse "develops meaningful rituals for practicing gratitude, forgiveness, surrender, and compassion" (p. 282). Leininger (1984, 2012) characterized compassion as the essence and central focus of nursing, while Roach (2002) included compassion was one of the "*Five C's of Caring (compassion, competence, confidence, conscious, commitment)*" (p. 66). It is important to note that the concept of *caring,* which is often described in terms of *compassion*, is a central value of the nursing profession and has been studied and supported by nursing scholars as the basis of everything that nurses do in the profession (Benner & Wrubel, 1989; Leininger, 1984; Watson, 1999).

Due to an overlap in the use of these terms in the literature, Dewar and Nolan (2013) sought to clarify further the definition of compassionate care and conducted a

comprehensive narrative synthesis of the literature on compassionate care using the key terms *caring*, *compassionate care*, *dignity*, and *patient-centered care*. The review revealed that the definition of *compassion* indeed lacked clarity and there was no comprehensive model indicating how it could be achieved in practice. The researchers also acknowledged an overlap in the meaning of the words *compassionate care* and *caring behaviors*, finding that the literature implied that behaviors termed *caring* are often described as practicing with a sense of compassion, concern, and respect for individuals.

The interchangeable use of these terms is not a new phenomenon. Schantz (2007) completed a concept analysis of the term *compassion* and identified that neither *compassion* nor *compassionate care* are clearly defined concepts in nursing scholarship. Agreeing with Schantz, Burnell (2009) analyzed the concept of *compassionate care* and identified that "the provision of compassionate care is more than a professional mandate or an attribute of a model expressed in theoretical terms; it is the result of an authentic bond between a nurse and a patient" (p. 319). As a result of this concept analysis, Burnell concluded that even though compassion has not been universally defined or understood, it is nonetheless recognized as a component of nursing excellence. Burnell and Agan (2013) further asserted, "if compassionate care is an expectation in health care delivery models, nursing behaviors and actions that exemplify compassionate care should be easily identifiable to patients" (p. 180). However, a standardized scale measuring compassionate care attributes was not found in the literature. In response to the gap in the literature, the

researchers formulated a Compassionate Care Assessment Tool (CCAT), which included 28 phrases that described aspects of compassionate care. The phrases were developed based on two patient perspectives: the importance of the care to the patient, and the degree to which their nurses demonstrated these aspects of care during a patient's hospitalization. The strength of response was measured using a scale based on 1 through 4, with 1 being "not important" and 4 being "extremely important." Two hundred fifty hospitalized patients completed the CCAT and rated the following behaviors as important in the provision of compassionate care: the nurse's ability to establish a meaningful connection with the patient, the nurse's ability to meet the patient's expectations, the nurse's ability to exhibit caring attributes, and the nurse's ability to function as a capable practitioner. The researchers concluded, "The provision of compassionate care requires a holistic approach. Patients value nurses forming personal connections, serving as their advocates, and responding to their individual needs" (p. 180).

While the CCAT tool is valuable in adding to the body of knowledge about compassionate care, particularly from the patient's perspective, it does not address the gap in knowledge about how nurses can be taught to provide compassionate care. In response to this issue and nearly a decade later, Post et al. (2014) identified the need for a pedagogical model for healthcare professionals with weak empathic skills. A part of the project identified the need to clarify the meaning of the term *compassionate care*. They postulated that the meaning of compassionate patient care continues to be ambiguous. Nursing research and literature on healthcare have used

terms such as *caring*, *empathy*, *sympathy*, *compassionate care*, and *compassion* interchangeably, implying that these words are often and mistakenly used synonymously, resulting in misinterpretation (Post et al., 2014).

A concept analysis of the term *compassionate care* has shown a relationship between the terms *caring behaviors* and *compassionate care*, yet researchers continue to seek clarity on this phenomenon. For example, Hudacek (2008) explored additional meaning and conducted a phenomenological study to learn more about how nurses described the dimensions of caring as they relate to nursing practice. The researcher sought participants by collaborating with Sigma Theta Tau International (STTI) whose membership global database was used to obtain participants; 120,000 registered nurses were invited to participate. The nurses were asked to recall one caring practice during their career and write a reflective story about the experience. Two hundred stories were submitted to the researcher, who completed an analysis using Giorgi's methodology. The stories validated that nursing care goes beyond the technical aspect of what nurses are required to do. The stories written by the nurse participants illustrated seven caring dimensions: caring, compassion, spirituality, community outreach, providing comfort, crisis intervention, and going the extra distance. Hudacek concluded that, above all, compassion was a universal finding which requires emotional and physical presence going beyond hands-on skills and techniques to alleviate suffering and pain through one's empathic concern. The study also demonstrated that thoughtful reflections, written by nurses, might help to clarify

many essential components of nursing practice, including compassionate care (Hudacek, 2008).

Drumm and Chase (2010) conducted a similar phenomenological study to investigate the lived experience of nursing students attending a nursing program that integrated a caring nursing philosophy throughout the curriculum. Seven senior nursing students were interviewed at the end of their baccalaureate education. The interview included questions about the educational learning experiences in a nursing program, where caring is the central tenet of its philosophy. The students reported that they were not entirely aware of the value of caring in nursing when they first started the program; however, by the end of the program, they appreciated the significance of the caring philosophy in their nursing education and the impact it made on their ability to be caring nurses for patients in the clinical setting. The study demonstrated the importance of connecting caring theory to compassionate nursing practice (Drumm & Chase, 2010).

Compassionate care: Is it a lost art? Nursing has been considered both an art and a science (Palos, 2014). The terms *nursing* and *caring* share a grounded understanding that there is a unique connection between the professional nurse and caring for patients. Technical skills have challenged nurses to keep the "caring" in nursing; therefore, as a profession, we must strive to maintain our "caring" identity. Palos (2014) reminded the nursing profession that the art of nursing must not be forgotten or considered less valuable than the science of nursing, and asserted that the

most competent nurses are those who can appreciate the value of achieving a balance between the science and art of nursing.

Theoretical nursing frameworks based on caring and related research have also consistently supported the significance of providing compassionate care; however, Leininger (2012) expressed concern about what the profession ascribes to and what is actually happening in practice. Leininger contended that nurses may be placing too much emphasis on the medical aspect related to curing and may well be neglecting caring behaviors. This notion has been clearly supported by reports on the need for and lack of compassionate care, particularly from the patient's perspective (Badger & Royse, 2012; Bramley & Matiti, 2014; Crowther et al., 2013; Griffiths et al., 2012; Lown et al., 2011; Price, 2013; van der Cingel, 2014).

Badger and Royse (2012) studied the concept of compassionate care from the perspective of the burn survivor. Using focus groups as part of the study, the authors utilized qualitative data analysis to identify three main themes: "respect for the person, communication, and provision of competent care" (p. 772), concluding that the delivery of compassionate care requires multiple skills and behaviors.

Griffiths et al. (2012) reported the findings of a qualitative study conducted in England using focus groups with patients and family members to learn about the qualities they sought in nurses as well as to learn about the patient's view on nursing education. Thematic analysis revealed similarities in the qualities that patients valued in nurses. The participants reported that they expected nurses to demonstrate technical competence, knowledge, and willingness to seek help when they lacked necessary

knowledge or skills. Moreover, they prioritized "softer" skills such as a "caring professional attitude" as the most important quality (p. 126). This was further described as empathy, communication skills, and non-judgmental patient-centered or individualized care, which they perceived as sometimes lost in nursing. The patients who were interviewed were unified and clear in their responses that they wanted to return to the "care and compassion of the past" (p. 126). The findings highlighted how the patients' and caregivers' voices illuminated the need for improvement in the delivery of care that conveys a sense of compassion; however, there was concern about whether the educational preparation of nursing students can develop these caring qualities. The researchers concluded that nursing education should consider the voice of the patient when re-designing new curricula and also consider including the theoretical roots of caring and caring theories as an underpinning that may have been lost (Griffiths et al., 2012).

Bramley and Matiti (2014) conducted a similar study and explored how patients described their experiences of compassion with nursing care as well as their perspective of developing compassionate nurses. Using a qualitative exploratory descriptive design, the researchers interviewed 10 patients in a large U.K. teaching hospital. They digitally recorded and transcribed the interviews and utilized thematic analysis. Three overarching themes emerged from the data they collected. Patients expressed the need for nurses to: spend more time with patients so they could get to know them better, try and feel what it is like to be in the patients' shoes, and improve communication skills when interacting with patients. The patients reported that they

felt the nurses were lacking these behaviors and there could be relevance and value to informing nurses about which behaviors were perceived to lack compassion. The researchers agreed with the participants and concluded that informing staff nurses about the patients' perceptions of what is considered compassionate or uncompassionate actions could present opportunities to change individual and cultural behaviors.

Crowther et al. (2013) also sought to learn more about the delivery of compassionate care and interviewed family members on their perceptions of compassionate care. The subjects were family members of a loved one experiencing dementia and receiving end-of-life care in a long-term care facility. Family members were asked to provide examples of care that they felt were compassionate and kind. They reported "small things and little acts of kindness" (p. 106) as most meaningful to them. They were also asked to provide examples of care that they felt were uncompassionate or unkind during the care of their dying loved one. These included less interest in the patient's overall care and a lack of privacy when the loved one was dying. The findings identified the need for nursing education to improve curricula about the overall delivery of compassionate care. Additionally, the importance of educating nursing students on the care of patients dying with dementia and the significance of providing compassionate care to vulnerable populations were emphasized (Crowther et al., 2013).

Patients' and family members' reports on the delivery of compassionate care have provided insight into the nuances of this phenomenon. In addition, healthcare

environments, which are lacking in the provision of compassionate care, produce less than optimal patient outcomes (Adam & Taylor, 2014; Bramley & Matiti, 2014; Davin & Thistlethwaite, 2014; Halldorsdottir, 2012; Knight et al., 2013; Peters, 2006; Smith et al., 2010; Tanner, 1990; van der Cingel, 2014).

The nature of work that is experienced by healthcare professionals including nurses has been described as very difficult, yet Goodrich (2014) reported the challenges that are experienced are seldom acknowledged in these roles. Goodrich raised a concern that stressful work conditions may have a negative effect on both the healthcare professional and the patient's well-being, and acknowledging that the work is hard may result in improved quality care and reduced risk of burnout. A pilot program called the "Schwartz Centre Rounds," originally launched in 1997 by the Kenneth B. Schwartz Center in Boston, Massachusetts, was created for the healthcare team to be able to acknowledge and discuss the non-clinical emotional challenges that they encountered when caring for difficult patients and whether they felt these challenges compromised their ability to provide compassionate care. The Schwartz Rounds have been implemented in 180 hospitals in the United States as well as 21 hospitals and eight hospice programs in the United Kingdom. While multidisciplinary clinical rounding is not a new concept to the U.S. healthcare system, the Schwartz Rounds were instituted in response to reports that compassionate care was lacking in the U.K. healthcare system. The program has provided new knowledge on the delivery and practice of compassionate care in the United States (Lown & Manning, 2010) and in the United Kingdom (Goodrich, 2014).

Adam and Taylor (2014) discussed other environmental factors such as inadequate staff-to-patient ratios, financial constraints, and an existing focus on curing rather than caring. Bramley and Matiti (2014) reported patient experiences of uncompassionate actions that resulted in poor patient care. Halldorsdottir (2012) asserted that it is only through increased studies on the behaviors of caring and uncaring that the nursing profession will be able to progress toward a better understanding of compassionate care as a nursing competence. It is therefore understood that compassionate care will include actions that may be defined as caring behaviors and be based in human caring; however, there is an additional need for 21st-century research to generate evidence that will provide a deeper understanding of this concept as it relates to nursing practice (Halldorsdottir, 2012).

21st-Century Nursing Education

The Institute of Medicine's (IOM, 2010) *The Future of Nursing: Focus on Education* report stated that healthcare challenges facing the nation have shifted dramatically. American population demographics have also changed. The geriatric population has increased, and patients are socioeconomically and culturally more diverse. In addition to the shift in demographics, the nation's healthcare needs are changing, with a higher number of patients developing chronic conditions. This shift suggests that the nursing education of the 20th century is no longer adequate for dealing with the 21st-century needs of healthcare. As healthcare becomes more complex, nursing education will need to adjust curricula to meet these changes. In order to meet these demands, evidence-based pedagogies will be required to meet the

needs of the changing population. Nurses will be called upon to function as leaders and healthcare professionals to deliver safe, high-quality, patient-centered care (IOM, 2010).

Patient-centered care. *Patient-centered care*, also referred to as *person-centered care* and *relationship-centered care* (Kitson, Marshall, Bassett, & Zeitz, 2013), have been characterized as being compassionate, empathetic, and respectful of the patient's values, needs, preferences, and culture (Marshall, 2010). The IOM's (2010) *The Future of Nursing: Focus on Education* report recommended a reform in nursing curricula to support the vision of a healthcare system that is *patient-centered*. Health organizations around the world recognize compassionate care as an essential element of patient-centered care (Price, 2013). Conversely, the onset of global technological advancements has created an environment in the healthcare setting that has devalued the importance of caring behaviors and the delivery of compassionate care. These concerns have prompted professional nursing regulatory boards to recommend research-based pedagogies that could respond to the issues of the changing healthcare environment and the call for *patient-centered* compassionate nursing practice (AACN, 2015; NLN, 2003, 2005, 2013).

Lown et al. (2011) posited that compassionate care could be achieved if all members of the healthcare team were to understand that compassionate care is an essential part of *patient-centered care*. This is significant since patient-centeredness is the third "Aim for Improvement" in the IOM's (2001) report *Crossing the Quality Chasm: A New Health System for the 21st Century*. The acknowledgement that

compassionate care is a component of *patient-centered care* is further supported by the AACN's (2015) Quality and Safety Education for Nurses (QSEN) competency definition for *patient-centered care* which stated, "Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values and needs" (n.p.).

As has been pointed out, *patient-centered care* is sometimes used synonymously with compassionate care because some of the qualities central to these two concepts overlap, such as professionalism, excellent communication skills, and caring behaviors (Clarke, 2014; Marshall, 2010). These qualities also overlap with the multidimensional model of compassionate care described by Badger and Royse (2012), in that they share an emphasis on the need for excellent communication and include the need to provide patient care with compassion—thereby indicating that compassion is an aspect of *patient-centered care*. In the present study, the focus was specifically on how compassionate care is taught; however, since the term *patient-centered care* is frequently found in the literature and includes compassionate care, it is useful to specify that compassionate care can be understood to be a component of patient-centered care, but it is not a synonymous term.

Although the dimensions of compassionate care that patient value have been identified, studies have yet to clarify the process involved in delivering or teaching compassionate care. Given the heightened awareness and emerging discussions in both healthcare and academic institutions about compassionate care, The Arnold P. Gold Foundation, a public nonprofit organization, has collaborated with the American

Association of Colleges of Nursing (AACN) to launch a national initiative promoting compassionate care, respect, and empathy as the core of all healthcare interactions. The Gold Foundation supports efforts to spread the habit of humanism in healthcare and further defines humanism to include seven attributes, one of which is compassion. In support of this initiative, Bednash, former AACN Chief Executive Officer, stated, "Providing compassionate care, informed by a scientific base of knowledge, is a hallmark of professional nursing practice" (The Arnold P. Gold Foundation, 2013, p. 255).

While there is increasing emphasis on compassionate care and *patient-centered care* in the healthcare arena, nursing leaders and researchers have a limited understanding of how to promote and teach compassionate care and caring in the academic and clinical setting. Currently, to promote compassionate care, nursing education emphasizes the importance of the nurse-patient relationship. Compassionate care is the foundation of this relationship, which allows nurses to build effective relationships with their patients as they face the challenges that arise during patient care (Adam & Taylor, 2014; Blomberg, Griffiths, Wengstrom, May, & Bridges, 2016; van der Cingel, 2014).

A series of projects that focused on compassionate nursing care within the context of *patient-centered care* have been published in the United Kingdom. One major initiative included a comprehensive 3-year program entitled the Leadership in Compassionate Care Programme (LCCP) of Edinburgh Napier University in Scotland, from 2007 to 2011. The LCCP was developed in the United Kingdom as a

joint program of action research between Edinburgh Napier University and Lothian University Hospitals NHS (National Health Service), focusing on embedding compassionate care into practice and undergraduate nursing curricula while also supporting newly qualified nurses during their first year in practice to facilitate the transition from student to competent and compassionate staff nurse. The LCCP was created in response to reports of less than optimal patient care in the United Kingdom (Smith et al., 2010). The program used several research methods to gather information and identify what was uniquely important and contributed to compassionate care in different patient care environments. A series of projects and programs were created and aimed at providing information about ways to embed compassionate care into practice and education, based on related literature that focused on compassionate relationship-centered care (Adamson, 2013; Adamson & Dewar, 2011; Dewar & Cook, 2014; Dewar & Mackay; 2010, Dewar & Nolan; 2013; Dewar et al., 2014; Smith et al., 2010).

In response to the LCCP initiative, Dewar and Mackay (2010), Dewar and Nolan (2013), and Smith et al. (2010) studied compassionate relationship-centered care with a geriatric population in an acute-care hospital setting. They used the research approach of Appreciative Inquiry (AI) and the findings added to the conceptualization of a model for compassionate relationship-centered care. AI is an approach that incorporates the use of 4 “D” cycles or phases of inquiry which are intended to engage people at all levels to produce effective, positive change (Cooperrider, Whitney, & Stavros, 2003). The 4 “D” phases of activities include:

(a) discovery, (b) dream, (c) design, and (d) destiny. The first phase (discovery) evaluates what aspects of compassionate care are being done and whether or not they are effective in delivering such care; the second phase (dream) identifies what would be the ideal and most desired caring environment; the third phase (design) identifies the activities and necessary steps to achieve the desired environment; and the fourth phase (destiny) sets the direction and policy recommendations to improve the program. The researchers collected the data from patients, family members, and staff, and were guided by using data collection strategies that included participant observation, picture interpretations, focus group discussion, interview, feedback sessions, field notes, and document review as ways to identify patterns of essential information. The information learned contributed to a greater understanding about compassionate care, which requires leadership and commitment from the healthcare team. This led to the development of a model for healthcare professionals, which is based on engaging in appreciative caring conversations. In developing the "Model of Compassionate Relationship-Centered Care," Dewar (2013) identified the 7 C's of caring conversations (Courageous, Considerate, Curious, Celebratory, Collaborative, Connective, and Compromising). These highlighted the intricate but delicate interactions that occur during conversations with patients and families, and they emphasized the necessity of ensuring that all parties experience compassionate relationship-centered care. This model has also been used in the development of nursing leadership and management programs in the United Kingdom as a way to

create and shape a compassionate culture in healthcare organizations (Dewar & Cook, 2014).

Adamson (2013) participated in action research that added to the LCCP initiative and explored what compassionate care means in practice. The aim of the study was to incorporate compassionate care into practice and education. Adamson gathered stories and examples of clinical care, capturing the experiences of patients, relatives, staff, and students. The researcher found a relationship between compassionate care and personal satisfaction at work. In the analysis of the stories and observation data, six themes emerged: (a) caring conversations; (b) person-centered risk taking; (c) giving and receiving feedback; (d) knowing me, knowing you; (e) openness; and (f) adaptability. The stories gathered as part of the LCCP provided insight into the experiences of healthcare workers as they practice compassionate care and the satisfaction they experienced in doing so. By asking people about positive experiences, the program encouraged staff to understand compassionate care and patient-centered care better and to reflect on the vital part such care can play in both patient and staff experiences. The outcomes from the research have the potential to inspire and encourage nurses at all stages of their career and can also be translated into undergraduate and postgraduate learning education (Adamson, 2013, p. 61).

Steenbergen (2013) ascertained and compared the perspectives of nursing students and faculty about how patient-centered care was taught at two universities in the United Kingdom. The research supported the recommendations made by Dewar

(2013), Dewar and Nolan (2013), and Smith et al. (2010) that compassionate care be established in education and practice. These researchers suggested that the key principles of compassionate care be embedded and evaluated within undergraduate nursing curricula to support the vision of a healthcare system that is *patient-centered*. Using a qualitative approach, Steenbergen (2013) explored how *patient-centered care* is taught in nursing curricula and how it influences nursing practice. With data gathered from interviews, the findings revealed that *patient-centered care* was discussed in the first year of nursing school, but more emphasis on it was needed throughout the curriculum and through graduation. Also identified was the need to increase *patient-centered care* approaches during assessment classes, both theoretically and practically.

Research in the United Kingdom has sought to examine the concept of compassionate care and has highlighted some development in the area of nursing education. However, no U.S. studies have focused specifically on how nurse educators teach ways to provide compassionate care to baccalaureate nursing students.

The role of the nurse educator. Educating for compassionate nursing practice is a complex phenomenon. Nurse educators are required to ensure that core competencies, particularly knowledge and skills in compassionate care, are cultivated and developed in nursing students before they enter the profession as a practicing nurse. Despite the significance of and emphasis on the phenomenon of compassion as central to nursing, the professional literature continues to lack information and

pedagogical structures about teaching compassionate care as experienced by nurse educators. The literature revealed that faculty might assume nursing students know about compassion and other kinds of affective responses; therefore, they allocate little curricular time for this aspect of care (Adam & Taylor, 2013; Drumm & Chase, 2010; Murphy et al., 2009; van der Cingel, 2014).

According to Lown et al. (2011), educators who teach healthcare professionals how to provide compassionate care need new approaches to learning this competency. Their recommendations supported initiatives for faculty development that will include ways compassionate care can be taught to students who are entering healthcare professions. They also suggested curriculum development that includes standardized methods to assess the students' communication skills with and attitudes toward compassionate care.

Peters (2006) conducted a phenomenological study to explore baccalaureate nurse educators' lived experience of compassion within the context of nursing education. van Manen's interpretation of the data was utilized to determine emerging themes and meanings related to the educators' experience with compassion. Peters generated seven essential themes from the transcripts of 11 nurse educators who participated in face-to-face semi-structured interviews. The essential themes included: "forming connections with others; walking a mile in another's shoes; recognizing needs, burdens, and sufferings; embracing the emotional response to suffering; acting to make it better; giving and receiving gifts; and being aware of the boundaries of the professional role" (pp. 41-43). Peters discussed how in order to feel compassion and

practice compassionate care, healthcare professionals may need to establish a connection with others by "walking a mile in another's shoes" (p. 41). They must also recognize the individual care needs and feeling of burden that are experienced by each person as well as identify how they might contribute to each person's well-being. These findings also identified the need for nurse educators to obtain professional development and training that include learning modules which address the necessary boundaries of the professional role, as experienced during compassionate interactions with students, patients, and significant others (Peters, 2006).

Wiklund Gustin and Wagner (2013) asserted that in order for nurse educators to teach students how to provide compassionate care, they should have a sense of self-compassion. Therefore, they conducted a phenomenological study using hermeneutic interpretation to explore four clinical instructors' understanding of the meaning of self-compassion. Five themes were identified: being there with self and others, being respectful of human vulnerability, being non-judgmental, being the patient's voice as needed, and being able to accept compassion from others. A main metaphorical theme, "the butterfly effect of caring," was also identified (p. 180). The researchers described the "butterfly effect" as a metaphor for a compassionate moment between nurse and patient, which provides a deeper understanding of the mutual transcendence that occurs when compassionate care is experienced by both nurse and patient. Their findings provided a new understanding of compassionate care and concluded that it is not the sole act that the nurse provides, but rather an

intentional connection between nurse and patient, in which both are mutually engaged in the experience and benefit from the exchange of compassionate care (Wiklund Gustin & Wagner, 2013).

The ways in which educators interact with their students both in and outside of the classroom can also influence how students might interact with their patients when they become nurses (Adam & Taylor, 2014). Newton (2010) asserted that students model the behaviors of their teachers, and the vital quality of compassion can be taught by example. This places an emphasis on the importance of the interaction between nurse educators and their students in influencing the students' overall attitudes, behaviors, and capacities as nurses in the future. For example, students might adopt behaviors that they see their teachers exhibit during interactions outside the classroom (Baldwin, Bentley, Langtree, & Mills, 2014). This possibility led Livsey (2009) to caution that educators should be conscious of how their behaviors might be perceived by their students.

Teaching compassionate care as a core competency. The ability to provide compassionate care to patients is one of the core competencies and core values of baccalaureate nursing education (Betcher, 2010; Murphy et al., 2009; van der Cingel, 2014). Eskes et al. (2013) defined a core competency as "the functional adequacy of and capacity to integrate knowledge and skills with attitudes and values into the specific context of practice" (p. 2). Nurses are asked to demonstrate proficiency in the required core competencies set forth by the profession. These include excellence in specific technical skills as well as the ability to provide compassionate care to all

patients, the challenge of which is recognized, especially without the appropriate training (Baldwin et al., 2014; Monks & Flynn, 2014).

Teaching communication to facilitate compassionate care. The literature discusses effective communication skills as a core competency and its relationship to the delivery of compassionate care, which is worth noting. Barnard and Ganca (2011) discussed the necessity for possessing good communication skills when participating in difficult conversations with patients, such as the need for palliative care. They emphasized that communication is the consistent thread and competency required in the delivery of compassionate care, stating that "Effective communication incorporates attitudes of authenticity, sensitivity, compassion and empathy, all of which assist health care professionals to support patients, families, and each other" (p. 283). Some behaviors that reflect effective communication generally entail being able to listen and attend to other people, being comfortable in silence, acknowledging other people's emotions and needs, and being able to contain one's own emotions. Thus, these highlight that the nurse is the point of reference in this process and the link that can either positively or negatively affect patient outcomes. Barnard and Ganca further concluded that careful and compassionate communication may be challenging, but once mastered, can be rewarding to healthcare professionals and patients because patients are better informed and emotionally prepared for their future healthcare management.

Badger and Royse (2012) further incorporated communication within the context of compassionate care as both interpersonal and informational, with nurses

expected to demonstrate empathy and warmth when interacting with patients and to have the skills required to communicate medical information with compassionate care.

In a descriptive survey study, Wilkes, Cowin, Johnson, and Zheng (2014) explored what nursing students and graduate nurses perceived to be the most important qualities of a registered nurse. The participants cited caring behaviors as the most important quality, followed by the possession of technical knowledge and skills, the ability to empathize, and communication skills. The researchers concluded that since caring is emphasized as a critical component of nursing, educational opportunities should be presented to student nurses to integrate not only technical skills but also teaching and learning experiences about caring and empathy. The study also cited future implications for curriculum development that should emphasize a greater focus on communication and the ways nursing education can enhance the student nurses' learning experience to include more focus on caring behaviors and communication skills with patients and their families.

The nursing profession therefore understands that the core competency of using effective communication skills to convey information with compassionate care is one aspect of providing compassionate care to patients and is a necessary component of nursing education. The delivery of compassionate care is a core value and expected competency in nursing practice—and therefore a desired attribute in nursing students.

An extensive body of literature has discussed the ways in which nurse educators have attempted to align and revise nursing curricula to ensure that nursing students meet the specific core competencies that are required for graduation. A significant body of nursing literature is also related to teaching and learning in nursing education, which outlines many different strategies and initiatives to ensure that student nurses acquire requisite knowledge and skills. However, despite the availability of such literature, very little describes the ways in which nurse educators teach nursing students how to deliver compassionate care to their patients. Thus, this study was conducted to uncover what may be missing in nursing curricula as well as what is being done to teach nursing students how to provide compassionate care to their patients.

Teaching compassionate care. Research on compassionate care that has focused on practicing nurses and nursing students (Dewar & Mackay, 2010; Drumm & Chase, 2010; Horsburgh & Ross, 2013; Murphy et al., 2009; Wilkes et al., 2014) has identified the need for nursing education to develop curricula and pedagogical approaches that can facilitate the delivery of compassionate care. Given that nursing students are expected to establish patient-centered relationships that demonstrate respect, empathy, and compassion, Curtis et al. (2012) specifically explored this issue by conducting a grounded theory study involving 19 nursing students enrolled in a nursing program in England during 2009-2010. The nursing students reported several concerns including emotional vulnerability and uncertainty of the emotional requirements for compassionate practice. The researchers concluded that more

effective support is needed to meet the demands of 21st-century nursing and the professional expectation of compassionate practice. A secondary analysis of the study data completed by Curtis (2014) identified implications for future research that refers to the "hidden curriculum," which is lacking clarity and effective strategies for student learning about how to practice compassionate care. Curtis reported that debate continues over what compassionate practice is and how it is learned. In response to this concern, Curtis developed a new definition of compassionate practice: "Compassionate practice comprises the enactment of personal and professional values through behavior that demonstrates the emotional dimension of caring about another person and the practical dimension of caring for them, in a way to recognize and alleviate their suffering" (p. 212).

The literature reflects gaps in nursing curricula and has highlighted challenges for nursing education inherent within the professional expectations for compassionate practice; therefore, the present study explored the teaching strategies that educators use to develop nursing students' abilities to provide compassionate care in order to add to the body of knowledge on compassionate care and nursing education.

Environmental influences and teaching compassionate care. Curtis (2013) explored nurse educators' experiences and concerns in their ability to prepare nursing students for compassionate practice. A phenomenological approach was used to obtain rich descriptions of their concern directly from nurse educators. The findings included perceived obstacles about teaching in an economically driven healthcare environment. Curtis reported the challenges of managing larger clinical groups and

the limited time available to conduct small group discussions with students, which would enable compassion to develop in a meaningful and emotionally sustainable way. Other concerns included student observations of poor role modeling by practicing RNs and the need for strong nursing leadership that will actively challenge these constraints (Curtis, 2013).

Given the perceived environmental barriers and challenges of teaching nursing students, Loewenson and Hunt (2011) developed and implemented the use of a clinical service-learning experience as a part of a public health nursing course. The course included clinical work with a homeless population. The goal of the service-learning experience was to provide nursing students with a better understanding of the homeless population and, hopefully, to foster the development of learning and the ability to provide compassionate care to a vulnerable population. Developing curricula and structuring clinical experiences that provide opportunities for students to better understand the experiences of marginalized populations may influence students' attitudes and foster more compassionate care. A pretest-posttest intervention study examined 23 nursing students who attended a small Midwestern university. The Attitudes Toward Homelessness Inventory was used to measure students' attitudes at the beginning and the end of the course. Data analysis using descriptive statistics revealed significant differences in students' attitudes toward people experiencing homelessness. The findings indicated that service-learning clinical experiences positively influenced students' attitudes and supported the value of integrating service-learning clinical opportunities with homeless individuals into nursing

curricula. It also demonstrated that service-learning might help to provide clarity to many essential components of nursing practice such as compassionate care (Loewenson & Hunt, 2011).

The cultivation of compassion develops in clinical practice during the nurse/patient interaction. Halifax (2014) created the G.R.A.C.E. process as a simple and efficient intervention for nurses who work in stressful healthcare environments to use as a guide for cultivating compassion during nurse/patient interactions. Halifax discussed the increasing importance of training nurses to be compassionate caregivers, given the impact of added work stress that is caused by changes in technology, staffing shortages, increased workloads, and institutional demands that are expected of nurses. The mnemonic for the G.R.A.C.E. intervention is: "G" gathering attention, "R" recalling intention, "A" attuning to self/others, "C" considering, and "E" engaging (p. 123). The process guides the nurse to pause briefly and *gather* his or her attention about the interaction; briefly *recall* his or her intention of care; refer to the process of *attunement* to determine if any emotional biases might affect the compassionate interaction; *consider* what is necessary to facilitate the interaction; and *engage* the patient in the cultivation of a compassionate interaction. Halifax's intention in developing the G.R.A.C.E. process was to provide a guide that will assist each nurse to pause and be more mindful of the importance of compassionate interactions with patients. The researcher also concluded that "the G.R.A.C.E. process could be used in everyday interactions for an individual who wants to cultivate more compassion in his or her own life" (p. 125).

How is compassionate care taught in nursing curricula? Affective learning is essential to the nurturing and caring perspective of the professional nurse. Valiga (2014) defined affective learning as "having to do with values, beliefs, humility, and personal insight" (p. 247). She described how learning in this domain occurs when students are challenged to think deeply and critically about what guides their actions and how they relate to others, reflect on their values, and make conscious decisions about the kind of people they want to be in this world. Researchers have implied that it is not a matter of sacrificing attention to the cognitive or psychomotor aspects of learning; rather, it is about bringing all three aspects into better balance (Brien, Legault, & Temblay, 2008; Valiga, 2014). The complexity of compassionate care and how it can be taught in nursing curricula is difficult to quantify and measure. The literature has suggested that compassion and caring are acknowledged as less important elements in nursing curricula, with greater emphasis being placed on the technical components (Adamson & Dewar, 2011; Curtis, 2014).

Traditional approaches of teaching such as lecture and clinical instruction are effective in supporting the cognitive and psychomotor aspects of learning, but may be inadequate for achieving the affective competencies, which include an emotional element. Some of the teaching approaches that nurse educators use in an effort to develop the ability to provide compassionate care in nursing students include classroom discussions and presentations, clinical supervision, feedback and summative assessments, real-life opportunities that can hone communication skills, and narrative-based medicine (Adam & Taylor, 2013; Knight et al., 2013).

As a part of the LCCP initiative, Adamson and Dewar (2011) conducted focus groups, generated questionnaires, and sent emails to elicit responses from students and educators to better understand the elements behind the teaching and learning of compassionate care. The researchers' intention in their research project was to determine ways to integrate compassionate care in academic curricula and clinical practice. Using this information, Adamson and Dewar developed a project in which they analyzed a third-year nursing module that teaches nursing students about care during the acute phase of an illness. The researchers focused on all aspects of the teaching strategies and assessment tools utilized in this module. They identified what they felt was intended to be implied in teaching and learning about the delivery of compassionate care in the learning module. However, it was conveyed as a less prominent aspect of learning as compared with the technical component, thus identifying the need to making compassionate care more explicit in nursing curricula. The project also identified that students focused more on technical skills rather than interpersonal skills, which are integral to compassionate caring. The project recommendations identified the need to redesign the module and add teaching and learning materials that reflect compassionate care in a more explicit way. One example was by using simulated patient scenarios that teach students to engage in conversations with patients who require a compassionate response. After the simulation experience, the student interaction was evaluated during a reflective discussion. Other suggestions included writing assignments that asked the students how they might ensure compassionate nursing care was provided during a specific

situation with a patient. The researchers noted that the project provided some insight into the processes and interventions for teaching nursing students how to provide compassionate care; however, they suggested that research is needed in this area.

In order for educators to teach the provision of compassionate care to nursing students, educators should have an understanding of the dimensions of compassion (Knight et al., 2013). Knight and colleagues (2013) applied the use of a three-dimensional framework of compassion that educators can use to guide the ways in which they teach compassionate care to students: (a) personal and organizational, (b) theoretical, and (c) practical dimensions (p. 3). Within this framework, the personal and organizational dimension refers to self-compassion and students/staff are asked to explore various aspects of the organization and their influence and impact on their own sense of compassion. The theoretical dimension is rooted in the tenets of humanity courses and social sciences such as biology, culture, psychology, and religion by using a range of literature and media to gain a better understanding of compassion as it relates to each discipline and the participant's individual belief systems. The practical dimension refers to the application of compassion or ways to utilize a range of teaching strategies, with a specific emphasis on communication, reflection, and shared experiences. The model was initially piloted in health-related academic courses at the University of Greenwich, London, and deemed a success by the participants, which suggests that a multidimensional approach may prove to be helpful for teaching the components of compassionate care. The model is currently being piloted at Masaryk University, Czech Republic, with Master's-level nursing

students specializing in intensive care nursing and will be reviewed and evaluated upon completion of the pilot.

Among the researchers who have introduced new teaching approaches for compassionate care, Baldwin et al. (2014) utilized themes from the motion picture *The Wizard of Oz* and applied the needs of Dorothy's traveling companions to the essential qualities that a student nurse will acquire during the educational process, or what the authors referred to as the students' journey on the "yellow brick road." Based on themes from the movie, a scarecrow, a tin man, and a cowardly lion accompany Dorothy to the Land of Oz with the hopes of gaining a brain (knowledge), a heart (compassion), and courage (professional confidence). Baldwin et al. claimed that knowledge, compassion, and professional confidence are essential characteristics of graduate nurses. The researchers addressed the brain or knowledge through teaching and learning experiences that contribute to the development of nursing knowledge, including an evaluation of these characteristics through classroom proficiency exams and technical performance of skills. In addition to the evaluation of students' cognitive abilities, the heart or compassionate care requirement was evaluated by the students' ability to demonstrate empathy and deliver compassionate care in the practice setting. Baldwin et al. noted that the nurse's role as the coordinator of the patient's care requires personal confidence (courage) in the execution of the plan. The student attribute of personal confidence was evaluated by direct interaction with the healthcare team, including the ability to inquire about the patient's individualized plan of care, and the self-direction to seek nursing peer

support as needed. Baldwin et al. posited that the concepts of the brain, heart, and courage were guiding symbols of the identification and evaluation of the attributes that nursing students should possess, while instilling the value of identifying those attributes and applying them to patient care when they enter the profession as practicing nurses (Baldwin et al., 2014).

One teaching approach that has been found to be an effective teaching strategy when complex ideas are tied to emotional content is called photo elicitation, the use of which is discussed by Linz (2011). This approach involves using photography as a way to comprehend complex ideas that may evoke an emotional response. The researcher noted that this approach is particularly well suited for engaging visual learners. One example suggested was the use of photographs that portrayed sick elderly patients as a way to stimulate discussions about death and dying—a topic that nursing students often express feeling apprehensive about. Another example suggested was the use of photographs of homeless people as a way to elicit the beliefs and negative attitudes students might have toward this population, leading to a better understanding of their own feelings toward the homeless and issues of homelessness. Linz reported that her students described the use of photo-elicitation as stimulating, interactive, and thought-provoking. Photo elicitation is an effective strategy that enhances learning in the affective domain and could be applied to teaching nursing students about the delivery of compassionate care.

Brien et al. (2008) discussed the use of emotionally charged learning activities and how they may have an appreciable effect on the affective learning process. The

nursing faculty at the University de Montréal, Québec, designed the use of emotionally charged reflective and experiential activities, which were intended to stimulate an emotional response in the students. Using a competency-based approach, the researchers developed a 4-week project on teaching and learning strategies that targeted affective learning. The project was implemented within an undergraduate nursing course that focused on end-of-life care. Teaching and learning included the use of competencies that addressed interpersonal dynamics during end-of-life care; however, the outcome of the project revealed difficulties for both the nurse educators and the students in evaluating derived learning in the affective domain. The researchers' evaluation supported the idea that reflective and experiential activities that stimulate an emotional response are important to end-of-life care in nursing education. However, they validated the difficulties that nurse educators endure when observing and evaluating students' actual affective learning in terms of observable skills. The project also illustrated the complexity of using competency-based tools and whether they are effective in demonstrating outcomes of affective learning. The researchers reported that although difficult to evaluate, emotionally charged learning activities positively contributed to the learning process of teaching nursing students about compassionate interventions for end-of-life care. Given the subjective aspect of this type of learning, future research that supports affective learning expectations for nursing students was suggested (Brien et al., 2008).

Chambers and Ryder (2012) viewed excellence in compassionate nursing care as a key element to nursing practice and leadership and presented their ideas in a

book titled *Excellence in Compassionate Nursing Care: Leading the Change.* The book discussed the need for the profession to regain its balance and restore the delivery of compassionate care as it was in the past. The authors stated that the United Kingdom was ahead of the United States as it related to patient-centered care, yet the literature in both the United States and the United Kingdom lacks specificity and direction, thus presenting challenges for the nursing profession. The book focused on potential professional difficulties and offered practitioners ways to build on knowledge and experiences so they might act as catalysts for change. Specific issues in theory and practice were discussed, including reflective exercises and case studies that offer thought-provoking inspiration for nursing education (Chambers & Ryder, 2012). However, the authors' approach was general and lacked evaluative methods that validated whether the approaches were effective in teaching nursing students how to deliver compassionate care.

The delivery of compassionate care, thus, is important to the profession (AACN, 2015; ANA, 2015; NLN, 2003, 2005, 2013). The literature review for the present study discussed the significance of compassionate care and how practicing nurses view this as the most important quality of the profession (Halifax, 2014; Hudacek, 2008; Price, 2013; van der Cingel, 2014; Wilkes et al., 2014). Researchers have discussed whether compassionate care is innate or whether it can be taught (Crawford, Gilbert, Gilbert, Gale, & Harvey, 2013; Davin & Thistlethwaite, 2014). Patients have agreed that compassionate care is the most important attribute they seek in healthcare professionals, yet a degree of lack of this attribute has been identified in

the United States and other healthcare systems in the world (Badger & Royse; 2012; Bramley & Matiti, 2014; Griffiths et al., 2012; Lown et al., 2011; van der Cingel, 2014). Family members have reported that compassionate care is becoming less of a priority in healthcare and often the patient healthcare experience has been described in a negative light (Crowther et al., 2013; Griffiths et al., 2012).

Although student nurses and novice nurses are expected to enter the workforce and deliver care with compassion, they have expressed concerns over the clear lack of preparation in the socialization, education, and instruction of such care (Curtis et al., 2012; Drumm & Chase, 2010; Wilkes et al., 2014). Conversely, experienced nurses in practice have expressed similar concerns (Monks & Flynn, 2014). Studies conducted with nursing faculty (Brien et al., 2008; Curtis, 2012; Peters, 2006; Wiklund Gustin & Wagner, 2013) have concurred with nursing students and reported concerns indicating that ongoing changes in healthcare and challenges in nursing education have created tension for nursing faculty and challenged their ability to address effectively the multiple dimensions of learning required of nursing students for skilled and compassionate practice.

Compassionate care is not a new phenomenon in nursing practice or theory. Nursing pioneers have set the groundwork for nursing education (Roach, 2002; Watson, 1979), yet compassionate care is not easily found in nursing curricula or in the profession's body of knowledge which guides nurse educators in ways to teach students to deliver care with compassion.

Authors in the United Kingdom have published a few different strategies to develop the skills needed to provide compassionate care. These include classes that integrate reflective discussions, reflective diaries, and summative assessments (Adam & Taylor, 2014; Knight et al., 2013), and simulation exercises or web-enhanced assignments (Adamson & Dewar; 2011). Some authors have emphasized the significance of faculty role modeling when teaching students to provide compassionate care (Livsey, 2009; Newton, 2010; Post et al., 2014), while others have discussed how multidisciplinary rounds (Goodrich, 2014; Lown & Manning, 2010) have benefitted new knowledge of the delivery of compassionate care across the nation.

In addition, authors in the United States and in other countries have implemented a few innovative teaching strategies as a way to teach and cultivate learning about compassionate care with nursing students. These include emotionally charged learning activities using role-play simulation (Brien et al., 2008), service-learning experiences (Loewenson & Hunt, 2011), the use of analogies with motion pictures (Baldwin, 2014), and photo elicitation (Linz, 2011). Nevertheless, given the subjective aspect of this type of learning, it is difficult to assess and evaluate outcomes derived from such strategies and whether they will have an impact on compassionate practice.

The review and analysis of the literature have demonstrated that nursing pedagogy is lacking empirical evidence on how nurse educators teach baccalaureate nursing students to deliver compassionate care. The literature review for this study

identified a scarcity of quantitative studies (Murphy et al., 2009) on the delivery of compassionate care; moreover, a standardized scale that can measure student nurses' attributes in the delivery of compassionate care was notably absent. While some qualitative studies have addressed aspects of this issue within the context of nursing and healthcare (Crowther et al., 2013; Curtis et al., 2012; Griffiths et al., 2012; Dewar & Mackay, 2010; Dewar & Nolan, 2013; Peters, 2006; Smith et al., 2010; Steenbergen, 2013; Wiklund Gustin & Wagner, 2012), no studies have yet explored nursing faculty beliefs about the value of teaching compassionate care and pedagogical expectations and requirements, including the approaches that they do or do not use, as well as any facilitators and barriers to teaching nursing students how to provide compassionate care. Thus, the present study was designed to address these identified questions and gaps in the literature.

Summary

The provision of compassionate care involves various skills, attitudes, and knowledge that can be developed within the curriculum of a school of nursing, and educators play a key role in teaching nursing students how to provide compassionate care to patients (Adam & Taylor, 2014). Compassionate care has been categorized as an essential nursing competency that nursing students are expected to learn and one that contributes to positive health outcomes by increasing patients' knowledge of their condition and establishing relationships with families (Smith et al., 2010). A review of the literature indicated that trends in nursing education have failed to

provide sufficient knowledge and skills related to compassionate care among nursing students (Price, 2013).

In keeping with the recommendations of the IOM (2010) report *The Future of Nursing: Focus on Education,* a change in nursing education to support the IOM vision of a healthcare system of patient-centered care is required, and curricula will need to reflect this. The NLN, in its position statements of 2003 and 2005 as well as in its mission statement and report of core values (2013), has challenged nurse educators to develop evidence-based pedagogies that incorporate compassionate care into the training of nursing students, emphasizing the need to be responsive to the changing healthcare environment (NLN, 2003, 2005, 2013).

The research is clear that nurse educators play a key role in contributing to the preparedness of nursing students in providing compassionate care. The review of previous studies indicated that compassionate care is a difficult concept to integrate into nursing curricula, noting the scarcity of information from the literature about how compassionate care should be taught to nursing students (van der Cingel, 2014). Much remains unknown in terms of how nursing students are helped to value and understand how to provide compassionate care as well as what beliefs and values nursing educators hold concerning their responsibility in this aspect of nursing education. This study was intended to offer a first step to understanding how faculty and curricula in schools of nursing educate for compassionate practice.

Chapter III

METHOD

The Research Approach

Interpretive description was the research method used to explore how compassionate care is taught in baccalaureate nursing programs. Nurse educators play a significant role in shaping the competencies that are required of nursing students during their nursing education; therefore, they were a key source in describing their experiences with teaching the competency of compassionate care in baccalaureate nursing programs. Interpretive description is a qualitative approach to inquiry that can be applied when studying complex human health phenomena within its natural context (Thorne, 2008; Thorne, Kirkham, & MacDonald-Emes, 1997).

Polit and Beck (2010) concurred that an interpretive descriptive design, which includes thick descriptions, can provide a rich, contextualized understanding of human experience through the investigation of the phenomenon itself (p. 1454). Interpretive descriptive design draws upon methodological principles that were developed in grounded theory and naturalistic inquiry. It allows the researcher to draw on theoretical, practical, and professional knowledge to guide analytical reasoning, reflection, and data interpretation (Thorne, 2008), making the method a good fit for discovering how nurse educators teach nursing students to provide compassionate care in educational environments. It is a naturalistic approach that

uncovers the complexity of human experiences within the context of a real setting. The researcher obtains rich descriptions of the phenomenon of interest from different subjective perspectives, while accounting for variations among individuals. In addition, the theoretical and practical knowledge that the researcher contributes to the study is considered a platform on which to design the approach (Hunt, 2009).

The literature review for this study indicated that the phenomenon of interest concerning the ways in which nurse educators teach nursing students to provide compassionate care lacked adequate description and explanation in published research studies. Thus, nurse educators were asked to define compassionate care, share their beliefs about the value of teaching compassionate care, and describe some of the teaching approaches they have found effective in teaching nursing students how to provide compassionate care in both the classroom and the clinical area. According to the AACN's (2008) *Essentials of Baccalaureate Education for Professional Nursing Practice*, teaching students how to provide compassionate care is a pedagogical expectation in nursing curricula. Therefore, nurse educators were asked to describe their beliefs about this expectation, including the barriers they have experienced when teaching nursing students about compassionate care. Teaching and education are considered forms of clinical practice for nurse educators. By asking nurse educators to describe their approaches to teaching compassionate care and the complex challenges associated with this educational phenomenon, new knowledge was uncovered that educators can apply in classroom and clinical contexts. The findings help to better understand the dynamics of compassionate care as well as offer

strategic educational directions aimed at realizing the goal of a more compassionate healthcare system.

Interpretive description is a qualitative research approach that is less prescriptive than other qualitative designs, but also generates a plausible and meaningful way of generating knowledge while meeting specific needs within nursing science. It is a useful research method in dealing with complex and experiential questions in clinical and health-related practices such as nursing (Sandelowski, 2000; Thorne, 2008). Similar to other qualitative research designs, interpretive description considers the use of patterns and themes in order to describe and understand a phenomenon thoroughly. Use of inductive analysis provides more than descriptions; it provides implications for advancements in knowledge, which can be applied both theoretically and practically. The researcher is required to understand implications to theory and practice based on the experiences shared by participants while being cognizant of his or her own experiences and what is known. The researcher must understand what perspective he or she brings to the study, which involves a process of examining individual or professional perspectives based on theory and practice. This will guide what data are relevant, how to conceptualize the findings, and how the findings will be disseminated (Thorne 2008; Thorne, Kirkham, & O'Flynn-Magee, 2004).

Interpretive description is a qualitative approach in which the nurse researcher goes beyond a description of findings and explores meanings and explanations that may provide new implications to be applied in practice. Thorne (2008) referred to this

as the art and science of conceptualizing the findings, which may provide the researcher with a deeper understanding of a phenomenon such as the teaching of compassionate care. The goal was to strive toward capturing the important elements within the phenomenon in a manner that could be understood, appreciated, and applied in practice. Interpretive description provides a focus in the generation of new information based on the use of reflective thinking and critical examination that can change practice (Thorne et al., 2004). The purpose of the present study was to gain deep insights, theoretical relevance, and practical application in teaching compassionate care to nursing students.

The Question of Bias

My experience as a nurse educator has included teaching opportunities with nursing students in the classroom, clinical setting, and various types of community-based settings. As a practicing, registered nurse and a nurse educator in the clinical setting for over 30 years, I have had many opportunities to observe the ways that registered nurses and nursing students may or may not provide compassionate care when interacting with patients. These experiences have taught me that many individuals enter the field of nursing because they want to provide compassionate care; however, at times they are unable to do this in practice. My observations have caused me to wonder why compassionate care does or does not occur during the delivery of patient care and whether certain influences in the educational experience developed each nurse's ability to provide compassionate care.

The role and expectation of the nurse educator include teaching nursing students to provide compassionate care to their patients, and I believe this capacity can be developed during the educational process. As a nurse educator with beliefs about and experience in teaching the provision of compassionate care, I realize that I need to be aware of my viewpoints and be able to set these aside, committing myself to an unbiased attention and openness to the experiences and viewpoints offered by the study participants.

Interpretive description acknowledges the theoretical and practical knowledge that I brought to my study. Thorne (2008) used the term *theoretical scaffolding* as a way for a researcher to sort out his or her intellectual assumptions, values, and beliefs. The researcher must consider what is known and what is not known about the topic and then state what he or she is seeking to find out. The literature review for this study indicated that the phenomenon of interest requires further research and the research questions posed are worthy of study. Thorne suggested that the literature review should ground the study with existing knowledge, reflect on what does and does not exist, and provide commentary on the strengths and weaknesses within the overall body of knowledge.

As a researcher, I needed to be aware of what I was bringing to the study, or what Thorne (2008) referred to as accounting for theoretical "baggage" (p. 54). The findings should inform and make sense of the variations noted in the literature and observed in practice. My experience was considered a good beginning point and added to my understanding of the phenomenon under question; however, I recognized

the need to make continual efforts to remain aware of what constituted my own background knowledge and disciplinary orientation, as separate from the knowledge gained from participant responses, and remain attentive to what would be shared in the course of the research process.

Protection of Human Subjects

When including human participants in a research study, it is necessary to ensure that the procedures are ethical and there is no risk of potential adverse effects to the participants. Prior to the commencement of the research, I sought approval through the Institutional Review Boards (IRB) of Seton Hall University and the research site. This ensured that the participants' rights and welfare were adequately protected. For the purpose of this study, individuals were formally invited (Letter of Solicitation, see Appendix A) to participate in the study, and informed consent (see Appendices B and C) was obtained from each individual prior to actual participation in either an individual interview or a focus group session. The informed consent document included my affiliation with Seton Hall University, College of Nursing. An explanation of the purpose of the research was detailed, including the expected duration of each person's participation. A description of the procedures to be followed was also presented. A specific statement indicated the voluntary nature of the participation, clarifying that refusing to participate or discontinuing participation at any time would involve no penalty. A statement indicating confidentiality was also included to assure participants there would be no way to link the data to any participant. The consent form requested each participant's written permission to

audio-record the interview and indicated how the participant would be identified on the tape. For this study, the use of names was avoided and a code number was assigned to each participant to ensure confidentiality. Additionally, a simple demographic questionnaire was given to participants and identified with a code number, rather than a name, to maintain confidentiality (Demographic Questionnaire, see Appendix D). The questionnaire requested information about the participant's (nurse educator) age, gender, current role/position, degrees obtained, type of program, years of experience teaching in both the clinical area and the classroom, and specific focus of teaching in either the classroom or clinical area (see Demographic Data Chart, Appendix E). I transcribed all recorded interview data and obtained a certificate in the protection of human research participants which was approved by the Seton Hall IRB. After transcribing the data, I stored them on a USB memory key that was maintained in my locked office. The audiotapes and any other printed materials that were reviewed including the transcribed data will be stored for at least 3 years after the completion of the project. The participants were also provided with information that included my faculty advisor and the IRB office in the event they had questions about the research. My college of nursing email address and a cell phone number as contact information were also provided.

Participants

The sample for this study consisted of 19 nurse educators from two different baccalaureate nursing programs: 10 participants from a secular city university and 9 participants from a faith-based private university. The participants chose to

participate in either an individual interview or a focus group session. Four participants participated in one focus group session and 15 participants participated in individual interviews. The criteria for the participants included having 2 or more years of teaching experience and current employment in the capacity of full-time or part-time nursing faculty at the selected university. Faculty with less than 2 years of teaching experience and/or who did not teach nursing students in a baccalaureate nursing program were excluded in this study because this study sought to learn from the experiences of nurse educators who taught in a baccalaureate program. Those with less than 2 years of teaching experience have not acquired the experiences about which I sought to learn. The participants' teaching experience ranged from 2 years to more than 20 years of experience in both the classroom and clinical area. This purposive sampling technique was utilized to maximize the quality and richness of information provided. This type of sampling is valuable when using interpretive description, particularly when the participants being interviewed have experience with the phenomenon and can provide additional meaning about it (Thorne, 2008).

All of the participants were female nurse educators ranging in age from 42 to 74 years. Seventy percent were under the age of 60, and 30% were over the age of 60. Nine of the participants were adjunct faculty, nine were full-time faculty, and one participant was part-time. All of the participants held both Bachelor's and Master's degrees in nursing. Four participants held a Ph.D., one held an Ed.D., two completed a Doctorate in Nursing Practice (D.N.P.), and two were Ph.D. candidates.

The participants were also asked to indicate the type(s) of program with which they had teaching experience. All were required to have experience teaching undergraduate nursing students in either a 4-year traditional nursing program, a second-degree program, or an RN-BSN program. Some participants had additional experience teaching Diploma Nursing/Associate's degree and Master's degree. One participant taught on the doctoral level. The participants' teaching experience ranged from 2 years to more than 20 years. Fifty percent of faculty had between 4 and 10 years of teaching experience in the classroom and 45% had more than 15 years. Sixty percent of faculty had between 4 and 10 years of teaching experience in the clinical area and 35% had more than 15 years. Additional demographic characteristics of the study participants such as teaching experience and areas of expertise are included in Appendix E.

Setting

Attempts were made to conduct all interviews and the focus group at each faculty member's educational institution, unless the participant requested a location that was more convenient. One participant requested the interview take place at her home, which I accommodated. All individual interview sessions and the focus group session were privately conducted between myself and the participants and lasted for approximately 45 to 90 minutes each, with respect and consideration for a convenient time and location that was suitable for every participant. All participants were informed about the time requirement to ensure they allocated sufficient time to answer the questions appropriately.

Gaining access and establishing rapport. Individuals who agreed to participate in the study were asked to read and sign an informed consent document prior to participation in an interview or focus group session. All participants were recruited from two different independent baccalaureate nursing programs. IRB approval was sought through each university. Upon receiving Seton Hall University IRB approval, I sent requests to the programs' dean and/or research committee, depending on the institutional protocol to request permission to send formal invitations to nursing faculty with more than 2 years of teaching experience in the baccalaureate nursing program via email and faculty mailboxes. The letter of invitation (see Appendix A) requested that each faculty member consider participating in either an individual interview session or a focus group session. Upon acceptance of the invitation, each participant volunteered for an individual interview or a focus group session and signed a participant consent form on the scheduled day of the interview or focus group session (see Appendices B and C). A discussion with the dean and/or designated faculty included a request to review program documents such as the programs' mission, philosophy, and outcomes. These documents were accessible to me and I reviewed them. In addition, I was given permission to ask the participants to provide course syllabi and any other course-related materials that might provide information about teaching compassionate care to nursing students. Sixty-three percent of the participants provided me with either a syllabus or other course-related material. These documents were examined to identify the ways in

which these materials were utilized when teaching compassionate care to nursing students, as discussed in Chapter V.

Data Collection

For the purpose of this interpretive descriptive study, multiple data sources were reviewed: 15 individual interviews, one focus group session with four participant members, and course documents. The programs' mission statements, philosophy, and outcomes were accessed and reviewed to identify elements or concepts related to compassion or compassionate care, and also compared for similarities and differences. At the end of each session, I requested if the participants would provide course-related documents for review to identify descriptions of concepts or strategies to teaching compassionate care. The participant may or may not have referred to the documents during the interview sessions and not all participants submitted documents for me to review. The submitted documents included course syllabi; course assignments including writing assignments; project assignments; required reading lists including nonfiction books, referenced articles, and poetry; and a faculty teaching philosophy. Multiple data sources can serve to provide different perspectives, add depth to the findings, and contribute to the trustworthiness of the findings generated (Hunt, 2009; Munhall, 2007; Thorne, 2008; Thorne et al., 2004).

A purposive sampling of nurse educators who teach nursing students how to provide compassionate care in a baccalaureate nursing program was selected to ensure that data collection would be targeted toward a population who could provide valuable insights into the phenomenon of interest. Each faculty member volunteered

to participate in either an individual interview session or a focus group and was asked to sign an informed consent. The consent form specified which session the participant would be joining according to a determined schedule of dates.

Interviews. Individual semi-structured interview sessions were used to gather descriptive narratives of nurse educators' experiences with teaching baccalaureate nursing students about the provision of compassionate care and each session was audiotaped. Thorne (2008) suggested the use of individual interviews when a researcher wants to gain a better understanding of a particular issue. Conducting individual interviews with nurse educators provided information about the phenomenon of interest and guided me in making sense of and organizing any common elements. Each participant was interviewed in single sessions, using a set of open-ended questions aimed at answering the research questions (Individual Interview Guide, see Appendix F). Semi-structured interviews were conducted and, depending on the teaching experiences of each individual educator, additional questions were prompted from the flow of the responses to give greater depth to the questions that were asked.

Focus group. One focus group including four participants was used to elicit a range of perspectives and experiences, including similarities and differences in participant responses. I acted as the group moderator, fully cognizant of the influence of group dynamics and interactions while collecting verbal and observational data. A list of focus group questions was used to guide the session (Focus Group Interview Guide, see Appendix G). The focus group session was audiotaped and the participants

were informed that notes would only be taken as a reminder for additional questions that may be required during the session. The use of focus groups provides an opportunity to study the ways participants make sense of a topic and construct meanings around it, giving the researcher a way to investigate the participants' reasons for holding certain views. Doody, Slevin, and Taggart (2013) emphasized that when using focus groups, participants may answer a question one way but, after hearing others' responses, decide to modify their answers. During the focus group session for this study, the participants gave responses that were prompted by comments made by other participants during the session; this was noted in the analysis. The use of focus groups can be a powerful source of data when the goal is to bring together people with similar experiences to exchange ideas (Thorne, 2008). In this study, one focus group was used to create an environment that brought together a variety of perspectives about the ways in which nurse educators use educational strategies in teaching nursing students about providing compassionate care. I as the moderator asked questions that encouraged the participants to share their views freely in a supportive, nonthreatening environment, with the intention of gathering a range of diverse viewpoints on this phenomenon. After the session was completed, observational field notes and reflective notes were written in separate journals. Each journal was analyzed as a way to maintain awareness of bias, add meaning to the data and the flow of logic.

Collateral data sources. A review of the requested program and course documents elicited information about how compassionate care was taught and what

value was or was not placed on compassionate care within the context of the nursing program's curriculum. For this study, the programs' mission statements, philosophy, and respective outcomes were reviewed. I also requested additional course-related materials from each individual participant; however, only 63% of the participants provided course-related materials.

For review of the undergraduate programs' mission statement, philosophy, and outcomes, I searched for the terms *compassion* and/or *compassionate care.* These terms were not found in the documents.

Thirty-seven percent of the participants provided a syllabus for the course they taught. The syllabi that were provided were didactic nursing courses that focused on Fundamentals of Nursing, Adult Medical-Surgical Nursing Care, Community Health Nursing, Care of the Dying Patient, Issues in Health Care and Professional Nursing, and the Senior Nursing Student Capstone Course. The participants provided a total of seven syllabi from both programs. I examined the course overview, student learning outcomes, and teaching strategies for elements that were related to teaching and learning about compassionate care. Additionally, the syllabi were reviewed for student learning activities, required readings, and any other course-related information that would pertain to teaching compassionate care. One participant provided a supplementary reading list when the documents were requested; this contribution made me aware it was important to ask future participants for additional learning materials that support teaching and learning about compassionate care which may not necessarily be found in the course syllabi. I also emailed participants who

did not provide materials during the interviews, and some additional materials were received as electronic attachments at a later date. The ways these assignments were utilized as teaching strategies are discussed in the findings in Chapter V.

During the interviews, some of the participants provided or made reference to various articles they used when teaching about compassionate care; the articles they discussed applied caring-based theorists. The participants provided the titles, authors, and dates, or hard copies. In some cases, the articles mentioned during an interview were also cross-referenced in the syllabus when provided. The ways the participants used these articles to teach compassionate care is also discussed in the findings in Chapter V.

Similarly, during the interviews, some of the participants placed an emphasis on reading powerful nonfiction books and the impact certain works have on teaching compassionate care. One participant provided a separate reading list, and one participant provided an actual book she uses when teaching compassionate care. When the syllabus was provided, I was able to compare and confirm the books the participants talked about during the interviews as required reading assignments for the course. Additionally, some courses had specific assignments that connected themes about the books to learning about compassionate care; in both cases, this added to the credibility of the findings.

One participant felt strongly about the use of poetry when teaching compassionate care and provided me with a poem that she uses when teaching nursing students about compassionate care (this is discussed in Chapter V). I carefully

reviewed all additional course materials provided to clarify and insure the significance for using them when teaching nursing students about providing compassionate care; in all cases, they added credibility to the findings.

Thorne (2008) suggested that documents be used as a collateral data source to offer a range of subjective and objective knowledge. In this study, documents provided evidence of strategies that the participants reported to be used effectively in teaching about compassionate care. All of the strategies reported are discussed in Chapter V.

All interview sessions and the one focus group session were audiotaped with the permission of the participants; however, no personal identifiable information was used throughout the study. I transcribed interview and focus group responses verbatim in preparation for analysis. As well, I maintained a reflective diary and observational field notes that included entries of pertinent information written immediately after the interviews and the focus group session.

Data Analysis

Interpretive description, a qualitative research method, was used for this study. This research used the techniques of concurrent data collection and constant comparative analysis, which are commonly used techniques in interpretive description analysis methods, as described by Thorne (2008).

I read all transcripts in their entirety several times and compared them to the audiotapes before I began coding. Data analysis was inductive, as the study sought to promote understanding. Thus, codes were generated from the data which, for this

study, consisted of transcripts from the individual interviews and the focus group. Thorne (2008) discouraged premature coding and suggested that a researcher should have a thorough understanding of the data to maintain depth of analysis before initiating coding. Thus, I coded the transcripts and data according to Thorne's synthesis of accepted approaches.

In the first stage, I grouped data into small units and attached a descriptor or code to each unit. The codes were handwritten on hard copies of each transcript next to the related section. The codes and their definitions were recorded in a separate file; for example, one of the study codes was CCM = "Compassionate Care Meaning." To maintain anonymity, a code number was assigned to the participant interview to which the code pertained, including the transcript page number. For example: CCM - "To feel with a patient" - Subject #2, page 3. This could then be traced to the original transcript to provide further contextual details that might become necessary as data analysis proceeded. A separate file was used to ensure that the use of each code remained consistent and clear. During data coding, I made analytic notes about how I determined the coding and added new codes as necessary. These were then electronically stored in a file with the name of the code. One hard copy of each coded transcript with manual coding was retained, in addition to the electronic copy.

Once coding was completed, I began the second stage and I merged the codes that had common elements to form categories. Some codes were placed in more than one category. The categories which were derived from the data collected during the

interviews and clustered around each research question contributed to answering them.

In the third stage, the categories and their interrelationships combined to form themes that described the phenomenon being studied. Through interpretive description, deeper contextual meanings and implications through inductive analysis offered both theoretically and clinically useful material (Thorne et al., 2004). I looked beyond the obvious and asked, "What is happening here? What are the dimensions of the concept? What variations exist? How are the phenomena similar or different from one another?" (Thorne, 2008, p. 50). Further analysis revealed similarities, differences, and identifiable patterns that I combined to form the themes that emerged in this study about the phenomenon of teaching compassionate care to nursing students.

The programs' mission statement, philosophy, and outcomes were reviewed separately and then compared. The documents were analyzed for the presence of the terms *compassion,* and/or *compassionate care*. Nursing terms that addressed the art of nursing were also reviewed. Similarities and differences were recorded in the analytic notes. Documents that were provided to me included: seven syllabi, one poem, a supplemental reading list with five books, a faculty teaching philosophy, one article, and one book. I analyzed each syllabus for teaching and learning strategies or assignments that would be effective in developing compassionate care. I did not know some of the books that were listed in the syllabi or on a reading list and mentioned by the participants during the interviews. An additional way for me to clarify the use of

the books was to read each one. In doing so, I was able to gain a better understanding of how the participant was able to connect the teaching and learning about compassionate care and the theme of the book with the student learning assignments. Analytic notes and personal reflections were recorded separately in a journal after reading each book. The same process was followed after reviewing the poem, article, and faculty teaching philosophy. Articles that were not provided but mentioned during the interview and/or cited in a syllabus as useful when teaching compassionate care were also reviewed to gain an understanding of how the participant connected teaching and learning about compassionate care.

Rigor

According to Thorne et al. (1997), attention to rigor in the research process and the reporting of that process is critical to an interpretive descriptive study. A trustworthy research report must include evidence that the researcher used coherent logic with a definite audit trail of the inductive reasoning process that occurred during the analysis (Lincoln & Guba, 1985; Sandelowski, 1986).

Guba (1981) developed four criteria for judging the rigor of naturalistic research: credibility, transferability, dependability or reliability, and confirmability or objectivity. Credibility refers to the accuracy of the meaning of the data that the researcher reports, based on details provided by the study participants. Transferability refers to the extent to which the findings of the study denote enough rich description so that the reader might be able to apply the findings to another population of interest. Dependability refers to the tracking and understanding of the data's similarities and

differences. Confirmability refers to the ability of the researcher to be objective and prevent personal biases from influencing the findings (Guba, 1981).

Thorne et al. (2004) stated that the importance of credibility is clearly articulating the research conclusions based on the data and findings from which they were drawn. The process should be accessible and logical to the reader. The manner in which the conclusions were made from the data should be clear and the findings should be credible to the knowledgeable audience. Trustworthiness was enhanced by the use of triangulation between data sources. Fifteen individual interviews and one focus group with four participant members were conducted, and a document review was undertaken. Transferability was strengthened by including nursing faculty from two different baccalaureate nursing programs: a secular city university and a faith-based private university with varying levels of teaching experience, education, and areas of specialty.

Consistency or dependability was enhanced by maintaining coding records and analytic notes which were kept in a separate data file and dated. The analytic notes included questions, inspirations, and evolving interpretations about the day, some of which required follow-up about the actual research and/or emerging themes and patterns. Clarification about the research questions and newly emerged themes were documented, often requiring me to follow up or explore new additional information.

Confirmability was enhanced through observational notes and a reflective diary as a way to understand the meaning of the data and the flow of logic more fully.

The use of a reflective diary included reflections about my beliefs and personal feelings when exploring the phenomenon. It also included theoretical allegiances, expert clinical opinion, or other sources of previous knowledge. Transcript analysis and interpretations were reviewed by an experienced qualitative researcher. This process assured future readers of the study's credibility and reduced the potential for personal bias.

As Thorne (2008) wrote, "Interpretive description is an invitation toward the audacity of imagining that we might begin to answer some of our most pressing questions about the mysteries of human experience" (p. 246). From this study design, conclusions were based on the analytic process that Thorne described and were supported by my effort to assure all readers that the findings were clear, logical, and trustworthy. Chapters IV through VI discuss the findings of the study.

Chapter IV

FINDINGS: NURSE EDUCATORS' DEFINITIONS, EXPERIENCES, AND BELIEFS ABOUT TEACHING COMPASSIONATE CARE

As described in Chapter I, *compassionate care* is a difficult term to define. Researchers have stated that it is an individual and subjective term, making it challenging to articulate and measure (Adamson & Dewar, 2011; Crawford et al., 2014; van der Cingel, 2014). Nurses offer multiple perspectives on compassionate patient care, yet its meaning continues to be ambiguous. Nursing research and literature on healthcare have used such terms as *caring*, *empathy*, *sympathy*, *compassionate care*, and *compassion* interchangeably, implying that these words are often and mistakenly used synonymously; this, unfortunately, results in misinterpretation (Post et al., 2014).

To gain an understanding of how this study's participants perceived compassionate patient care, I asked them several open-ended questions about teaching compassionate care, including their definition of this concept. Chapter IV presents the study's initial set of findings that relates the perceptions of compassionate care from the study participants, which included 19 nurse educators from two different baccalaureate nursing programs, 10 participants from a secular city university, and 9 participants from a faith-based private university. First discussed are

the participants' definitions of compassionate care. Next are their worldviews of compassionate care related to personal experiences in their practice. Finally, this chapter concludes with rich descriptions of the participants' personal values, beliefs, and attitudes within the context of the nurse educator role and the teaching of compassionate care in a nursing curriculum.

Meanings of Compassionate Care

During the participant individual interviews and the focus group session, nurse educators were asked to provide their personal definition of the term *compassionate care* and were given the question, "What does the term *compassionate care* mean to you?" Of the 19 participants in this study, 15 were interviewed individually and four participated in the focus group. The transcripts of the participants' descriptions and personal views on the meaning of compassionate care were coded, analyzed, and grouped into meaningful categories, and further analysis revealed similarities, differences, and identifiable patterns. Two overarching themes describing the participants' meanings of compassionate care conveyed their definitions: (a) entering the worldview of the patient, family, and community; and (b) recognizing and meeting patient needs.

Entering the worldview of the patient, family, and community. All of the participants provided similar descriptions of compassionate care that underscored the importance of the nurse entering the worldview of a patient, family, or community. Twelve participants described compassionate care as an experience while meeting a patient's needs whereby a deep, mutual, and caring human connection is felt and

meaningful for both the nurse and the patient. Six participants described the nurse as "being present in the moment" and "feeling with" the patient. Three participants described identifying with the patient by putting themselves in the "other's shoes" or being empathic; in particular, they referred to the term *empathy* as an aspect of providing compassionate care.

Recognizing and meeting patient needs. The participants' definitions described the nurse-patient relationship and therapeutic communication as components of compassionate care. Participants spoke of how compassion played a part in a therapeutic patient-nurse relationship; they identified how through this process, the nurse comes to recognize, listen, and become more aware of the patient's intimate needs. As the relationship grows, the nurse is able to recognize what is necessary to provide thoughtful, nurturing, loving, and gentle care.

In summary, the participants in this study defined *compassionate care* within the context of nursing as entering the worldview of the patient, family, and community by making a deep, mutual, and caring human connection which is felt when the nurse recognizes intimate needs and provides care that is thoughtful, nurturing, loving, and gentle. This type of care invokes an emotional connection that is meaningful for both the nurse and the patient while meeting the needs of the patient.

Experiences With Compassionate Care

To gain a deeper understanding of the participants' worldviews and beliefs about compassionate care, I asked nurse educators to share their personal experiences

with delivering compassionate care. I listened to the recordings of the participants' personal experiences many times; I then coded and analyzed the transcripts to reveal similarities, differences, and identifiable patterns. As a result, three identifiable themes emerged that expressed important aspects of compassionate care delivery: (a) making extra time to listen and talk with patients or families, (b) being present when a patient is dying, and (c) assuming/adopting a physically gentle approach to care.

Making extra time for patients and families. One example of the importance of making extra time to talk and listen to patients or family members is emphasized by participant Sara, who described the need for nurses to balance their focus on more than just the medical diagnosis or technical aspects of care, and broaden the scope of practice to include the emotional needs of patients. Sara stated:

> One particular patient that I can recall had a prescription painkiller problem. She had multiple admissions for nonspecific pain. It was clear in talking with her, even through just ordinary care activities, that she was very distressed and that she was trying to relieve distress through pain medication. The complaints were always the sort of thing that would be very difficult, objectively, to identify. She expressed pain in different areas of the body, like lower back pain or abdominal pain or joint discomfort, headaches. If you don't have a tumor growing, if you don't have clear evidence of rheumatoid arthritis or something like that, it can be very difficult to document organically that there is a reason for the pain. At the time, there wasn't as much attention given to alternative ways of managing pain that was probably more psychogenic than organic. She was given prescriptions and she was given them fairly freely, and she would over-medicate herself. On one particular evening, she was insisting that she had to leave the hospital. It was also very clear that her physician was not going to discharge her. She was climbing out the bed. She was woozy and dizzy and obviously not able to function on her own. I went into her room and sat with her and spent some time talking with her. Not about the fact that she was in pain, but talking about her ability to function and what that would mean at home, for herself, her husband, her children. By tuning into an area that she could deal with and acknowledge, I

> was able to convince her that walking out of the hospital was not in her best interest, and so she agreed to stay. She went back into the bed and we went on with our care. I think if I had faced her with the idea that she was overusing pain medication, she would've simply denied it, and fought about it, and would've insisted upon getting dressed and trying to leave. I think by being able to tune into what was going on with her physically as well as emotionally, it was possible to then get her to cooperate and do the thing that was better for her in the long run. Subsequent to that, I saw her a number of other times when she was hospitalized and on one particular occasion, she was experiencing similar circumstances. I walked in the room she said, "I knew they were going to call you to come and see me." We spent some time talking and she agreed, she wasn't going to sign herself out. Over time, her dependency on pain medication had improved as did her medical ailments. One day, many months later, perhaps even a year, I met her outside of the hospital, a totally different situation. We greeted each other, she was with someone and she affectionately introduced me as "her nurse." That was when I knew that the care I provided was compassionate and it was because I had taken the time to tune in and meet her needs.

Sara's description of a compassionate experience within the context of making time to talk to a patient further validated the importance of compassionate care and its positive impact on patient outcomes.

Being present with a dying patient. Chochinov (2007) described the meaning of compassion as suffering with someone. A few of the participants' worldviews within the context of compassionate care needs centered around being present with a dying patient and end-of-life (EOL) care. One example of how participant Liz described this type of an experience was when she was caring for two male homosexual patients who were diagnosed with HIV/AIDS. They both suffered and died within a few months of each other. Liz described an experience of compassionate care within the context of the dying patient, which underscored the importance of compassionate care among practicing nurses when caring for challenging patients. Liz stated:

> Compassionate care. I remember that there was a patient in the hospital who had HIV/AIDS very early on when there was not much known about it. I took care of him and I got to know his partner who was very involved in the care. The patient with HIV/AIDS also developed cancer and needed a lot of total care, psychological support, and so on. The partner was very involved in the care, so it was important that the compassionate care I provided was for both of them since they both needed compassionate care. The patient died and a few months later his partner was admitted with HIV/AIDS. He had been ostracized from his family because of his lifestyle and being gay. When the nurses cared for this patient, he was very much alone so he relied on us. At one point, he became blind from CMV retinitis and in his last moments, he said, "Please, I don't want to die alone." I reached out to my fellow colleague nurses and said, "Look, he's pretty close to the end. He's really afraid of being alone. He's blind so he feels even more isolated." The nurses recognized that it was important I stay with him and spend time talking to him, listening to his wishes and hold his hand until he passed away. They distributed my patient assignment and covered for me so I could stay with him during his last breaths. I realized the nurses' team effort was twofold: without a doubt, they were compassionate towards the dying patient so I could stay with him, but they were also compassionate to me by taking caring of my other patients. After my patient passed, they told me to take some time alone. To give myself time to recover. In other words, they didn't say, "Okay, now he is deceased. Now take care of your other patients." This experience was not only about me being compassionate to the patient, but also my fellow nurses being compassionate to me. It demonstrated compassionate care can be experienced on many different levels.

Being present with patients and their families when a patient is dying was a common thread that was voiced among the study participants during the delivery of compassionate care. Chapter V further discusses teaching strategies that hone compassionate care within the context of death and dying and EOL care.

A physically gentle approach to care. Participant Julia, who worked as a community health nurse, talked about the importance of compassionate communication and acknowledging privacy and dignity when caring for the sick and vulnerable. Community health nurses care for patients in their homes and are often required to perform intimate care, exposing a patient to feelings of embarrassment

and fear. Julia described a compassionate care experience when she felt using a particularly gentle approach in talking and offering physical care was important to facilitate patient trust and a sense of reassurance. Julia stated:

> As a community health nurse, I was going out to change a urinary catheter for a client who required changes on a routine basis; we call this a chronic Foley Catheter. This was the first time I was assigned to this case, and I was thinking that I am a stranger coming into the client's home to perform this very intimate act. I completed the assessment and all of the other parts of her care first. As I was doing this, I was talking with her, putting her at ease about me and giving her a sense of who I was. It was really important for me to know she was comfortable with me and I continued to keep interacting with her the whole time. During the procedure, I asked her if I was doing anything to make her feel uncomfortable or if I was hurting her in any way. It was also important to place her in a physical position that insured she was comfortable and allow for best access to insert the catheter, because she was a big lady, obese in nature. It was really important for me to be gentle both about the awkwardness of the situation, her body size and the procedure itself, not to be rushed, things like that. We interacted the entire time that I was changing the urinary catheter and when I was finished, she kept repeatedly saying, "That was the best catheter change I've ever had, that was the best catheter change I've ever had." She repeated this to her daughter multiple times and in such a way that I knew it was partially about the technique, but it was more about spending time talking to her before and during the procedure which helped to alleviate some of her fear and feelings of embarrassment during the procedure.

The varied experiences that the participants described provided an understanding of their worldviews about compassionate care. The next section of this chapter describes the participants' responses related to their beliefs of whether or not nursing curricula should include specific requirements for educating baccalaureate students in how to provide compassionate care. During the interviews, the participants shared additional interesting perspectives about what they believed were related to the teaching and learning of compassionate care in nursing education.

Values, Attitudes, and Beliefs of Teaching Compassionate Care

The nurse educators participating in the study were asked to share their beliefs about whether or not nursing curricula should include specific requirements for educating baccalaureate students in how to provide compassionate care. In addition to answering this question, the participants shared rich descriptions of their many personal values, beliefs, and attitudes related to the teaching of compassionate care in a nursing curriculum.

All of the participants agreed that nursing programs need to include teaching and learning about compassionate care, and curricular design should reflect pedagogical principles that address this concept. One participant cited the position of the AACN and the Baccalaureate Essentials (AACN, 2008), stating that teaching compassionate care in baccalaureate nursing programs is required and necessary. Moreover, all participants agreed that nursing curricula that contain education on compassionate care stand to develop the ability of nursing students to provide compassionate care to their future patients. All of the participants supported the idea that compassionate care can be developed, and nurse educators can influence one's values and beliefs about its importance by linking the art and the science of nursing through teaching. They also articulated that both the teaching and learning of compassionate care are built on nursing ethics and the knowledge, skills, and attitude that are provided through a holistic approach to care. For this kind of learning to occur, nurse educators must include compassionate care in their teaching.

Further data analysis of the nurse educators' stated values, beliefs, and attitudes about compassionate care identified common links between a nurse educator making time to teach about compassionate care, role modeling compassionate behaviors, and establishing student trust to foster learning about compassionate care. Three themes emerged from descriptions of the participants' values, beliefs, and attitudes related to teaching compassionate care: (a) making time for what matters, (b) role modeling, and (c) caring about student trust.

Making time for what matters. All of the participants agreed that teaching nursing students about compassionate care is important and spoke about the value of the nurse educator role as the navigator and facilitator for the teaching of compassionate care in nursing education. Four participants chose to clarify that they believed sensitivity to providing compassionate care was an intrinsic attribute of a nursing student; however, they also believed a curriculum could foster the development of that attribute. Several participants stated that nurse educators need to shift some of their focus from emphasizing psychomotor skills to making time intentionally to include teaching and learning activities that center around compassionate care. Two participants, Liz and Beth, shared insights into the need for nurse educators to make time to "develop" compassionate care. Liz stated:

> I definitely think that compassionate care can be taught, although each student's starting point may be different and so their development will vary from where they begin. Regardless, the nurse educator needs to take the time to teach and evaluate each student's baseline and build on their development to insure growth.

Beth stated:

> I think being compassionate is innate, but there is another aspect to this and that is: To what extent are you willing to go? I think that's the whole thing, it is about how much are you going to put yourself out there in practice. Nurse educators need to spend time on this aspect of learning in order to develop students' abilities.

According to the study participants, nurse educators need to make time to teach and develop students' abilities to provide compassionate care. The participants consistently agreed these efforts are valued and necessary in nursing curricula, and nurse educators need to be knowledgeable and recognize that individual starting points and the capacity to develop compassionate care will vary among students.

Role modeling. All of the participants held strong beliefs of the value of role modeling, reporting it as one of the most effective methods of teaching and developing a student's ability to provide compassionate care. This belief was congruent with the actual teaching strategies they reported as being effective when teaching in the clinical setting and classrooms (this is discussed further in Chapter V). Some of the participants shared that they were influenced by a nurse educator during their nursing education and have emulated the teaching of compassionate care by role modeling in the same way.

Two of the participants talked about the importance of self-evaluation and self-reflection and discussed that nurse educators must self-evaluate and self-reflect on their personal beliefs about compassionate care before teaching and modeling the delivery of compassionate care effectively. One of the two participants, Connie, specifically emphasized how role modeling can influence both positive and negative behaviors and nurse educators need to be aware of this. Connie stated:

> I think we see different types of behaviors in different settings, and things happen when there are different hierarchies. Bullying occurs everywhere particularly in the workplace. We see this in the clinical setting and the Operating Room is one of the worst areas. I think because it starts from the top and filters down. If someone is treated poorly, this continues and it filters down. Students view the nurse educator as the authority person and they watch everything we do. They're watching us more than we know, and so you have to be very cognizant of what you're modeling as a behavior. If you model negative, the chances are it will filter down and surface negatively at one point or another.

These participants also discussed their beliefs of the importance and impact of faculty mentoring and role modeling. Novice nurse educators observe seasoned educators as a part of the learning process. Seasoned nurse educators need to mentor the importance of teaching compassionate care in nursing education while also role modeling compassionate care behaviors with patients, students, and colleagues. The participants believed this will promote and sustain future learning of this concept on all levels.

Caring about student trust. All of the participants shared a common belief that there is relationship between faculty compassion toward students, faculty-student trust, and student learning about compassionate care. Several of the participants believed that nurse educators who are compassionate toward students will develop a trusting faculty-student relationship that facilitates student learning about the delivery of compassionate care. The participants also discussed the potential consequences of student fear during the learning process, agreeing that student fear impedes the learning process, but student trust enhances the learning process, particularly within the context of delivering care with compassion. They believe compassionate role modeling and exhibiting consistent professional behavior are necessary for gaining

student trust and teaching compassionate care. The participants discussed different ways in which faculty-student trust can develop and suggested that mainly through this trust will students gain the faculty members' respect. In turn, by feeling support, learning is enhanced.

Participant Liz stressed the importance of nurse educators being compassionate toward student diversity. She referred to the term *diversity* with a broader perspective, not only within the context of cultural diversity. She noted students bring different kinds of diversity to the learning experience such as varied academic and generational diversities, and faculty need to be prepared to teach students based on their needs. Liz stated:

> I think faculty also have to be compassionate to their students. That's not always the case. It's hard for faculty to teach compassion when they're not compassionate toward diverse student populations. I use the term *diverse* broadly, meaning, students come with a broad range of diversities. They are academically diverse, culturally diverse, and even generationally diverse. Faculty need to be aware and understand the differences. If faculty can be compassionate toward students and what their diversities are, they will establish a trusting relationship and this in turn translates into the importance of being compassionate to each individual and what they are experiencing.

Another participant, Margaret, shared Liz's insights about student trust, teaching, role modeling, and the way she evaluates compassionate care in an online course. Margaret shared a personal experience of how a nurse educator can establish student trust through an online course and what kinds of online activities support the development and teaching of compassionate care in a web-based nursing course. Margaret stated:

> I took an online nursing course and the nurse educator who was teaching the course wanted to get to know us, so one of the learning activities included a video chat with each one of us so we could see him face to face. He didn't solely focus on the student learning outcomes for the class. He integrated questions in a way that he could get to know you better, as a person. It was through this aspect of the learning activity that I came to trust him and I found him to be a very compassionate nursing educator. As a nurse educator currently teaching several online nursing courses, I use this approach to teaching and believe it facilitates learning compassionate care.

Margaret's experience with teaching compassionate care in an online format similarly portrays the positive influence of nurse educators who role modeled compassionate care behaviors during her nursing education.

Summary

Chapter IV presented the first set of findings that relate to nurse educators' perceptions of compassionate care. The participants shared their definitions of compassionate care and their worldviews of compassionate care related to personal experiences in their practice. They provided rich descriptions of their personal values, beliefs, and attitudes within the context of the nurse educator role and the teaching of compassionate care in a nursing curriculum.

The three main themes that emerged from these data expressed important aspects of compassionate care delivery: (a) making extra time to listen and talk with patients or families, (b) being present when a patient is dying, and (c) assuming/adopting a physically gentle approach to care.

By identifying the definitions, attitudes, values, and beliefs about teaching compassionate care, it will be possible to understand better the kinds of instructional strategies that can be used to teach compassionate care in the classroom, online, and

in the clinical area. Chapter V next provides a second set of findings that discuss specific teaching strategies for educating nursing students on how to provide compassionate care in the classroom, clinical settings, and other kinds of educational learning environments that support this learning.

Chapter V

FINDINGS: TEACHING COMPASSIONATE CARE

Chapter IV presented the study's initial set of findings that relate to nurse educators' perceptions of compassionate care which included the participants' definitions of compassionate care; worldviews of compassionate care related to personal experiences in their practice; and descriptions of the participants' personal values, beliefs, and attitudes within the context of the nurse educator role and the teaching of compassionate care in a nursing curriculum.

Chapter V discusses the study's findings related to the teaching of compassionate care, in which the participants reported effective teaching methods for educating nursing students on how to provide compassionate care in the classroom, clinical settings, and other kinds of educational learning environments that support this learning. The participants in this study were asked about the specific teaching strategies they used when teaching compassionate care in the classroom and clinical area. They were also asked about other types of learning environments or educational experiences that they felt facilitated learning about compassionate care.

Nursing is considered both an art and a science (Palos, 2014). Technical skills and increased responsibilities have challenged nurses to keep the *caring* in nursing; therefore, as a profession, nurses must strive to maintain their caring identity. The participants in the study agreed that the art of nursing must not be forgotten or

considered less valuable than the science of nursing, and several shared the same view that this distinction must be introduced early in the foundation of the nursing students' education. Moreover, these participants discussed the importance of teaching nursing students about the theoretical roots of caring and caring theories as an underpinning to teaching nursing students about the art of nursing, which includes compassionate care. Three of the participants specifically referred to Watson's (1979) caring theory and how they applied it to some of their class and clinical assignments. Participant Lynne gave an example of how she taught nursing students about the art of nursing by incorporating theory and compassionate care into the course's required writing component. Lynne stated:

> They learn about history and the beginning of nursing theory, how it is developed, and then we introduce different theorists and their focus. After we basically ask the class "What theorist do you identify with and why? How would it affect your care with a patient? How would you approach it?" This provides us with the perspective of different students. After they have a basic understanding of the theory, we give them a patient description. They are all given a patient and we ask how they would approach that patient based on a given theorist. For example, if the focus of the patient requires Health Promotion, they are required to apply the Nola Pender Health Promotion Model [2011]; if the focus is Caring, we have them apply Watson's caring theory or a theory that they feel addresses the caring component. The assignments include different questions that will relate to the concept such as caring. These kinds of assignments help to teach theory and the relationship that some theorists have linked to the *art of nursing* and the teaching of compassionate care.

The participants agreed that compassionate care is built on the art of nursing and may include actions that can be defined as caring behaviors and based on human caring theory. However, the participants stated there is an additional need for nursing research to generate evidence for nursing curricula that will provide a deeper

understanding of how this concept can be taught and evaluated during nursing students' education. It was their hope that the findings of this study would begin to fill this gap. The initial findings described the teaching methods that the participants reported as effective for educating nursing students on how to provide compassionate care in the classroom.

Teaching Compassionate Care in the Classroom

The participants agreed that the focus of certain courses may afford a greater opportunity for teaching about compassionate care; however, they described that nurse educators should include an aspect of teaching compassionate care in all courses. During the individual interview sessions and the focus group session, the participants identified a broad range of teaching strategies they used in the classroom when teaching about compassionate care. I coded, analyzed, and grouped these strategies according to similarities and differences, and further collapsed them into four major categories: storytelling, role play, case studies, and watching videos or YouTube segments. All of the participants agreed that rich classroom discussion is a critical part of these strategies and essential to each one.

Storytelling. Seven of the participants described storytelling as a way for nurse educators to teach about compassionate care. They stated that storytelling facilitates open discussion among students so they feel comfortable and open-minded about sharing their attitudes, values, and beliefs. They described a nurse educator as a moderator who challenges the issues and ideas that the stories provoke during class discussions. The participants concurred that storytelling is an impactful strategy when

teaching the topic of compassionate care, especially when instructing students about complex and challenging situations in practice. The participants made particular reference to the emotions that the stories often evoked in class and how emotions play a role in learning. Moreover, they shared similar ideas that compassionate care in practice can be very emotional and that opportunities to explore emotions in a classroom environment through storytelling, reflection, and ultimately rich discussion about the stories' meaningfulness are very useful. Finally, the participants agreed that teaching through storytelling appears to be a sustainable method of teaching; during their teaching careers, educators reported that students often shared feedback they remembered from their faculty's stories and real-life situations throughout the nursing program that proved invaluable for them as practicing registered nurses in later years.

Role play. Several of the participants in the individual interviews and four in the focus group session reported role play as an effective strategy when teaching nursing students about the delivery of compassionate care. They all agreed that well-designed role play can be used to teach nursing students in all learning domains, particularly the affective domain which they considered was more difficult to teach than the cognitive and psychomotor domains. The participants reported that role play allows nurse educators to teach and evaluate student performance in many areas. According to them, customized role play is a useful teaching and learning activity that may take many forms; when it is centered around specific topics such as compassionate care, it allows for spontaneous interactions when learning about the topic. During role-play activities, nurse educators can observe the students' simulated

interactions and communication skills. During and after role play, the nurse educator provides formative and summative feedback that stimulates rich classroom discussion about the learning objective. The participants agreed that role play creates a non-threatening environment because the focus is on each student's spontaneous interactive performance rather than grades, thereby reducing student anxiety and further enhancing learning.

The participants also talked about the importance of debriefing after role play. Debriefing is a constructive teaching and learning process for teachers and students which includes discussion, analysis, and student reflection while providing an opportunity for the nurse educator to provide summative feedback related to the specific focus (Waznonis, 2014). The participants agreed that debriefing enables self-reflective thinking through structured discussion and feedback. When utilized after a role-play activity, debriefing enhances future decision making and allows students to adjust undesirable nursing performance based on self-assessment, reflection, and faculty feedback. The following quotation describes how Maria, a focus group participant, used role play in the classroom. Maria stated:

> During maternity class, I conduct a role play about what happens immediately after the birth of a child. There is so much going on with mom and baby. One student is to act as the family member, usually the spouse, who wants to understand what is happening. Other students play the part of the nurse and doctor who are not communicating, and even though the family is asking many questions, neither they nor the staff are addressing the concerns. The student in the role of family member needs to express they are frustrated because they don't understand what is going on.

Examples of different role-play activities were reported in several of the interviews; four of the participants talked about using role play with live actors and

models acting as standardized patients during simulation labs. Although clinical simulation lab experiences are considered a part of the clinical component in nursing curricula, several of the participants talked about role play in the classroom as a link to rich discussions. Simulation-based learning as a clinical teaching strategy for compassionate care is discussed later in this chapter.

Case studies. The participants also discussed their experiences of teaching students through case-based learning. They discussed different aspects of the process, starting with a clinical situation where students are required to understand what is happening based on the patient data provided. The data that are given require the students to reflect and make informed decisions about the care they will be providing. In particular, the participants discussed the use of case studies when teaching about ethics and how they required students to analyze a case and distinguish between moral and non-moral problems which often involve acts of compassion. They agreed that the learners' motivation and participation are greater when using case studies because students feel better prepared after building on the body of knowledge they are given. The participants also reported that case-based learning requires students to think more deeply and more critically and prepares them for future practice. Several participants explained that by using case studies, students are required to research the topic prior to class, helping them to learn about best-practice protocols. Participant Beth specifically discussed case-based learning in a nursing medical-surgical course and the importance of introducing the psychosocial component for certain diseases to support teaching about compassionate care. Beth stated:

> Medical-surgical case studies that bring in the psychosocial piece are something that certain faculty don't address in the classroom. I think that's a mistake because you can teach a student about a disease process. You can say, "Yes, this is the disease and these are the symptoms, and this is the nursing management, and this is the medical management," and it's very cut and dry. "This is what we are going to do," but then you have to say to them, "Okay, so now this patient has this event." It is usually that they end up with a cancer and have an ostomy or a burn patient with third-degree burns on twenty-three percent of their body or whatever, or they have an unfavorable surgical event, or they are young and have a Myocardial Infarction and can no longer work nor support their young family. I ask them questions, for example, let's think about this patient outside the context of medical nursing management. Now they have this issue and how are you going to address their concerns outside of the medical piece, outside of the disease process? They have to go home with this ostomy and they want to ask you some questions about not so much managing the care of the ostomy, but how are they going to explain it to other people and how comfortable are they going to be in that environment? Now they're going to go home and wonder will people notice that they have this bag? Is there an odor that's going to come out of the bag, and so you need to ask the student: how are you going to answer those questions? Because it's not just a nursing question, it's also answering with a compassionate response and helping them to manage the emotional aspects of the disease. I assign the students into groups and provide questions for them to discuss about how they would handle these kinds of situations. After they discuss in small groups, engage in a larger group discussion so everyone can share what they contributed to the smaller groups. We discuss bringing in another interdisciplinary team member and who else they think would be beneficial to address their concerns at that time. It's very interesting because they come back with ideas and suggestions that I may not have thought of. They bring their varied backgrounds, cultures, and life experience about how they might answer certain questions.

In this excerpt, Beth raised the issue of how nurse educators teach about extensive and complex diseases processes to meet learning objectives. She emphasized the importance of including the psychosocial aspect of the disease process, including the emotional toll these conditions may take and the importance of including the patients' emotional response to their experience; this supports the teaching and learning about compassionate care. Beth highlighted the nurse sducator

role in facilitating the discussion to make the students see, feel, and think more deeply about what it might be like to be in the shoes of patients with so many complex dynamics.

In short, the participants described case studies and case-based learning as a creative way to bring real-life patient scenarios into the classroom. Through this method/strategy, nurse educators can facilitate deeper learning through discussion and feedback in a non-threatening environment. The ultimate goal of case-based learning is to prepare students to connect theory to real life when practicing in the clinical setting, including cases that center around concepts like compassionate care.

YouTube and online videos. The participants talked about the effectiveness of viewing educational videos and YouTube videos as a way to promote learning about compassionate care. Ten out of 19 participants reported the use of showing videos as a teaching method to facilitate student engagement by energizing classroom discussion while meeting course learning goals. They also talked about generational teaching and how the millennial generation is accustomed to more interactive teaching and learning that feature technological connectivity. These kinds of activities build on what is known about a particular concept and also provide opportunities for students to reflect, talk, listen to, and write about what they learned. The participants reported how the depth and breadth of the material create a more impactful learning experience as nurse educators facilitate discussion and learning when teaching about concepts like compassionate care. During the focus group session, all four of the participants spoke about the use of videos and YouTube segments as a strategy for

teaching compassionate care. One focus group participant, Christine, specifically talked about a video the students view prior to their nursing home clinical experience. Christine stated:

> I just thought of the same thing when you said video, and we show it in class before the students go into the nursing home for a clinical experience. It's called "See Me, Nurse" and it's about an elderly woman. She wrote about what her life was like before and she hopes people could see her this way now. "See me as a woman, as a mother, a wife, et cetera." It's a good video for them to watch. "It's an old person sitting there [in a wheelchair], but they had a whole life before, so it's important to talk with them about that life, because that's what they want you to bring up." Asking questions like "When you were my age, what kinds of things did you do?" Stuff like that. Take the time out to talk about things they are able to share in. It's so important and teaches about compassion and caring for the elderly and what it feels like. Sometimes we can say "Imagine what it feels likes to be in this person's shoes" and then have some discussion. This can be impactful if it is realistic, but it isn't all the time. Asking a twenty-year-old to imagine what it is like to be an eighty-five-year-old in a nursing home doesn't have the same effect. Impactful videos about aging, death, dying, and situations that people often have difficulty relating to have a deeper impact. They think about it the next time they are in a situation that is similar, and hopefully they are more sensitive and compassionate toward the person.

The use of YouTube and online videos as a teaching strategy for teaching compassionate care was reported as an effective way to engage students' learning when teaching about this concept. The participants also discussed the beneficial use of videos when teaching topics about healthcare and global disparities, cultural barriers, and sentinel events within the context of compassionate care. Impactful videos were reported as an effective way to engage rich classroom discussion and foster meaningful reflective writing activities about concepts that are more challenging to teach and evaluate through traditional lecture and exams.

The next section of findings discusses the teaching methods that the participants reported as effective for educating nursing students on how to provide compassionate care in the clinical area.

Teaching Compassionate Care in the Clinical Setting

The participants were also asked about the types of teaching methods and strategies they used when teaching compassionate care in the clinical setting. During both the individual interview sessions and the focus group session, the participants shared a broad range of teaching strategies they used in the clinical setting when teaching about compassionate care. All of the participants reported pre- and post-conference time as an opportunity for nurse educators to address the importance of compassionate care. Although it is not a specific teaching strategy, it is an appropriate aspect of the clinical experience when nurse educators can focus on concepts like compassionate care. Some of the participants' responses overlapped as they named the teaching strategies they used in both the classroom and the clinical setting. I coded, analyzed, and grouped the clinical teaching strategies according to similarities and differences, and identified three major strategies as most effective when teaching compassionate care in the clinical setting: role modeling, guided questions, and simulation laboratory experiences. Each of these is discussed separately.

Role modeling. In discussing effective teaching strategies for communicating about compassionate care in both the classroom and clinical setting, all of the participants specifically identified role modeling as one of the most effective ways to do so. I coded, analyzed, and grouped the examples of role modeling as reported by

the participants into categories. Upon further analysis, I identified three specific sub-categories as important to the use of this role-modeling method, particularly in clinical situations. The three overarching sub-categories describing when nurse educators' role modeled compassionate care specifically in the clinical setting included: during pre- and post-conference, at the bedside with patients and families, and among the healthcare team interactions including nursing students.

The following excerpt from participant Margaret described how nurse educators can role model compassionate care during post-conference time. Margaret stated:

> I was waiting to gather all of the students to begin post-conference. There were students observing in different parts of the MCH areas and we were meeting in a conference room for the last thirty minutes of the clinical day. My planned focus had suddenly changed, I had to "switch hats." The nurse from Labor and Delivery came into the room and said "I need to talk to the clinical instructor alone first. I'm like, "Oh no, what happened?" thinking my student did something really bad. As an instructor, we are always worried when students are in observational areas and we are floating in and out to check on them. It ended up totally unexpected that a mom came in, she was thirty-four weeks pregnant, was in a car accident, and they had to deliver the baby in an emergency via C-section. They totally didn't expect this, they coded the baby, and the baby did not make it. My student was in the corner of the room for the whole thing, because I guess they just got caught up in the moment. They had no idea that this was going to happen. It really was very unexpected. That was a very difficult post-conference to get through. It really just brought everybody down. I needed to cover the loss of a child from A to Z and the impact this kind of loss can have on everyone, from the mother, the father, siblings, the healthcare team, and the student. This was clearly a longer than usual post-conference time. It was important to go through this with the students because losing a child is probably the hardest thing a person can go through. As nurses, we will care for children who die, the parents who lose a child, and even the very old who lose an adult child. Making time to discuss the impact of losing a child at birth through adulthood is so important. I felt by doing this I was teaching compassionate care about death and loss. The extra time I spent was a way of role-modeling the importance of being mindful and compassionate for this family.

Role modeling at the bedside is another effective way of teaching students how to communicate and deliver patient care with compassion. Participant Nicole discussed how some students do not know how to connect with patients or families in a compassionate way. She described some students as "uncomfortable or unaware," but noted how nurse educators who emulate compassionate behaviors can teach students how to develop the ability to deliver compassionate care. The following excerpt describes how Nicole intentionally role modeled compassionate care at the patient's bedside to develop a student's ability to develop compassionate care skills. Nicole stated:

> I can recall one particular student right now, but there have been many. I typically ask the student certain questions about the patient that would require them to speak and get information from the patient. There have been times when the student response has been "Oh, she doesn't talk." This was the answer, or "Oh, she doesn't want to talk." They always seem uncomfortable or unaware. When this happens, I go into the room and assess if in fact the patient is difficult to talk with. This one day, I went in during my rounds which is at the very end before post-conference, to make sure everybody's safe, quiet, needs are met, et cetera, and I said to the patient, "So, how are you?" She said, "Okay." She had a flat face and a flat affect and I could see this was a challenge for the student. I knew I had to break the barrier and teach the student there are ways to manage patients who are not as talkative. I noticed something in her bag that looked like a gardening book. I love gardening. Here we go. This is how I show them. I demonstrated to the student how you can tie them in, because people like to talk about themselves. This is how I show them. I noticed the book, and I said, "Oh, you're interested in gardening." She said, "Yeah, I do but I'm stuck here." I then got into it; we started talking about how to put tomatoes in, and the time of the year, and how it rained last year and before you knew the patient was talking away. And then, the student looked at me and said, "Wow, I'll never forget this." I said, "Yes, this is how it works."

When Nicole was asked how the situation felt after she role modeled the delivery of compassionate care at the bedside, she described it as a win-win. It was rewarding for

her and the student who validated that the teaching and learning were effective, but it was also a positive outcome for the patient who enjoyed the conversation.

The participants as well discussed the importance of compassionate care among professional colleagues and members of the healthcare team, including students. Several remarked how healthcare professionals often lack compassion toward each other and nurse educators should role model compassionate care in these kinds of situations. Several participants emphasized they were inspired during their own education by a nurse educator, who influenced them to model similar behaviors with their students. They also reported using conference time to discuss compassionate and non-compassionate interactions observed during the clinical day. In talking about role modeling, participant Amanda identified some ways nurse educators can dispel certain impressions to which students are exposed. Amanda talked about role modeling compassionate care for students in this excerpt:

> One of the things about teaching compassionate care is being compassionate to the students. I find that, and my students will tell you this, I'm tough in terms of my grading and what you have to maintain, you have to do the right thing and stuff. My students see that part of me and then they'll see the other part of me when a student is down. I had a student whose parent was dying this semester. If they observe you go above and beyond to make sure that the student's needs are fulfilled so that they can flourish, they learn compassion. They learn you care. Or when you have a student that comes in and says, "I was just in a car accident" or something valid, and you say, "Okay, I'm not going to mark you late. Come and see me and pick up the handouts and we can talk about what you missed." During these situations, they see the nurse educator's compassion and it makes an impression, it's like a pay-it-forward type thing. They see their role models doing it, then they do the same in return. Role-modeling compassionate care doesn't have to be in a clinical area, it can be anytime and anyplace when you're teaching and with students.

The majority of the participants discussed the significance of students observing when the care delivered was lacking compassion and the importance of talking about the ways in which the nurse or healthcare professional could have managed a situation with more compassion. For example, participant Liz specifically described how it can be addressed during a post-conference or in a group discussion:

> I ask about bad experiences. When students observe staff members not being compassionate, I try to flip it around and say, "Okay, what would you do instead? How did that make you feel, and what might you do as a registered nurse to try to make a difference and develop a more compassionate relationship with the staff members, regardless of whether it was the housekeeper or the physician?"

While the participants reported role modeling can be done during class and conference discussions, they concluded that it was more powerful when nurse educators have opportunities to model real-life compassionate behaviors during clinical situations with patients.

Guided questions. The second strategy utilized in the clinical setting identified by the participants discussed providing nursing students with specific questions they can ask patients or families as a way of making a compassionate introduction and teaching compassionate communications skills. Asking certain questions can also provide the nurse with answers to questions that will foster the delivery of compassionate care. Some of the participants referred to the questions as guided questions, prompt questions, or scripted questions, indicating they are intended to facilitate teaching and learning about compassionate care. During pre-conference, the instructor focused on the significance of the questions within the context of compassionate care and empathy. During post-conference, the nurse

educator asked the students to share the patient responses and what they learned. The nurse educator is the facilitator for the discussion about various topics, including compassionate care.

The following is an example of how participant Gabriella used guided questions to teach about the importance of compassionate care in the clinical setting. Gabriella stated:

> After I receive report, I create assignments and develop a plan. Pre-conference is the time to set the clinical objectives. The focus should not solely emphasize technical aspects that sometimes students or clinical instructors tend to focus on, but also holistic care. Demonstrating role modeling is really very powerful to incorporate in this type of care. Using a lot of guided questioning for each student to ask their patients hones the importance of compassionate care. Guided questions provide the student with information. During post-conference, we talk about the answers to the guided questions. I continue to build on these questions and ask the students additional questions about the actual interaction. I ask questions like "How do you think the patient feels about needing to have a bed bath or needing some kind of assistance? How would you feel about that if you were the patient?" I try to develop empathy during pre-conference through the use of guided questioning and follow-up questions. Post-conference is the time to follow it up. I include sharing by asking the group as a whole, "What was the most important learning that you experienced today? Did you experience any feelings that were especially aroused? Name one feeling and something that prompted that or tell me how you demonstrated caring today."

The participants discussed many of the 21st-century changes in healthcare and their impact on how students learn to prepare for the role of the registered nurse. They emphasized how changes due to advanced technology have altered the nurse's role, and that the former task of writing *nursing care plans* has become an activity of the past. In keeping with these changes, nursing curricula have been given the charge of modifying learning activities that meet the needs of practicing contemporary nurses. In addition to using case studies in the classroom, clinical instructors reported using

case studies as clinical assignments instead of nursing care plans. Students are being asked to apply the nursing process to a realistic plan of care for a client for whom they are caring in the clinical setting. The types of assignments vary from concept maps to teaching plans as well as other types of learning tools that develop clinical judgment and decision making. While the participants shared mixed views about how technology has changed the nurse's role, they all agreed that newer types of clinical assignments and case studies have created positive changes that foster deeper learning and afford nurse educators teaching opportunities that can investigate deeper concepts such as compassionate care.

Simulation laboratory experiences. The participants discussed simulation-based learning and how it has emerged as an innovative teaching method that provides nursing students with more opportunities to acquire the necessary knowledge, skills, and attitudes for developing clinical judgment. During the focus group session, one participant talked about teaching nursing students through simulation scenarios according to learning domains. She indicated that student learning objectives are based on three domains of learning: cognitive, psychomotor, and affective. Moreover, these domains are widely accepted to describe the breadth of learning and guidance for evaluating nursing students' performance. The participants also reported that educational experiences, including simulation, can help students learn about providing compassionate care. They remarked that scenarios requiring cultural sensitivity, EOL care, and ethical issues that can affect patients throughout their lifespan were especially relevant to the delivery of compassionate care. Eight

interview participants and the focus group members reported that simulation debriefing is a valued component of simulation-based learning, particularly within the context of teaching nursing students about compassionate care. They described the debriefing component as a time when the facilitating nurse educator guides the process so that students can reflect on their simulation performance.

Teaching/Learning Activities Beyond the Classroom or Traditional Clinical Setting

After participants reported which teaching strategies they identified as useful in both lecture settings and clinical settings, they were asked if there were other types of teaching/learning experiences that had not been explicitly used in a classroom or clinical site. This section describes such educational settings and strategies that utilized additional contexts the faculty found helpful in teaching and developing compassionate care capacities in their students. I coded, analyzed, and grouped these strategies separately from those the participants reported using in the classroom and clinical setting. The initial analysis of findings indicated some overlap in teaching and learning strategies previously reported, such as hospice, EOL, and palliative care. The findings also indicated additional components of community health courses that could be defined as clinical teaching but were not reported under clinical strategies. The participants stressed the importance of providing experiences in the community and public health settings that address health disparities. They also discussed a wide range of educational experiences that promote teaching and learning about compassionate care, even underscoring a few as most impactful—namely, working with special needs children and their families, visiting a correctional facility, and working with

individuals/families living in homeless shelters. Moreover, the participants emphasized how certain educational opportunities provide an ideal environment for students to examine the effects of certain situations, such as poverty and homelessness. They further reported that clinical exposure to vulnerable populations increases knowledge about feelings of compassion, and that the students' reflective journaling feedback was consistent in indicating that these experiences overall impacted learning about compassionate care. Participant Sara felt strongly about educational experiences that expose nursing students to caring for children and families with multiple handicaps. Sara stated:

> Well, I think one of the things that can be helpful can be the opportunity to deal with a special population, talking now about pediatrics, that have multiple handicaps or that have terminal illnesses or chronic illnesses. Because in those situations, the parents and the child tend to have frequent and very different types of interactions with healthcare system in general. The family becomes very sensitized to care and to whether or not care is holistic and thoughtful and compassionate. You can see the distress level rise in the family when the healthcare provider is being very routine and very focused on getting the task done and not paying attention to the person on whom the task is being done. I think building this into an undergraduate pediatric experience, some opportunities to be with children who are more seriously ill, even if they're not doing anything much in the way of physical care is beneficial to teaching compassionate care. It could be anything and it might not be an illness that's particularly visible to the naked eye, so to speak, but where they are likely to have multiple contacts with the healthcare system where they will have more difficulties in the family dealing with the health of the child because it requires daily intervention, multiple medications, multiple visits to different providers or even the same provider, frequent lab testing of some sort or another. It raises for the parent anxiety about how the child is doing, multiple, sometimes invasive, blood tests and other kinds of tests that have to be done. It is beneficial for the student to see how this impacts the entire family, and to be able to look at the impact on the family who is raising a child with a chronic illness over a period of time.

Julia addressed teaching and learning in a correctional facility:

> The correctional facility is another educational experience that I'm grateful for. We are going there tomorrow. It is a really interesting place of practice, that I had no experience with but was a part of course I am teaching. I needed to educate myself on it since I'm teaching the course, and I really enjoy going back there with the students. These students have to look at criminals basically, or at least accused criminals, accused persons that have to be provided healthcare. It gives it a whole different feeling, and we hear from the nurse and the role of nurse in the correctional facility, we hear from the correctional officers and the students are toured through minimum security-type areas. I love to hear back the feedback after and what they think. We talk about the reasons they may have made bad choices. Reflective journaling is a powerful way to learn about what they felt. It's interesting to see they feel compassion for these individuals. There's always one student that tells me they would love to work there, which I always think is very interesting. It also exposes the student to the various types of patients they might care for in the ER or acute care setting.

Some of the educational experiences the participants reported were linked to specific courses in which they had assignments that included projects focusing on compassionate care or trips to homeless shelters and soup kitchens. The participants also cited required reading assignments using specific literary nonfiction books that they considered powerful ways to teach compassionate care to nursing students. The books are included as forms of documents that I reviewed and discuss in the next section.

Document review. The programs' mission statements, philosophy, and outcomes were reviewed to identify elements or concepts related to compassion or compassionate care; neither term *compassion* nor *compassionate care* was found in these documents. A review of the programs' mission statements and philosophy identified they were similar. They discussed educating graduates about the importance of learning as a lifelong and continuous process, and stressed the importance of cultivating values and commitment to service and leadership for the

greater good. Similarly, the program outcomes were alike in stating that baccalaureate students from both institutions will graduate with competencies in effective communication, problem-solving and decision-making skills, delivery of care based on best practice, and service as a leader in the community.

At the end of each session, some of the participants provided course documents for me to review. For this study, 63% provided documents for review. Not all of the participants referred to the documents during the sessions. The documents that were submitted included: six course syllabi, including reading and writing assignments and projects, a supplementary reading list of nonfiction books, one article, one poem, and a faculty teaching philosophy. The syllabi provided were didactic nursing courses that focused on Fundamentals of Nursing, Adult Medical-Surgical Nursing Care, Community Health Nursing, Care of the Dying Patient, Issues in Health Care and Professional Nursing, and the Senior Nursing Student Capstone Course. I received syllabi that the participants provided from both programs and initially analyzed the documents for the presence of the terms *compassion* or *compassionate care.* These terms were found in only two of the reviewed syllabi. The courses using these terms were Care of the Dying Patient and Issues in Health Care and Professional Nursing. Moreover, Care of the Dying Patient listed a specific student learning competency about teaching the student how to provide *compassionate* end-of-life care. The syllabi were reviewed for learning assignments, required readings, and any other course-related information on teaching compassionate care. During the interviews, all of the participants with classroom

teaching experience discussed teaching and learning strategies that they use when teaching compassionate care; however, not all of the syllabi provided included teaching and learning about compassionate care. For example, during the interviews, nurse educators who taught adult medical-surgical nursing courses reported that they discuss the importance of compassionate care and provide many examples of how they teach and support learning about compassionate care in the classroom, yet the medical-surgical nursing course syllabi did not include student learning outcomes, strategies, or any assignments related to learning about compassionate care. Moreover, one adult medical-surgical nurse educator provided a supplementary reading list that supported one way she taught compassionate care. The participant talked about how she connected certain themes in the books to certain diseases that were being covered in the classroom. For example, when discussing EOL care for oncology patients and neurological patients, she incorporated the patient perspective by discussing *Tuesdays With Morrie* (Albom, 1997).

Another participant who also taught medical-surgical nursing referred to assigned readings in Lance Armstrong's (2001) autobiography *It's Not About My Bike: My Journey Back to Life* and his battle with recurrent cancer. The participant discussed how she assigns powerful excerpts from the book, specifically the parts about the patient's experience of undergoing chemotherapy and when he received news that his cancer had metastasized. She engages the class in thoughtful discussion and shares her own personal experiences with cancer, chemotherapy, and metastases. She emphasized that the book was a useful way to incorporate compassionate care

into a medical-surgical course. The participant gave me a copy of the book after the interview. This was a source of new information that was learned through the request of additional documents in this study. It was interesting to see that two of the participants who taught medical-surgical nursing lectures used books to teach compassionate care in a medical-surgical course.

Two of the course syllabi included clear information about teaching and learning about compassionate care. The courses Care of the Dying Patient and Issues in Health Care and Professional Nursing both included required readings with assignments that taught about compassionate care. The course syllabus for Issues in Health Care and Professional Nursing dedicated an entire week of learning activities, topics, and required readings to teaching compassionate care. The learning objectives included a focus on preventing errors and promoting quality healthcare through care of self. Class lecture and assignments were focused on compassionate care, compassion fatigue, and self-care. Several required readings were also stated in the syllabus and class assignments, two of which included "The Arnold P. Gold Foundation joined with AACN to launch a national initiative promoting compassionate care in nursing" (2013) and Mazzotta's (2015) "Paying Attention to Compassion Fatigue." The students were expected to read the articles prior to the lecture, bring hard copies to class, be prepared to engage in class discussion, and submit a written reflection on each (questions about evoked feelings, motivation, and future action related to the topic were to be answered).

During the interviews, some of the participants provided or made reference to various articles they used when teaching about compassionate care. Three participants cited specific authors who have published peer-reviewed research and applied Watson's (1979) theory to the concept of compassionate care. They provided the titles, authors, and dates, or hard copies. In some cases, the articles mentioned during an interview were also cross-referenced in the syllabus when provided. One participant who emphasized the importance of introducing caring-based theory and self-care provided me with an article that she referenced to teaching compassionate care within the context of women's health and the difficulty couples endure during experiences with infertility (Özkan, Okumus, Buldukoğlu, & Watson, 2013). The participant discussed the topic of infertility, which is difficult to empathize with unless one has experienced it; she felt it was important to spend extra time teaching about providing compassionate care to couples experiencing this problem. The participant uses the article to engage student learning by incorporating Watson's caring-based theory and self-care within the context of infertility and focuses on the psychosocial aspect of nursing and caring for these couples. Students engage in lecture, rich discussion, and reflective writing about the article and the topic.

Similarly, during the interviews, some of the participants emphasized reading powerful nonfiction books and the impact certain works have on teaching compassionate care. One participant provided a separate reading list while another gave me an actual book she uses when teaching compassionate care. When the syllabi were provided, I was able to compare and confirm the books they talked about during

the interviews as required reading assignments for a course. Additionally, in some courses, specific assignments connected themes about the books to learning about compassionate care, in both cases adding to the credibility of the findings. For example, the syllabus for the Death and Dying Course listed *Tuesdays With Morrie* (Albom, 1997) as a required reading assignment and indicated several specific required writing assignments about different parts of the book.

As researcher, I read the books listed in the syllabi or on a reading list as mentioned by the participants during the interviews in order to understand better the ways they were used. In doing so, it was possible to gain a deeper understanding of how the participants were able to connect the teaching and learning of compassionate care and the theme of the book with the student learning assignments. The books referred to during the interviews and/or listed in the syllabi or on a separate reading list were: *Tuesdays With Morrie* (Albom, 1997), *Being Mortal* (Gwande, 2014), *The Good Nurse* (Graeber, 2013), *It's Not About My Bike: My Journey Back to Life* (Armstrong, 2001), and *Man's Search for Meaning* (Frankl, Lasch, Kushner, & Winslade, 2006).

Another participant felt strongly about the use of poetry and provided a poem she uses when teaching nursing students about compassionate care. The poem entitled "An Old Lady's Poem" is by an unknown author. The participant distributes the poem to entry-level nursing students on the first day of clinical. The poem tells the reader about the old lady's full life and accomplishments while going through the bittersweet aging process. The significance of the poem is to see beyond the image of an old

aging person, and to think more deeply about who she was as a young vital person. The participant underscored the importance of the poem and the reaction she has observed with entry-level nursing students. During the interview, the participant also shared her difficulty as a nurse educator with her own language barrier and challenges of learning English as a second language while teaching important topics that require rich discussion. She described the use of impactful poetry as a way to engage rich discussion, particularly when faculty experience a language barrier. This was an interesting source of new information learned through the request of additional documents, and the use of poetry was one way the participant engaged nursing students to participate in rich discussion when teaching about compassionate care.

Participant Allison wrote a personal teaching philosophy which she submitted as a part of her academic scholarship requirements for the institution. During the interview, Allison referred to the teaching of compassionate care as an educational "nursing journey" and the ways she personally identified with her own values and beliefs before teaching about this concept. Allison talked about this during the interview and provided a syllabus and her teaching philosophy, which supported this information. Allison stated:

> One of the most important parts of this nursing journey is to focus on teaching compassionate care, and in one of my courses, I use a variety of teaching strategies. Before I could re-design the course, I needed to reflect on my values and beliefs. In doing so I wrote my teaching philosophy and I described how I am the educational navigator on this journey with the students.

Allison's teaching philosophy addresses the challenges and solutions for teaching compassionate care with patients and their families. The course syllabus is consistent

with her philosophy and the varied approaches that were emphasized as critical elements when teaching about compassionate care. The conclusion of Allison's teaching philosophy stated:

> Hopefully, when reaching the endpoint of this journey students should be compassionate, competent and safe to be mainstreamed into the community to share their skills with others. As their student journey is concluded, my job as educational navigator is now complete."

Summary

Chapter V built on the findings of Chapter IV by relating the teaching of compassionate care as including certain methods and learning environments the participants reported as most effective. The teaching strategies faculty used when teaching compassionate care in the classroom or clinical area and other types of learning environments or educational experiences which they felt facilitated learning about compassionate care were presented. In addition to the information provided during the interviews and focus group, some of the documents reviewed such as books, course records of syllabi, reading and writing assignments, and projects supported the teaching and learning strategies that facilitate learning about compassionate care. Building on the findings of this chapter, Chapter VI next discusses the ways the nurse educators evaluated whether students were able to provide compassionate care and which obstacles and challenges the participants faced during the teaching and evaluation process.

Chapter VI

FINDINGS: EVALUATION OF LEARNING AND EDUCATIONAL CHALLENGES

Chapter V discussed the study's findings related to the teaching of compassionate care. The participants reported effective teaching methods for educating nursing students on how to provide compassionate care in classrooms, clinical settings, and other kinds of educational environments that support this learning. Chapter VI now discusses the ways in which the faculty evaluate learning about compassionate care and some of the obstacles and barriers to teaching compassionate care.

Evaluating Learning About Compassionate Care

The evaluation of learning is a process of making judgments about student learning and performance. By evaluating student outcomes achieved, the effectiveness of programs can be measured and decisions can be made about needed improvements (Oermann & Gaberson, 2014). The nurse educator role is critical in insuring that the quality of teaching provided leads to the learning outcomes that the nursing curricula have set forth for nursing students to achieve prior to program completion. During the interviews, the participants were asked how they evaluated learning about compassionate care. They agreed that most of the learning in nursing education involves analyzing test scores and assessing skill proficiency, whereby the

instructor makes a value judgement about the quality of learning and performance through a variety of formative and summative evaluative methods and measures. The participants referred to the use of terms such as *outcomes* and *competencies* to evaluate learning, yet agreed that the use of these terms is difficult to measure within the context of teaching and learning about compassionate care. The nurse educators in this study also referred to the terms *knowledge*, *skills*, and *attitudes* as learning competencies that nursing students need to develop to achieve outcomes. Billings and Halstead (2016) defined outcomes as the characteristics that students should display at a particular point in time, while competencies were the behaviors needed to develop those characteristics. Regardless of the terms, however, the participants agreed that teaching compassionate care is valued and important in the nursing curricula; moreover, to teach compassionate care, nurse educators must develop learning outcomes that include compassionate care. Several of the participants talked about outcomes or objectives that are written according to the three domains of learning, thus specifying: knowledge to be gained as the cognitive domain, skills to be performed as the psychomotor domain, and values to be developed as the affective domain. All of the participants agreed that teaching and learning about compassionate care are part of the affective domain of learning, and the evaluation component of the affective domain requires the educator to observe student behaviors and elicit values that are consistent with the delivery of compassionate care. The participants described various ways to evaluate student behaviors that were consistent with learning and exhibiting compassionate care.

The transcripts of the participants' descriptions were coded, analyzed, and grouped into categories. Three overarching themes emerged to describe the ways in which the participants evaluated the learning of compassionate care: (a) direct observation, (b) feedback from others, and (c) assignments.

Direct observation. The participants described the evaluation of learning compassionate care while observing student behaviors as most valued. Various forms of observation within the context of the concept of compassionate care included: during physical care with patients; in communication with patients, families, peers, faculty, and other members of the healthcare team; and during clinical simulation experiences. During the individual interviews, 14 participants as well as the focus group reported that they observed compassionate care behaviors when students spent time talking with patients. The participants gave the following examples to illustrate: self-directed student nurses went the extra step to meet the needs of a patient without being asked to do so, and student nurses made extra time to talk with a patient and identified something new and important that a healthcare professional had not previously noted in the plan of care. The participants also reported the evaluation of the following student behaviors: using appropriate touch beyond routine nursing skills, speaking in a gentle tone of voice, and paying special attention to a patient's privacy and dignity. The participants emphasized the importance of nurse educators recognizing and reinforcing positive behaviors as a part of the evaluation process. One focus group participant, Angela, talked about the importance of touch and physical proximity when caring for patients. Angela stated:

> I think that a student that stands back too far from the patient isn't right. I prefer when I go into a room and see a student is sitting right next to the bed, instead of standing over the patient. It's even better when I see them holding their hand or touching them, saying something like "It's okay, it's okay." Just actually showing compassion through words and touch.

The participants also discussed evaluating compassionate care during simulation lab and other kinds of interactive learning experiences. They reported the simulation experience as an opportunity to observe students and considered the debriefing session as an opportunity for educators to offer students timely and meaningful constructive feedback. The participants also discussed debriefing as a significant evaluative approach to improving students' technical and nontechnical skills, such as raising situational awareness particularly when addressing concepts like compassionate care. Other interactive learning assignments such as case studies, role play, and presentations include students' observational and classroom discussion components, both of which provide educators with opportunities to observe and evaluate students' attitudes and beliefs on different topics within the context of compassionate care. The participants reported that it was also important to observe and evaluate the students' communication skills and behaviors during these kinds of assignments. One focus group participant, Angela, spoke of evaluating compassionate care during simulation by incorporating cultural diversity and care for the lesbian/gay/transgender/bisexual population with real-life patients. Angela stated:

> Sometimes we will have an instructor wear cultural garb and model as the patient for example; as an orthodox Jewish or Muslim patient, this is one way to incorporate cultural care and cultural sensitivity. We bring in religious items, so the student learns about their meaning and some of the significance to different cultures as health care providers. The student's response is important and this is one way we evaluate compassion and culture

> competency. We also use real-life patients for certain scenarios. One example is where two males represent the LGTB community, they are live actors. The students go into simm lab, three students at a time. They talk with the actors, they ask them questions, and afterwards the actors come into the debrief and tell the students how they felt. How they were making them feel, or maybe things that they should have done, or could have done to make them feel better or more sensitive to their situation. This is one way to evaluate student compassion toward individuals who may not be exactly the way they are and to accept that everyone is different.

During the interviews, the nurse educators reported that certain student behaviors—such as sitting next to the patient and acknowledging their personal religious items, listening carefully to their beliefs with a non-judgmental or biased opinion, responding in a culturally sensitive and compassionate way, using a physically gentle approach during care, and communicating important information—were consistent with compassionate care. When the students were directly observed during patient care or interactions exhibiting these behaviors, they were evaluated as compassionate caregivers.

Feedback from others. The participants described reported feedback from patients, families, peers, preceptors, and other members of the healthcare team as a way of evaluating compassionate care. Eight of the interview participants and the focus group reported they especially valued verbal feedback when evaluating students learning within the context of compassionate care. One focus group participant Maria stated:

> When a post-partum mother makes a point to tell me that a student has patience and takes the time to stay and assist the mother during a challenging breast-feeding experience and that the student was especially helpful to her.

The participants reported verbal feedback from patients, families, preceptors, and other healthcare providers as valued sources for evaluating nursing students' learning about compassionate care. Moreover, the nurse educators' direct observations of such behaviors further validated these reports.

Assignments. As a third emergent theme, the participants discussed different assignments they felt provide opportunities to evaluate compassionate care. They considered assignments involving reflective journaling as an effective way to evaluate learning about compassionate care. They agreed that reflective writing challenges the depth and breadth of a student's thinking. Moreover, they spoke of how reflective writing often contains rich information about students' abilities to demonstrate their awareness of their own perspectives and biases as well as their capacity to communicate caring, compassion, empathy, and respect. In addition, the participants believed that reflective writing is a useful tool for nurse educators to evaluate further whether students have insight into and self-awareness of their performance and can recognize the need to take action to correct deficiencies in their knowledge, skills, or attitudes. For example, participant Lynne discussed the use of reflective journaling and writing to evaluate compassionate care in both the clinical and classroom setting. Lynne stated:

> I use reflective journaling in different ways. When a student writes a reflection you can find out more information because you can't be with all of the students all of the time in a clinical day. You can find out more about what went on sometimes through their writing and you can use that information to evaluate them. Sometimes students feel more comfortable writing instead of talking about feelings and thoughts. I find reflective journaling to be helpful in this way. I learn things about students that I may not have learned about talking. Similarly, in the classroom and the way they participate. Some are

> shy, for example; in role playing and what they get out of it. Sometimes when the students role play, it doesn't always represent them accurately because they aren't comfortable with an audience. Reflective writing about the role play requires them to write about the scenario, what went well, what could have been better. It is great way to evaluate learning within the context of the theme, in this case compassion, but it is also a great way to assess if the student is able to self-evaluate their performance which is even more valuable.

Focus group participant Angela talked about evaluating a student when using a concept map assignment. Angela found it meaningful when a student thought beyond a patient's medical diagnosis and addressed other needs. Angela stated:

> I like when they go the extra step on a concept map assignment. For example; I think this patient needs social services for something more than a medical issue. In my opinion, that's compassionate care.

The use of assignments with a specific focus was also reported as a useful way to evaluate concepts like compassionate care. All of the participants reported that making time to include rich classroom discussion or pre-/post-conference discussion provides an opportunity to evaluate student learning about compassionate care. One participant discussed how she valued the use of narrative pedagogy when teaching "tough topics." When I asked the participant more about this approach, she replied, "It is often more simply termed, as storytelling, to teach complex topics. Narrative pedagogy is an approach that evolves from descriptions of stories told by teachers, clinicians, and students." Ironside (2015) linked and further defined the participants' descriptions of narrative pedagogy as a way to create opportunities for educators to talk with students about their thinking, how they understand (interpret) the situations they encounter, and what this means to their emerging nursing practice.

In summary, the participants reported that the predominant method for evaluating compassionate care was through direct observation and performance of students in clinical practice. In addition, some of the participants talked about eliciting verbal feedback and using class assignments that involved reflective writing to provide an additional dimension about a student's ability to provide compassionate care.

Faculty Challenges to Teaching Compassionate Care

During their individual interviews and focus group session, nurse educators were asked about specific barriers or obstacles they perceived to be challenges when teaching nursing students about the delivery of compassionate care. I coded and analyzed the transcripts of the participants' descriptions and views of these challenges.

Lack of knowledge about different cultures. At least eight of the interview and focus group participants reported students have lack of knowledge when interacting with patients from a different culture, which they viewed as a barrier to teaching compassionate care.

Cell phones. Five participants identified certain distractions as 21st-century changes that have presented new challenges—cell phones, texting, and social media—as other barriers. The participants talked about the need to remind students continuously not to use their cells phones in the clinical and classroom setting, and felt in fact that the temptation to use these devices was an obstacle for both the student and the nurse educator within the context of teaching and learning.

Generational differences. Some participants discussed generational differences of individuals who were entering the profession and how nurse educators are challenged to meet these varied generational learning needs. Participant Cynthia found it difficult to articulate the precise terms for the change in the type of student entering the profession; however, she emphasized the importance of reinforcing compassionate care. Cynthia stated:

> I will say I notice that there is a different mentality in students. I can't put my finger on exactly what it is. I notice that the students are younger than they were when I first started teaching. They are less worldly. They are naïve. I think that has a lot to do with not showing enough compassion or empathy sometimes. I hate to sound like an old person, but I think it's the new generation. They just don't get it. They really don't get it. You need to reinforce with them constantly about how they need to look at things from the patient's view. I think if they keep hearing that over and over again, maybe at some point in time it will sink in. Everything with this generation is their cell phone or their computer. They have information right at hand and everything is immediate. Always immediate gratification. I feel this is a part of it. They don't really take the time to sit back and breathe, and really think about what they're saying, what they're doing, and what the implications are. I tell students there is always a reaction to every action. Be aware of that. Be cognitive of that. We need to keep reinforcing with this generation.

Learning environments. The participants reported being faced with the challenge of teaching nursing students to be both clinically safe and compassionate caregivers, yet they all concur that nursing education places a greater emphasis on 21st-century technical proficiency, nursing knowledge, and evidence-based practice. As a result, they agreed there is less of a focus on concepts like compassionate care. Some participants talked about demanding work environments and how they create a challenging teaching environment. They reported accounts in which nursing students may have observed practicing nurses with taxing workloads or incivility in the

workplace, which impeded their abilities to provide compassionate care. Moreover, these factors predisposed the nurses to compassion fatigue. The participants shared concerns about the negative perceptions and impressions this may leave on nursing students. They all agreed that allocating dedicated classroom and conference time to discuss compassion fatigue is important, particularly after students witness negative events in the clinical setting. They emphasized the importance of talking about compassion fatigue and its impact on patients and families. On this point, all of the participants felt strongly that nursing education must mentor students as they advocate the importance of compassionate care so that the "art of nursing" is not lost.

Compassion fatigue. Participant Liz talked about challenges of compassion fatigue and the importance of educating for this early in a nursing student's education through the concept of self-care. Liz stated:

> This semester, I came across an article about compassion fatigue. The students also read about this under the topic of self-care so learning the importance of self-care, not being overly fatigued, resources to help with dealing with really sensitive stressful issues in the workplace and so on. I've addressed it like that. In one course, the students read Dr. Connie Vance's [2011] book on mentoring. She talks about self-care, and mentoring, and compassion, and the relevance to nurses not eating their young and being supportive. Certain learning activities are introduced in the first semester so that the nursing students will be more attuned to self-care, lifelong learning, mentoring others and seeking mentoring, which I feel is also an important part of being compassionate. The students are given discussion questions that I post on the course blackboard. These can be used as either prompts for the online environment or part of the discussion in the classroom. They weave in a lot of the attitudes, values and feelings. Questions like "How did you feel about that?" Reflecting in action and how to be more compassionate in a particular situation. I also use this approach when I teach about nursing history. I have an article where there's several different case exemplars in the past about nurses. They pretty much give examples of compassion or altruism and so on. Has it been beneficial for nurses to be too compassionate? Is it possible for that to occur and how has that really affected the profession? A

> lot of combined reflective journaling. Every week there are questions about what they did, how they feel, what did you think, what prompted those thoughts, those feelings? Now what actions are you going to take? It's a combined way to approach cognitive, affective, and psychomotor learning.

The nurse educators in this study discussed the challenges they face when preparing student nurses for the realities of healthcare delivery while continuing to foster a meaningful understanding of what constitutes compassionate care in professional practice. The examples they shared demonstrate how nurse educators manage these challenges while continuing to influence and teach their students about compassionate care through the nursing curriculum.

Summary

Chapter VI built on the findings of Chapter V by relating the ways nurse educators evaluated whether nursing students were able to provide compassionate care. The use of direct observation, verbal feedback, and assignments were reported as the best means of evaluating whether a student nurse demonstrates compassionate care in his or her practice. This chapter also reported the participants' challenges to teaching compassionate care, which included the impact of 21st-century societal changes. Concerns about compassion fatigue were also reported as a challenge to teaching compassionate care. In Chapter VII, the findings and conclusions of this study are discussed.

Chapter VII

DISCUSSION OF FINDINGS

The goal of this study was to explore and describe the ways in which nursing faculty educate baccalaureate nursing students on how to provide compassionate care. A description of how to provide compassionate care is rarely found in nursing curricula or in the profession's body of knowledge. The literature review (presented in Chapter II) discussed a considerable amount of published research on the value of providing compassionate nursing care, yet only minimal research has been concerned with how this capacity can be taught to and developed in nursing students.

The nurse educators in this study were asked to define compassionate care and describe how they taught and evaluated learning about compassionate care in baccalaureate nursing programs. They described experiences as well as barriers to teaching compassionate care. Knowledge of the personal and first-hand experiences of nurse educators adds valuable, practical insights into which behaviors, methods, and resources they considered useful for helping students develop the competencies they need to provide compassionate care to patients. Moreover, they shared additional examples of what they believed develops teaching and learning about compassionate care in baccalaureate nursing programs.

Papadopoulos et al. (2016) explored nurses' understanding of compassionate care from 15 nations in the world. Using a questionnaire, they explored the

perspectives of compassionate care as related to the different roles of the 1,323 nurses participating in the study. The findings revealed that compassionate care is not adequately addressed in nursing education nor supported in the practice environment. These findings supported the importance of the contributions and significance of the present study to nursing education.

The IOM (2010) report *The Future of Nursing: Focus on Education* recommended a reform in nursing curricula to support the vision of a healthcare system that is *patient-centered*. These concerns have prompted professional nursing regulatory boards to recommend research-based pedagogies that could respond to the changing healthcare environment and the call for *patient-centered* compassionate nursing practice (AACN, 2015; NLN, 2003, 2005, 2013). Provision One of the ANA (2015) Code of Ethics stated that nurses are to "practice with compassion and respect for the inherent dignity, worth and unique attributes of every person" (p. 7). The findings discussed in this present study addressed some of the gaps in nursing curricula that were identified in the literature and recommended by nursing regulatory boards and the Nursing Code of Ethics.

The contributions of this study are discussed in two parts through an examination of the findings. The first part describes the participants' personal experiences in providing compassionate care, includes a definition of compassionate care derived from their descriptions, and relates the meaning that participating faculty attributed to their experiences with and beliefs about the provision of compassionate

care. In addition, similarities and differences between these findings and those found in the current literature are identified.

The second part discusses the participants' descriptions of the effective teaching methods they used to develop nursing students' ability to provide compassionate care. Similarities and differences between these findings and those of other published studies related to the teaching of compassionate care are brought to light. It is hoped that the approaches revealed in this study will contribute to evidence-based nursing pedagogies that maintain the past and shape the future of a compassionate profession.

Understanding Compassionate Care

The review of the literature revealed that the definitions of *compassion* and *compassionate care* lacked clarity. The term *compassionate care*, as defined by Dewar et al. (2014), is "A relational activity that is about the way we relate to other human beings when they are vulnerable. It can be nurtured and supported. It involves noticing another person's vulnerability, experiencing an emotional reaction to this, and acting with the person in a way that is meaningful for people" (p. 1741).

Given the context and depth of the term *compassionate care* and how it can be defined, learned, and achieved in everyday practice, I began each interview by asking the participants what the term *compassionate care* meant to them and what their worldview and beliefs were about compassionate care. A definition of *compassionate care* within the context of nursing was synthesized based on the participants' responses and is expressed here as follows:

> *Entering the worldview of the patient, family, and community by making a deep, mutual, and caring human connection which is felt when the nurse recognizes intimate needs and provides care that is thoughtful, nurturing, loving, and gentle. This type of care invokes an emotional connection that is meaningful for both the nurse and the patient while meeting the needs of the patient.*

This definition by the study participants is broader than the definition posed by Dewar et al. (2014). It not only adds depth to the importance of a meaningful human connection that both the nurse and the patient feel, but the participants also emphasized the elements of providing thoughtful, gentle care that does not necessarily require the patient to be in a state of vulnerability.

In addition to being asked about the meaning of compassionate care, the participants were asked to share their worldviews and beliefs about delivering compassionate care through their own personal experiences. Three overarching themes were derived from the analysis of these findings: (a) making extra time to listen to and talk with patients or families, (b) being present when a patient is dying, and (c) assuming/adopting a physically gentle approach to care.

In addition, the nurse educators in this study described the value they attributed to the provision of compassionate care. They expressed their beliefs about how compassionate care can be achieved in practice and how important it was to root the teaching of compassionate care in nursing curricula. The findings also provided

evidence of ways to preserve the teaching of compassionate care, despite technological demands and rapid changes in nursing education and healthcare.

All of the participants agreed that the capacity to deliver compassionate care was critical. Each participant spoke of *"making time" to listen and talk to patients* as a critical element in establishing the nurse-patient relationship. Through this relationship, effective communication translates into compassionate care. The literature in fact underscored this by indicating that patients felt they received compassionate care when nurses took time to explain important medical information pertaining to their care. Simultaneously, the literature reported that nurses felt that imparting compassion and compassionate behaviors during interactions with patients and families enhanced their professional relationship (Badger & Royse, 2012; Griffiths et al., 2012; Smith et al., 2010). The participants' descriptions and the themes discovered in the analysis emphasized the need for nursing curricula to underscore the significance of *not losing sight of "making time" to listen and talk to patients* and include ways to reinforce this in nursing education.

Specifically, elements of making time were expressed in various ways. All of the participants expressed concern about the growing demands of producing competent graduates who will practice in an increasingly complex healthcare environment. They identified the challenges of equipping students with technical proficiency, conveying an enormous amount of medical and nursing knowledge, while insuring that methods of teaching are kept current with evidence-based practice. Given the current focus on cognitive and psychomotor skills in nursing education, the

participants were concerned about the inadequate emphasis being placed on caring and compassion in nursing, which they agreed was the nucleus of the profession. It is imperative to teach students to engage in authentic, caring conversations with patients. In fact, to them nursing education and nursing curricula are responsible to emphasize this, especially given that 21st-century demands relying on social media and formats of communication can diminish actual talking and physical interactions. Moreover, the participants expressed hope that the findings of this study might shape nursing curricula and guide nurse educators to develop useful compassionate care teaching practices that meet and incorporate today's reality.

Being present with a dying patient was another theme of the study. Specifically, being present with a patient who is dying alone and supporting nursing peers who care for a dying patient were added elements of this theme. The literature identified these nursing behaviors as critical for end-of-life (EOL) compassionate nursing care (Freeman, 2015); when practiced, they were beneficial to the overall well-being of the patient as well as the family and the nurse (Freeman, 2015; Norton, Hobson, & Kulm, 2011).

The participants described EOL nursing care as a unique area of the profession that provides content and educational experiences that are beneficial to teaching and learning compassionate care behaviors in the classroom and clinical area. The findings which featured rich descriptions of compassionate care given within the context of the dying patient extended the existing body of knowledge with additional evidence of compassionate care behaviors specific to EOL nursing care.

Furthermore, they emphasized the importance of teaching compassionate nursing care to nursing students.

Another aspect highlighted in the participants' descriptions of their compassionate experiences was the essence of compassionate touch. In their interviews, the participants described touch as a way of conveying compassion during an experience with a patient. They also described many nurse-patient interactions when they experienced touch as a way of conveying compassion during a patient encounter. The theme, *assuming/adopting a physically gentle approach to care,* emerged from the analysis of these narratives.

Regarding touch, the literature widely discussed it as a non-pharmacological approach to healing, but when reviewing the literature about the use of touch to convey compassionate care to a patient, specific articles were not found. The participants expressed concern about the changing role of the nurse in the 21st century, particularly in how nurse educators are expected to teach appropriate delegation to healthcare assistants for bedside-caring activities, thereby reducing the nurse's time for actual physical caring and mentoring. They expressed fear that caring behaviors, such as providing a gentle and attentive touch to a patient, will also become extinct because of increased reliance on technology and hectic schedules. They hoped nurse educators would not lose sight of these behaviors that have traditionally characterized the profession of nursing. Touch also permeated the participants' discussions of role-modeling behaviors and teaching strategies in the clinical area.

The idea of compassion also filtered into the relationships between nurse educators and nursing students. The participants expressed the importance of faculty being compassionate toward their nursing students themselves. They believed that establishing a faculty-student relationship built on trust and respect will foster the students' own learning about compassionate care. The literature supported these beliefs—specifically, the ethnomethodological study by Newton, Henderson, and Greaves (2015), which explored interactions and experiences in clinical nursing practice that enhanced learning for nursing students. One of the three central themes of that study were "entrustability" (p. 94), which referred to the rapport and trust that a student develops in a teaching and learning environment and which, thereby, facilitates the student's ability to demonstrate good decision making. The findings of the present study accentuated the importance of building trust in a learning partnership that is central to supporting knowledge development. The participants' views and Newton et al.'s findings supported that trust is important and meaningful if the students are to grow in their learning and professionalism, particularly within the context of compassionate care.

The nurse educators also discussed how faculty need compassion for student diversity—a term they used broadly to imply culture, academics, or even generational differences. The NLN's (2013) call for transformation of nursing education reflects the necessity for a paradigm shift that considers the needs of the current student population, specifically in providing learning environments that are conducive to its diversity. To this point, the participating nurse educators expressed concerns over

changes in the student population. For example, the Millennial generation currently comprises the majority of learners in the traditional university setting. Toothaker and Taliaferro (2017) reported that Millennial nursing students bring unique personalities, values, and collaborative natures to engaging in a traditional college classroom, but they place little value on traditional methods, despite successfully passing the NCLEX. Those students emphasize positive relationships with their peers and professors that ultimately provided a more collaborative classroom environment and enhanced learning. The Millennials also emphasize that trusting their professors was an important and valued element of their learning.

Similarly, the participants in the present study emphasized the need to blend newer interactive and traditional pedagogies while establishing faculty-student relationships built on trust. This will facilitate better instruction of this population, especially as nursing classrooms include multigenerational students. Thus, nursing faculty face the challenge of working collectively to balance pedagogies that appeal to these students while still meeting academic rigor. Their goal is to create a learning environment that engages students, builds trust, and ultimately fosters teaching and learning about affective behaviors such as compassionate care.

The findings of both Toothaker and Taliaferro's (2017) research and the present study provide a foundation on which to build an educational approach that can guide nurse educators to transform the classroom and potentially formulate a deeper understanding of knowledge that engages students while building mutual trust. In addition, the participants in this study were positively influenced during their own

nursing education by a particular nurse educator who emulated the delivery and teaching of compassionate care. This awareness suggests how such influences are sustainable over time. The participants all expressed hope that they too have influenced their nursing students about the delivery of compassionate care. Moreover, through their participation in this study, they were hopeful that their contributions might enlighten future nurse educators in the same way.

Teaching Compassionate Care

Regarding the teaching of compassionate care, the participants concluded that nursing curricula are lacking and need to be further developed within the context of educating nursing students about compassionate care. Moreover, no comprehensive model is available that indicates how teaching compassionate care can be achieved in practice, even though nurse educators are given the charge to teach students to provide compassionate care. The participants agreed that compassionate care can be developed and supported in nursing students, and nurse educators can influence their students' values and beliefs about its importance by linking the art and the science of nursing. In discussing their own values, beliefs, and attitudes, the nurse educators affirmed that compassionate care can be developed and supported, especially when a nurse educator makes time to teach about it, role models compassionate behaviors, and establishes student trust to foster learning about compassionate care. They also expressed how caring as a concept has been extensively cited in the literature as a core value in nursing education and nursing practice. However, what was not evident

in the curricular designs that nurse educators use is how to enable students to internalize caring behaviors and develop their capacity to deliver compassionate care.

Introducing foundations of care-based nursing theory and self-care. The literature has suggested that compassion and caring are being acknowledged as less important elements in nursing curricula, since greater emphasis is on technical components (Adamson & Dewar, 2011; Curtis, 2014). Although theoretical nursing frameworks based on caring and related research have also consistently supported the significance of providing compassionate care, Leininger (2012) expressed concern about what the profession ascribes to and what is actually happening in practice. The participants in this study asserted the importance of providing care-based nursing theory in the early foundation of a nursing student's educational process. They recommended revisiting the roots of nursing through entry-level courses such as Fundamentals of Nursing or other introductory nursing courses that focus on the importance of the art of nursing and the significance of compassionate care as it relates to nursing theory. The participants were clear about the importance of transitioning nursing curricula from a major emphasis on skill development and content knowledge to a stronger focus on caring and compassion. In fact, they believed this focus should be incorporated into entry-level nursing when compassionate behaviors can be taught and demonstrated through the art of nursing. At this crucial time, students intentionally form new relationships with their patients as they learn about the introductory phases of the nursing process.

The participants also discussed the importance of self-care within the context of compassionate care. It was important to teach nursing students about self-care and its relationship to caring before they extend care to others. Similarly, these concepts should be introduced early in the nursing students' educational process. Clearly, knowledge, skills, and attitudes acquired in foundation nursing courses are the building blocks to subsequent learning in higher-level nursing courses. Wiklund Gustin and Wagner (2013) further supported the position expressed by the study participants for introducing self-care early in a nursing student's education. They explored self-compassion as a source of compassionate care by conducting a phenomenological and hermeneutic interpretation of written and oral reflections on the topic. They interpreted data from four nursing instructors through the lens of Watson's (2008) theory of human caring. The metaphorical theme, "The Butterfly Effect of Caring" (p. 175), was identified as a way to highlight how a nurse's facial expressions and gestures can significantly influence someone's care. Wiklund Gustin and Wagner's findings have been supported by those of Barratt (2017), Brathovde (2017), Cino (2016), and Drew et al. (2016) in the importance of developing a compassionate self. Moreover, the research acknowledged how a nurse's ability to be sensitive, nonjudgmental, and respectful towards herself contributes to a compassionate approach towards others. This research supports as well the recommendations of the current study participants that introducing and reinforcing self-care during a nursing student's education may develop self-compassion and the ability to deliver compassionate care. Nursing faculty who emphasize modeling and

value self-care may increase the likelihood that nursing students will come to value and engage in self-care early in their professional careers. Thus, the participants expressed the need for the curricula to include a course introducing nursing students to holistic self-care because it immediately supports the development of self-compassion and the delivery of compassionate care.

Evidence-based Pedagogical Teaching Approaches to Compassionate Care

By expanding on these important concepts, nursing curricula can be designed to integrate structures that build on care-based nursing theory and the students' self-awareness that they are caring beings. The design of such curricula also serves to develop pedagogical approaches that support learning about compassionate nursing practice. During the educational development of nursing students, the nurse educators' role is to identify the students' individual capacity for growth in providing compassionate care and their proficiency in using compassionate care teaching strategies demonstrated in the classroom or clinical and other learning environments. This study provided real-life experiences of teaching strategies that faculty used to assist students in learning communication skills, cultural sensitivity, and other compassionate care practices.

Examples of teaching strategies such as storytelling, role play, videos, unfolding case studies, and guided questions were emphasized by the participants as effective ways to teach compassionate care. The participants discussed required reading assignments of specific literary nonfiction as effective in teaching compassionate care to nursing students, including: *Tuesdays With Morrie* (Albom,

1997), *Being Mortal* (Gwande, 2014), *The Good Nurse* (Graeber, 2013), *It's Not About My Bike: My Journey Back to Life* (Armstrong, 2001), and *Man's Search for Meaning* (Frankl et al., 2006). They emphasized how the themes from these literary works helped to guide teaching about compassionate care through rich discussion and reflective writing that also allowed faculty to evaluate student learning (see Appendix H, Teaching Approaches to Compassionate Care).

Role modeling as a teaching strategy illuminated throughout the study. The findings of this interpretive descriptive study brought new evidence to support faculty's acknowledgment that curricula need to have more time allotted to teaching about compassionate care. The nurse educators participating in this study described how faculty role model in various teaching and learning environments as well as among their peers to develop students' ability to provide compassionate care.

The literature has been clear about the importance of faculty role modeling for teaching nursing students to provide compassionate care (Livsey, 2009; Newton, 2010; Post et al., 2014). Moreover, Perry's (2009) phenomenological research study identified the major character traits of an exemplary clinical nurse and named role-modeling excellence as a major attribute. Additional attributes of an exemplary nurse that Perry included as compassionate care practices were making time to connect with patients and tending to little things that matter to a patient. Perry emphasized how positive role modeling by exemplary practitioners can contribute to the education of clinical nurses in the practice setting. Her findings suggested a relationship between role-modeling excellence and exemplary clinical practice and supported the present

study for using role modeling as an effective teaching strategy for compassionate care in nursing education. Nouri, Ebadi, Alhani, Rejeh, and Ahmadizadeh (2013) further studied the use of role modeling as a teaching strategy in nursing education to understand the perspectives and experiences of nursing students and nursing instructors. Like Perry (2009), they found that role models worked as catalysts to transform by instructing, counseling, guiding, and facilitating the development of others. Nouri et al. concluded that further research is required to understand better the role-modeling process in nursing education. The current participants also provided additional evidence supporting the use of role modeling as a teaching strategy when developing compassionate care practices with nursing students.

Conclusion

Despite existing nursing literature that has emphasized the importance of compassionate care delivery by the nursing profession, research describing nurse educators teach undergraduate nursing students to develop the ability to provide compassionate care is lacking. This study used interpretive description to understand nurse educators' experiences with compassionate care and their teaching strategies for developing this capacity. Given today's increasingly complex healthcare environment, this study sought to understand how nurse educators teach nursing students to provide compassionate care and, even more critically, what barriers are associated with doing so. As the educators described their own creative approaches to teaching compassionate care while managing highly complex technological healthcare challenges, the researcher was able to extract and interpret common and

distinctive patterns in their views about teaching strategies that can enrich nurse educators to focus the students to think about patient experiences within the context of compassionate care through a variety of creative teaching modalities. Storytelling, nonfictional books, poetry, case studies, videos/film, journaling, and role play with group discussion were viewed as the most effective strategies in the classroom, while role modeling, guided questions, and simulation with debriefing were viewed as the most effective in the clinical setting. They described 21st-century barriers to teaching about compassionate care as deficits in cultural awareness, cell phone distraction, or teaching in less than optimal learning environments. Despite these challenges, they adjusted their approaches and environments when teaching about compassionate care and emphasized the importance and responsibility of nursing education to adjust curricula and address these obstacles. These findings contribute to a deeper understanding of the dynamics involved in teaching compassionate care. They also offer specific strategies for adding to curricula on compassion and caring theories that can sustain and impact the future delivery of compassionate patient care.

Strengths

This is the first interpretive descriptive inquiry on education for compassionate care from the perspective of nurse educators who teach undergraduate nursing students in a baccalaureate nursing program. Data collection was targeted toward a sample who could provide valuable insights into the phenomenon of interest. The participants represented the perspectives of 19 female nurse educators with at least 2 to 20-plus years of teaching experience, several of whom are presently

teaching in more than one area of nursing education. Transferability was strengthened by teaching experiences from two different 4-year baccalaureate nursing programs: 10 participants came from a secular city university and nine participants came from a faith-based private university with varying levels of teaching experience, education, and areas of specialty. Multiple data sources such as individual interviews, one focus group, program documents, and course-related materials served to strengthen the data, provide different perspectives, add depth to the findings, and contribute to the trustworthiness and credibility of the findings. In some cases, these sources provided clarity on how compassionate care is taught and what value is placed on compassionate care in the curriculum. They also added new and detailed information to the study.

Limitations

All of the participants were asked to consider sharing supporting documents that would support teaching and learning about compassionate care. Sixty-three percent of the participants provided documents during the interview or emailed attachments at a later date. Others indicated they would email documents after the interview but did not respond even when the researcher made several follow-up requests. A consideration for future studies could be to mail the participants an envelope with pre-paid postage, reminding them to consider mailing course-related materials at a later date. Another limitation was that no male nurse educators were interviewed in the study. Comparing female and male nurse educators may have provided an interesting perspective to see if their descriptions contained any

similarities and/or differences about compassionate care. Additionally, the study did not provide perspectives about teaching compassionate care within the context of psychiatric nursing.

Implications for Nursing and Research

The findings from this study that are of particular value to faculty have several implications for the teaching of compassionate care. Because it is important for nursing curricula to include the teaching of compassionate care, the approaches revealed in this study may contribute to evidence-based nursing pedagogies that maintain the past and shape the future of a compassionate profession. The findings will guide nurse educators to build curricular designs that develop nursing students' capacity to deliver compassionate care, including ways to teach and learn about compassionate care. The narratives of the mission and philosophy statements and of the program learning outcomes were reviewed and the term *compassionate care* was found to be lacking. Although the participants described the various ways they teach compassionate care, only two syllabi included teaching compassionate care as a specific part of the student learning activities. Given the importance of including the teaching of compassionate care in nursing education, the findings from this study identified the need for nursing education to review nursing curricula and program documents to include not only the specific term *compassionate care* but also to incorporate the importance in the mission and philosophy, student learning outcomes, and teaching/learning strategies related to compassionate care when applicable.

Replication and expansion of this study in different universities may contribute new findings to teaching and learning about compassionate care. Similar kinds of attributes that nursing students are required to develop within the affective domain of learning may be understood in greater depth with additional research in this area. It would also be interesting to hear the perspectives of nursing faculty who do not believe that the teaching of compassionate care should be an integral part of nursing curricula.

Additionally, future research could be designed to determine the effectiveness of any of the teaching strategies described in this study for teaching about compassionate care. One example might be to study two groups of nursing students who are enrolled in an introductory Fundamentals of Nursing course, in which therapeutic compassionate communication skills are taught. One class could be taught in a conventional lecture and the other group might be taught using a non-conventional method of role play, where each student has an interactive part and is given a script. A pretest and posttest could be used to evaluate knowledge of compassionate communication skills in both groups. Alternatively, a measure of some quality related to compassion, such as empathy, could be used to evaluate for an increase or a decrease in that quality. Other strategies described in this study could be evaluated for effectiveness in various classroom settings, seeking to verify if the use of strategies suggested by the participants in this study positively impact student learning about compassionate care.

The participants raised concerns about societal changes and demanding work environments that have impacted the nurse's role. In turn, the barriers to teaching compassionate care were brought to light in this study, suggesting research is needed to discover the ways nurse educators can continue to uphold the history and traditional values of the nursing profession while balancing advances in 21st-century technical proficiency, nursing knowledge, and evidence-based practice.

Additionally, the findings of the study suggest the need for nursing education to transform learning environments, and nurse educators need to continue to find integral ways to enhance knowledge acquisition that meets the needs of today's generationally diverse nursing student. Given today's rapid changes in healthcare, the nursing student population and the patient voice continue to value the delivery of compassionate care. It is critical for nursing research to uncover how nurse educators can help students develop the knowledge, skills, and attitudes needed to deliver compassionate care to patients. This study is an initial step in that direction.

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Appendix A

Letter of Solicitation

Title of Study: Teaching Compassionate Care: Nurse Educators' Perspectives.

You are being asked to participate in the qualitative study "Teaching Compassionate Care: Nurse Educators' Perspectives" because you are a nurse educator that teaches in a baccalaureate nursing program who has first-hand experience with the research topic. Criteria for participating in this study are two or more years of teaching experience in a Baccalaureate Nursing Program.

Affiliation

My name is Jane DeFazio and I am a nurse educator and a Ph.D. student at Seton Hall University, College of Nursing. I am the nurse researcher who designed the study, "Teaching Compassionate Care: Nurse Educators' Perspectives" under the guidance of my advisor and dissertation chairperson Dr. Bonnie A. Sturm, Associate Professor at Seton Hall University, College of Nursing.

Purpose of the Research

The purpose of the research study is to explore and describe the ways in which nursing faculty educate baccalaureate nursing students on how to provide compassionate care to their patients. As a nurse educator with professional experience teaching baccalaureate nursing students, you have a valuable and insightful perspective to share on the research topic.

Participation Time

60-90-minutes in either an individual interview or focus group session.

Study Procedure

The researcher will ask you to sign a consent prior to conducting an individual interview or focus group session based on your individual preference. You will be asked open-ended questions about your experience and perspectives in teaching compassionate care in a baccalaureate nursing program including how you define compassionate care. The session will include questions about your beliefs and expectations concerning the value of teaching compassionate care in nursing education, as well as any educational approaches, facilitators or barriers to teaching compassionate care in your practice. The individual interview or focus group session will be audiotaped and transcribed.

Participation Is Voluntary

Participation in the qualitative study "Teaching Compassionate Care: Nurse Educators' Perspectives" is completely voluntary. Participation or non-participation will have no effect on your employment experience whatsoever. It will not affect your appraisal ratings or the way that you are treated by your department chairperson or Dean. If after signing the informed consent to participate in either an individual interview or a focus group session, you may change your mind and end your participation in the research study including ending the interview or focus group session short at any time. You do not have to give a reason for ending your participation.

Anonymity

Data will be collected without any identifying information. The data collected from each participant will be audiotaped without the use of names or any identifying information. A code will be assigned to each participant for transcription purposes and data analysis. The consent form will be kept in a secure locked site in the researcher's home.

Confidentiality

No names, addresses or other identifying information will be attached to the information that you provide. All recorded data will be stored on a USB memory key and kept in a secure locked site in the researcher's home. A typed transcript of the data and all forms of data will be safely stored and locked separately in the researcher's home for at least 3 years after the study's completion.

If you have any further questions, or would like to participate in the study, you may reach me, Jane DeFazio by cell phone 917-856-9751 or email me at defaziola@aol.com.

Appendix B

Consent for Participation in Research (Individual Interview Session)

Title of Study: Teaching Compassionate Care: Nurse Educators' Perspectives.

Investigator: Jane V. DeFazio, MSN, RN

Researcher's Affiliation: The researcher is a Ph.D. student in the College of Nursing at Seton Hall University.

Purpose of Research: The purpose of this qualitative research study is to explore and describe the ways in which nursing faculty educate baccalaureate nursing students on how to provide compassionate care to their patients. The expected duration of the study participant's individual interview is approximately 60-90 minutes.

Procedures: Signed consent from the participant will be obtained prior to conducting an individual interview session. Participating nursing faculty will also be asked to complete a demographic questionnaire. During the interview, participants will be asked open-ended questions about their experiences and perspectives on teaching compassionate care in a baccalaureate nursing program.

Typical Interview Questions: Typical questions will include how the participants define compassionate care, their beliefs and expectations concerning the value of teaching compassionate care in nursing education, and any educational approaches, facilitators or barriers to teaching compassionate care in their practice.

Voluntary Nature of Participation: Participation in the qualitative study "Teaching Compassionate Care: Nurse Educators' Perspectives" is completely voluntary. Participation or non-participation will have no effect on the participant's employment experience whatsoever. It will not affect appraisal ratings or treatment by the department Chairperson or Dean. Participants may choose to change their mind and end participation in the individual interview at any time and will not require a reason for ending participation.

Anonymity: The participants are not anonymous to the researcher; however, the data will be collected without any identifying information. A code will be assigned to each participant for transcription purposes and data analysis. Except for the signature on the consent form, names will not appear at any point in the research study. The consent form will be kept in a secure locked site in the researcher's home, separate from the data and will not be able to be linked to the study participant personally.

Confidentiality: No names, addresses or other identifying information will be attached to the information that the study participant provides. All recorded data will be stored only on a USB memory key and kept in a secure, locked site in the researcher's home. The only people to read the typed transcripts will be the researcher and dissertation chairperson. The typed transcripts will be kept by the researcher in a separate locked and secure site in her home. The recorded data will be kept for a minimum of three years after the completion of the study.

Risks: There is no anticipated risk for participating in the study.

Benefits: There is no direct benefit by participating in the study.

Compensation: There is no form of compensation for participating in the study.

Contact information: Participants with questions may contact the primary researcher, Jane DeFazio, MSN, RN at the Ph.D. Nursing Program at the College of Nursing, Seton Hall University, 973-761-9306, or by cell phone at 917-856-9751, or by email at defaziola@aol.com. The researcher's dissertation chairperson is Dr. Bonnie A. Sturm at Seton Hall University, College of Nursing and can be reached by email at [bonnie.sturm@shu.edu].

IRB: Address Phone # The Institutional Review Board at Seton Hall University may be contacted for answers to any questions about the study participant's rights involving human subjects research. The Director of the Seton Hall University IRB is Dr. Mary Ruzicka at 973-313-6314, or by email at [irb@shu.edu]

Audiotapes: The individual interview session will be tape recorded and listened to only by the primary researcher, dissertation chairperson and a professional transcriber if used. The audiotapes will be transcribed by the primary researcher or a professional transcriber if used. The audiotape will not be labeled by name but will be identified by a code number. The tape-recorded interviews will be stored in a locked cabinet in the researcher's home for a minimum of three years after the completion of the study.

Copy of Consent: The study participant will be given a copy of this signed and dated Consent Form.

By signing this consent form the study participant agrees to participate in an individual interview session for the qualitative study "Teaching Compassionate Care: Nurse Educators' Perspectives." It is understood that the individual interview session will be audio taped. It is also understood that no financial remuneration will be received for participating in the study.

Study Participant_____Date_____

Investigator_____Date_____

Appendix C

Consent for Participation in Research (Focus Group Session)

Title of Study: Teaching Compassionate Care: Nurse Educators' Perspectives.

Investigator: Jane V. DeFazio, MSN, RN

Researcher's Affiliation: The researcher is a Ph.D. student in the College of Nursing at Seton Hall University.

Purpose of Research: The purpose of this qualitative research study is to explore and describe the ways in which nursing faculty educate baccalaureate nursing students on how to provide compassionate care to their patients. The expected duration of the study participant's focus group session is approximately 60-90 minutes.

Procedures: Signed consent from the participant will be obtained prior to conducting a focus group session. Participating nursing faculty will also be asked to complete a demographic questionnaire. During the focus group session, participants will be asked open-ended questions about their experiences and perspectives on teaching compassionate care in a baccalaureate nursing program.

Typical Focus Group Questions: Typical questions will include how the participants define compassionate care, their beliefs and expectations concerning the value of teaching compassionate care in nursing education, and any educational approaches, facilitators or barriers to teaching compassionate care in their practice.

Voluntary Nature of Participation: Participation in the qualitative study "Teaching Compassionate Care: Nurse Educators' Perspectives" is completely voluntary. Participation or non-participation will have no effect on the participant's employment experience whatsoever. It will not affect appraisal ratings or treatment by the department Chairperson or Dean. Participants may choose to change their mind and end participation in the focus group session at any time and will not require a reason for ending participation.

Anonymity: The participants are not anonymous to the researcher; however, the data will be collected without any identifying information. A code will be assigned to each participant for transcription purposes and data analysis. Except for the signature on the consent form, names will not appear at any point in the research study. The consent form will be kept in a secure locked site in the researcher's home, separate from the data and will not be able to be linked to the study participant personally.

Confidentiality: No names, addresses or other identifying information will be attached to the information that the study participant provides. All recorded data will be stored only on a USB memory key and kept in a secure, locked site in the researcher's home. The only people to read the typed transcripts will be the researcher and dissertation chairperson. The typed transcripts will be kept by the researcher in a separate locked and secure site in her home. The recorded data will be kept for a minimum of three years after the completion of the study.

Risks: There is no anticipated risk for participating in the study.

Benefits: There is no direct benefit by participating in the study.

Compensation: There is no form of compensation for participating in the study.

Contact information: Participants with questions may contact the primary researcher, Jane DeFazio, MSN, RN at the Ph.D. Nursing Program at the College of Nursing, Seton Hall University, 973-761-9306, or by cell phone at 917-856-9751, or by email at defaziola@aol.com. The researcher's dissertation chairperson is Dr. Bonnie A. Sturm at Seton Hall University, College of Nursing and can be reached by email at [bonnie.sturm@shu.edu].

IRB: Address Phone # The Institutional Review Board at Seton Hall University may be contacted for answers to any questions about the study participant's rights involving human subjects research. The Director of the Seton Hall University IRB is Dr. Mary Ruzicka at 973-313-6314, or by email at [irb@shu.edu]

Audiotapes: The focus group session will be tape recorded and listened to only by the primary researcher, dissertation chairperson and a professional transcriber if used. The audiotapes will be transcribed by the primary researcher or a professional transcriber if used. The audiotape will not be labeled by name but will be identified by a code number. The tape-recorded focus group session will be stored in a locked cabinet in the researcher's home for a minimum of three years after the completion of the study.

Copy of Consent: The study participant will be given a copy of this signed and dated Consent Form.

By signing this consent form the study participant agrees to participate in a focus group session for the qualitative study "Teaching Compassionate Care: Nurse Educators' Perspectives." It is understood that the focus group session will be audio taped. It is also understood that no financial remuneration will be received for participating in the study.

Study Participant_____Date_____

Investigator_____Date_____

Appendix D

Participant Demographic Questionnaire

1. What is your current age? _____

2. Indicate your gender (circle one)

   Male
   Female

3. Indicate your current position (circle one)

   Adjunct faculty
   Part-time faculty
   Full-time faculty
   Other (specify)_____

4. **Circle all** of the degrees that you have obtained in nursing.

   Diploma/Associate's Degree
   Bachelor's in Nursing
   Master's Degree
   Indicate your concentration at the Master's level_____
   DNP
   PhD
   EdD

5. Indicate the type(s) of program that you have experience teaching in (circle all that apply).

   RN diploma program
   Associate's degree program
   A 4-year traditional baccalaureate nursing program
   A second-degree undergraduate baccalaureate nursing program
   RN-BSN program
   A master's-level nursing program
   DNP level
   PhD
   EdD

6. Indicate the number of years of experience that you have taught in the **classroom setting** (circle one)

   2 years or greater-4 years
   More than 4 years-10 years
   More than 10 years-15 years
   More than 15 years-20 years
   Greater than 20 years

7. What is the focus of the didactic content that you teach in the classroom (circle all that apply)?

   N/A
   Fundamentals of Nursing
   Medical-Surgical Nursing
   Maternity
   Pediatrics
   Mental Health Nursing
   Community Health Nursing
   Other (specify)_____

8. Indicate the number of years of experience that you have taught in the **clinical setting** (circle one).

   2 years or greater-4 years
   More than 4 years-10 years
   More than 10 years-15 years
   More than 15 years-20 years
   Greater than 20 years

9. What is the focus of the area that you teach in the clinical setting (circle all that apply)?

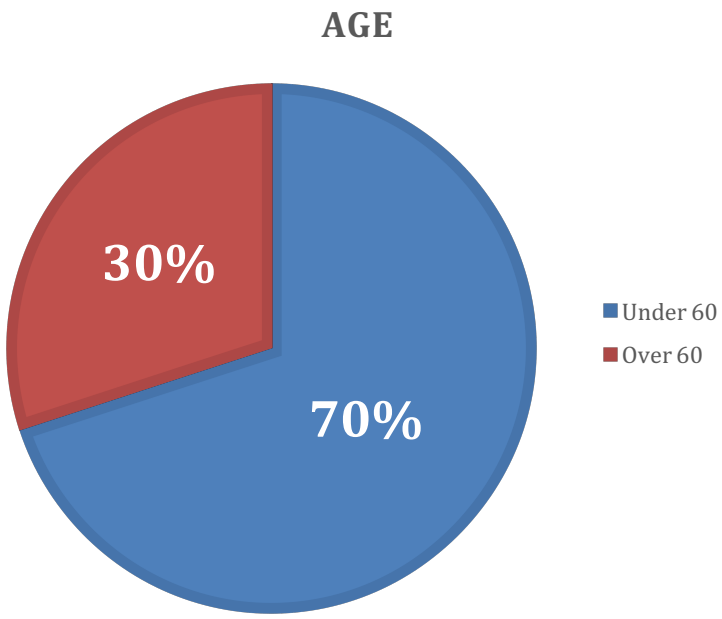
   N/A
   Fundamentals of Nursing
   Medical-Surgical Nursing
   Maternity
   Pediatrics
   Mental Health Nursing
   Community Health Nursing
   Other (specify)_____

Appendix E

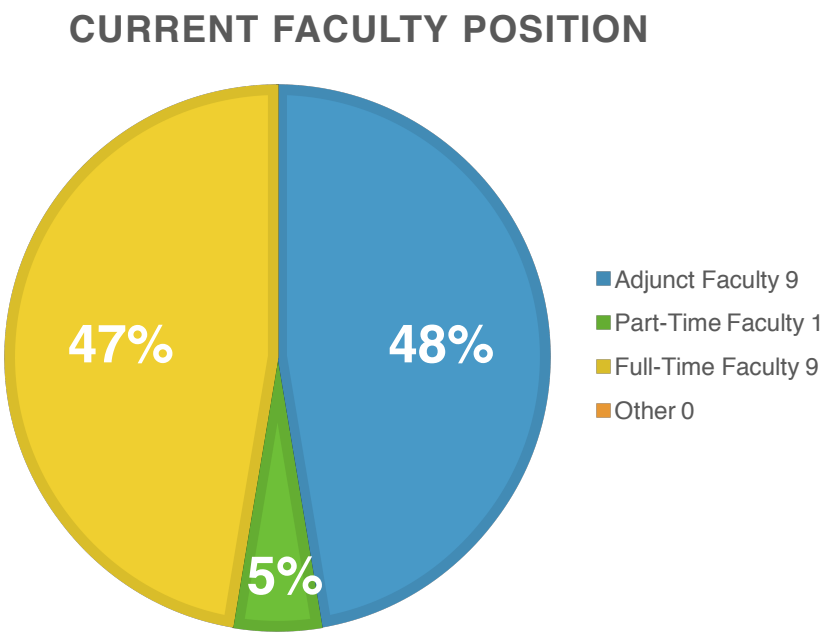
Participant Demographic Questionnaire—Graphs

19 Female Participants

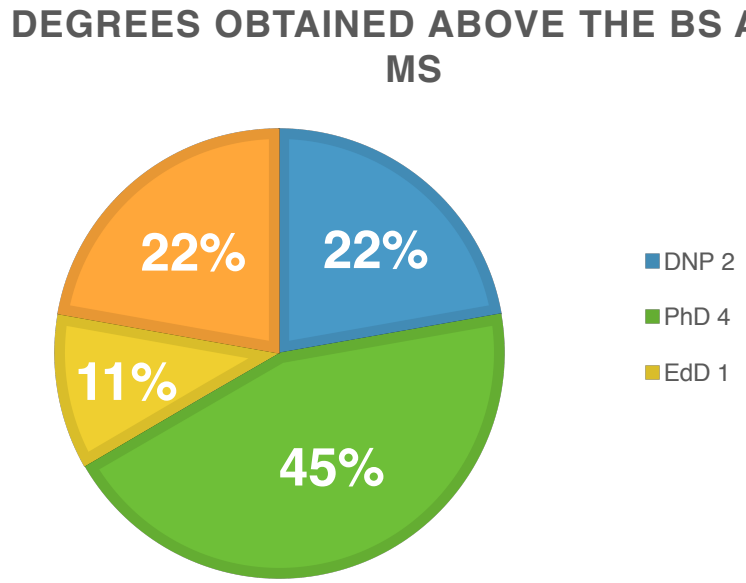
Age (Range 42-74)



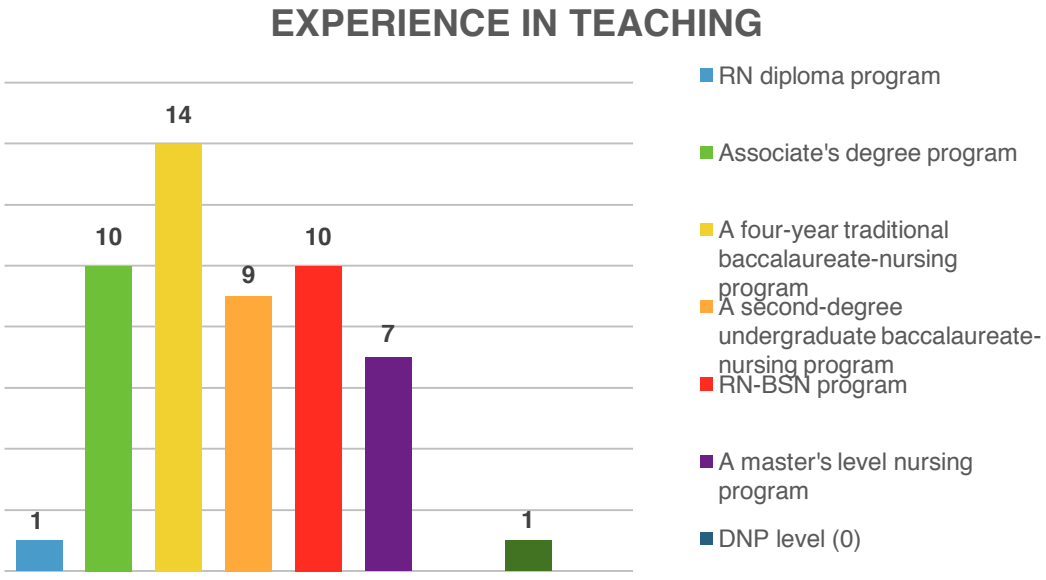
Current Faculty Position



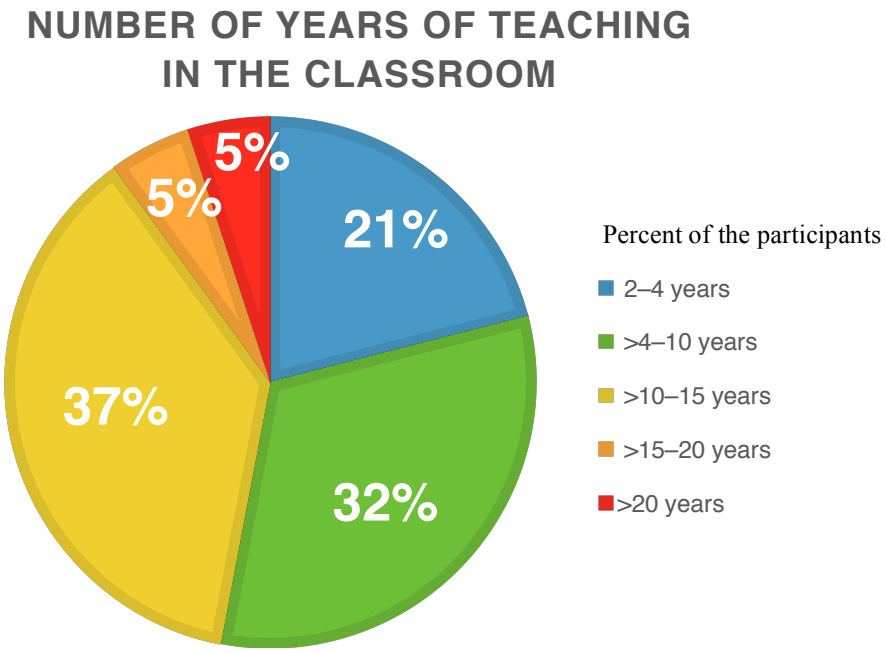
100% (19 participants) received a bachelor's and master's degree plus some had higher degrees.



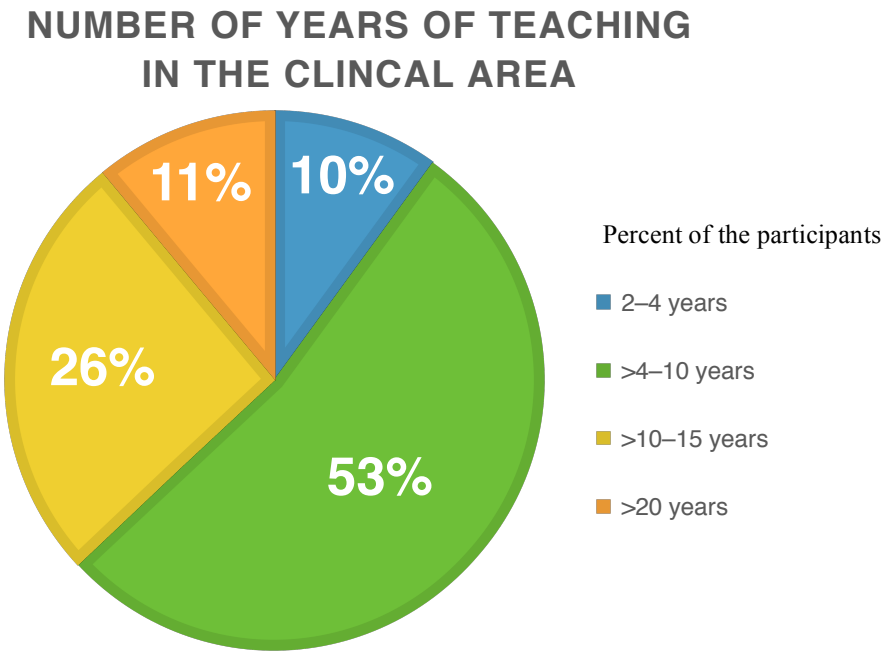
Types of program(s)



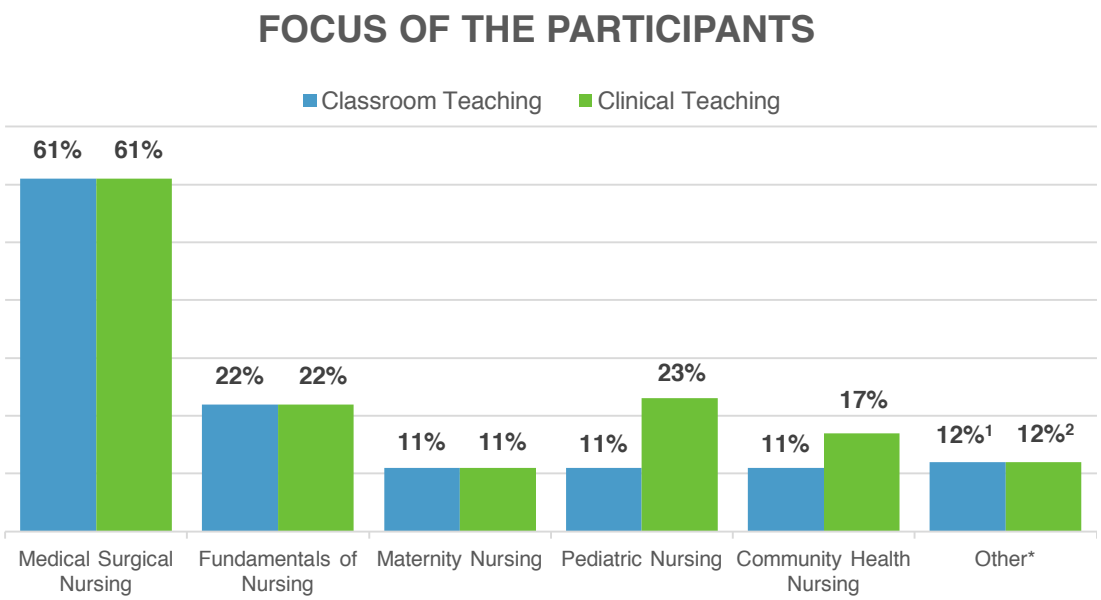
Classroom Teaching Experience



Clinical Teaching Experience



Participants specific focus of teaching in the classroom and clinical setting.



[1] Leadership, End of Life Care (EOL), Epidemiology, Cultural Awareness, & Professional Development of
the Nurse.

[2] Nursing Leadership in the clinical setting.

* Some of the participants taught in more than one area.

Appendix F

Individual Interview Guide

1. What does the term "compassionate care" mean to you?

2. Share a story or experience as a nurse that involved compassionate care?

3. Describe any specific strategies or techniques that can be used in the **clinical/classroom setting**, that you believe develops a nursing student's ability to provide compassionate care.

    a. Do you encounter any specific barriers?

4. How do you evaluate whether a student is able to provide compassionate care?

5. Describe any specific educational experiences that help faculty to evaluate the student's competency in providing compassionate care?

6. What are your beliefs (pro or con), about whether or not nursing curricula should include specific requirements for educating baccalaureate students in how to provide compassionate care?

7. Do you have any additional experiences related to teaching compassionate care that you are able to share?

Appendix G

Focus Group Interview Guide

1. What does the term "compassionate care" mean to you?

2. Describe any specific strategies or techniques that can be used in the **classroom setting**, that you believe cultivate a nursing student's ability to provide compassionate care.

3. Do you encounter any specific barriers?

4. Describe any specific strategies or techniques that can be used in the **clinical setting,** that you believe cultivate a nursing student's ability to provide compassionate care.

5. Do you encounter any specific barriers?

6. How do you evaluate whether a student is able to provide compassionate care?

7. What are your beliefs (pro or con), about whether or not nursing curricula should include specific requirements for educating baccalaureate students in how to provide compassionate care?

8. Describe any specific educational experiences that help faculty to evaluate the student's competency in providing compassionate care?

9. Is there anything more you would like to add to this discussion?

Appendix H

Compassionate Care: Teaching Methods and Strategies

Storytelling

The nurse educator can tell true stories from personal experiences in nursing practice. Students can be invited to share personal stories within the context of compassionate care. Storytelling can be used in combination with unfolding case studies or during simulation and writing assignments. Nurse educators can create writing assignments where the student finishes the story, imagining what could potentially happen after the situation portrayed in the case study or simulation is completed. Debriefing after these exercises ensures the learner has learned key points.

Case Studies

Nurse educators should select case studies about patient problems that have negative stereotypes or dynamics that may require a heightened need for compassionate care. Unfolding case studies can include information that adds detail and learning in the affective domain. Examples include patients with deteriorating chronic conditions that require hospice, palliative care, and ethical considerations.

Group Discussion

Nurse educators can use group discussion to provide an exchange of ideas on a topic that evokes an emotional response and learning about compassionate care. Group discussions are adjusted in every nursing course. Topics such as global poverty, hunger, inequality in healthcare, families inflicted with globally challenged children, substance abuse, mental illness, and chronic illness can foster rich group discussion and develop compassionate practice in nursing students.

Educational Learning Environments

Nurse educators can select learning environments that expose nursing students to vulnerable populations as a way to teach compassionate care. Settings such as homeless shelters, soup kitchens, correctional facilities and opportunities to work with children and families who have special needs.

Reflective Writing/Journaling

Nurse educators can use reflective writing either alone or in combination with other teaching strategies and can be used in different ways. Nurse educators can assign students questions or ask them to write a reflection about a movie, short video, poem, or story. Reflective writing is intended to evoke an emotional response or capture a student's feelings or emotions after an unexpected experience or unusual event. It can be a powerful way of stimulating students to think critically and address learning in the affective domain such as patient values, culture, religious beliefs, ethnicity, and sexual preferences. Often students are not comfortable talking about these topics. Reflective writing is way for students to express their ideas privately without feeling

judged or threatened. Simple assignments such as asking a student how they might feel if they were in someone's else's situation is one way to use reflective writing.

Videos/YouTube

Nurse educators can search the YouTube site to find multiple video clips on nearly any disease or surgical procedure. YouTube videos can be matched to address nursing content that addresses compassionate care. The nurse educator can apply YouTube video to any nursing course. For example; when teaching a medical-surgical course about colostomy care, the nurse educator can show a YouTube video with a teenager demonstrating self-colostomy care. After viewing the video and the steps of the skills, the nurse educator can engage the class in a group discussion about what it feels like to have a colostomy including the psycho social and body image issues experienced when one has a fecal diversion whether they are teenager or an older adult.

Literary Nonfiction Books or Films

Nurse educators can teach compassionate care using nonfiction books and films. Courses that include concepts about dying, and the effects of aging both physically, cognitively, and emotionally, including the many losses that are experienced when aging can be enhanced through powerful reading. Psychiatric disorders can be enhanced through reading nonfiction books and films about child and adolescent disorders, anxiety, suicide, schizophrenia, and chemical dependency.

Some suggested books/themes:
Tuesdays With Morrie by Mitch Albom (Terminal Illness)
Being Mortal by Atul Gwande (Aging and Loss)
The Good Nurse by Charles Graeber (Nursing Ethics)
It's Not About My Bike: My Journey Back to Life by Lance Armstrong (Cancer Diagnosis)
Man's Search for Meaning by Viktor Frankl et al. (Suffering, Hope, and Courage)

Some suggested films/themes:
A Beautiful Mind (2002) (Mental Health Issues)
I Am Sam (2001) (Developmental Disabilities)
Rain Man (1988) (Autism)
The Notebook (2005) (Aging and Alzheimer's Disease)

Poetry

The nurse educator can introduce compassionate care to entry-level nursing students on their first clinical day in a nursing home or acute care setting by having them read a poem during preconference about aging. One example is a poem by an unknown author entitled "An Old Lady's Poem." Nurse educators can select poems that broaden students' views and understanding of their patient's world through poetry.

Role Play

Nurse educators can use role- play and assign students to play a character to achieve objectives of learning in the affective domain. It can be scripted, unscripted, spontaneous, or semi-structured and include observation for evaluation of learning. Role play can be used to develop learning about compassionate care to explore feelings, values, attitudes, and beliefs. Nurse educators create scripts that include situations that students may not have clinical opportunities to experience during nursing school such as the care of a dying patient or a patient asking the nurse questions about a new diagnosis of cancer. Other examples of role-play scripts that require compassionate care include the nurse's role after a mother delivers a stillborn baby or the nurse's role when communicating with a family member after a loved one dies.

Role Modeling

Nurse educators can role-model and influence students' attitudes to achieve behavior change when the focus of teaching is in the affective domain. The can be done through behaviors, skills, or interactions that the student observes. The nurse educator's enthusiasm will influence the students' motivational level and desire to learn and perform in the same way. Nurse educators can role model in the classroom or clinical setting with faculty and other healthcare professionals. Role modeling compassionate care conversations with patients and families, delivering direct care to a patient with a student, and making time to engage in group discussions with students when they observe less optimal patient care conditions are ways nurse educators can role model teaching about compassionate care.

Clinical Pre- and Post-conference Sessions

Nurse educators can use clinical pre- and post-conference sessions for teaching and learning opportunities to develop compassionate care. Guided questions, storytelling, and debriefing about unexpected events are useful strategies to use during pre- and post-conference sessions.

Guided Questions

Nurse educators can teach communication skills by providing students with guided questions. Asking patients specific questions facilitates student-patient communication and will develop the students' ability to have compassionate conversations. During pre-conference, the instructor can focus on the significance of the questions within the context of compassionate care and empathy. During post-conference, the nurse educator can ask the students to share the student-patient interaction. This technique develops students' communication skills and provides an opportunity to address compassionate care in the clinical setting.

Simulation Experiences

Nurse educators can use simulation when teaching compassionate care by using standardized patients or live actors that are trained to portray a patient according to a script when teaching end-of-life care, difficult clinical situations, and vulnerable populations. It is also useful to develop compassion for diverse group of culture, religion, race, and sexual preference. Simulation provides opportunities to teach compassionate communication techniques and caring conversations with diverse groups in a non-threatening non-judgmental environmental setting.

Debriefing

Nurse educators can use this technique after a role-play activity or simulation exercise. Debriefing enhances future decision making and allows students to adjust undesirable nursing performance based on self-assessment, reflection, and faculty feedback.

Care-based Nursing Theory

Nurse educators that teach Fundamentals of Nursing courses or other introductory nursing courses that focus on the importance of the art of nursing and the significance of compassionate care can introduce care-based theory. Nurse educators teaching higher-level courses can teach compassionate care by assigning journal articles that apply caring theory to teaching difficult topics. One example: The nurse educator can engage student learning by incorporating Watson's caring-based theory and self-care within the context of infertility and focuses on the psychosocial aspect of nursing and caring for these couples. Students engage in lecture, rich discussion, and reflective writing about article and topic (Özkan, Okumus, Buldukoğlu, & Watson, 2013).

Teaching Compassionate Care through Self-care

Nurse educators teach compassionate care through self-care education. Self-care can be threaded through all nursing courses by including activities of learning about self-care practices, self-compassion, and compassion fatigue. Nurse educators can model self-care practices and include learning activities that require students to participate in self-care activities. Examples include student health fairs and guest speakers on special topics to enrich students on new topics such as mindfulness.

Appendix I

Institutional Review Board Letters

SETON HALL UNIVERSITY
1 8 5 6

January 11, 2017

Dear Ms. DeFazio,

The Seton Hall University Institutional Review Board has reviewed your Continuing Review application for your research proposal entitled "Teaching Compassionate Care: Nurse Educators' Perspectives".

You are hereby granted another 12-month approval, effective February 22, 2017. Your new stamped Consent Forms are enclosed.

If any changes are desired in this protocol, they must be submitted to the IRB for approval before implementation.

Thank you for your cooperation.

Sincerely,

Mary F. Ruzicka, Ph.D.

Mary F. Ruzicka, Ph.D.
Professor
Director, Institutional Review Board

cc: Dr. Bonnie Sturm

Office of Institutional Review Board
Presidents Hall · 400 South Orange Avenue · South Orange, New Jersey 07079 · Tel: 973.313.6314 · Fax: 973.275.2361 · *www.shu.edu*

SETON HALL UNIVERSITY
1 8 5 6

November 28, 2016

Dear Ms. DeFazio,

Re: "Teaching Compassionate Care: Nurse Educators' Perspectives"

Institutional Review Boards [IRB] are required by Federal regulation to conduct continuing reviews of research already approved. Since initial IRB approval is granted for one calendar year only, continuing review is mandated to take place at least 12 months after this initial approval. It can be sooner in certain situations. The purpose of the continuing review is for the IRB to reassure themselves, investigators, research subjects, and the public that appropriate measures are being taken to protect the rights and welfare of human research subjects.

Federal regulations do not provide for exceptions to this requirement for continuing review. Therefore, failure by the Principal Investigator to ensure timely IRB review is a serious matter that may lead to suspension or termination of the protocol. Reactivation of the study would then require a submission of a new protocol to the IRB.

The Principal Investigator is responsible for timely submission of a Continuing Review application to the IRB. Under IRB guidelines, research needs continuation of approval until all research related activities are completed [including data analysis and write up (and successful oral defense, if applicable)] and the study is closed.

Even if your research has been concluded, please fill out the enclosed form and return it to the IRB Office by **January 16, 2017**. See the enclosed Continuing Review form itself for more directions. If your research has been categorized as full review, please see "NOTE C" of Continuing Review form.

Thank you for your cooperation.

Sincerely,

Mary F. Ruzicka, Ph.D.

Mary F. Ruzicka, Ph.D.
Professor
Director, Institutional Review Board

cc: Dr. Bonnie Sturm

Office of Institutional Review Board
Presidents Hall · 400 South Orange Avenue · South Orange, New Jersey 07079 · Tel: 973.313.6314 · Fax: 973.275.2361 · *www.shu.edu*

THE CITY UNIVERSITY OF NEW YORK
College of Staten Island

2800 Victory Boulevard
Staten Island, NY 10314
T 718.982.3867 • F 718.982.3852
www.csi.cuny.edu

Office for the Protection of Research Subjects

November 10, 2015

Ms. Jane DeFazio
Doctoral Student (PhD Candidate)
Seton Hall University- The College of Nursing
400 South Orange Avenue
South Orange, NJ 07079

Dear Ms. De Fazio:

Thank you for your interest in including individuals in the Nursing Department at CSI in your interviews/survey, "Teaching Compassionate Care: Nurse Educators' Perspectives". As CSI is not "engaged" in this research, no formal IRB review is required.

CUNY is considered engaged in a particular human subjects research project when CUNY employees or agents (1) obtain, for the purposes of the research project, data about the subjects of the research through intervention or interaction with them; (2) identifiable private information about the subjects of the research; or (3) informed consent of human subjects for the research. [Note: Employees or agents refers to individuals who: (1) act on behalf of CUNY; (2) exercise institutional authority or responsibility or (3) perform institutionally designated activities. Employees or agents can include staff, students, contractors, and volunteers, among others, regardless of whether the individual is receiving compensation.]

Good luck with your interesting and important project.

Regards,

S. C. Brown

Susan C. Brown
Human and Animal Research Protections Program Manager
The College of Staten Island/CUNY

WAGNER COLLEGE

October 28, 2015

Dear Colleagues:

Please be advised that Wagner College, including the Human Experimentation Review Board, supports the endeavors and doctoral research of Jane DeFazio at Seton Hall University.

Please feel free to contact me if you have any further questions or concerns.

Best,

Steve Jenkins, Ph.D.

Steve M. Jenkins, Ph.D.
Associate Professor of Psychology
Chair, Human Experimentation Review Board
Wagner College
Staten Island, NY 10301
(718) 420-4490