
Abstract
Nurses’ ability to provide compassionate care has come under increasing scrutiny in the light of reports criticising shortfalls in care. In response to this concern, three possible learning journeys that may encourage compassionate care are discussed. The learning journeys address issues relating to the conceptualisation of care and related learning. This article is aimed at nurses with an interest in nurse education, who teach or mentor in practice and who wish to advocate changes within care relationships in practice. The first learning journey relates to improved understanding of narratives. The second learning journey involves revisiting clinical skills. The third learning journey relates to diversifying the mix of staff engaged in teaching, increasing opportunities for students to examine the nature of compassionate care and emphasising that the care relationship is also a teaching relationship, with patients often required to self-care.

Aims and intended learning outcomes
The aim of this article is to encourage discussion about what enhances compassionate care of patients. After reading this article and completing the time out activities you should be able to:

- Discuss what is involved in understanding patients and lay carers’ experiences of illness and nursing care.
- Re-examine your understanding of your nursing skills and how these might best be updated, particularly in relation to decision making and use of knowledge.
- Explore the merits and challenges of teaching as a vital skill for all nurses.
- Relate reading and local discussions to areas of need and concern identified in the Willis Commission (2012) report and the Department of Health (DH) and NHS Commissioning Board (2012) consultation document on compassionate care.

Introduction
The quality of nursing care has come under increasing scrutiny at a time when pressures on healthcare services have never been greater, resources are relatively limited and nurses have found themselves managing a new mix of healthcare staff (Care Quality Commission 2012). The chief concern has been that nurses have lost sight of basic, compassionate care. In addition, there are concerns that modern nurse education has not equipped nurses to deliver compassionate care. The Willis Commission was set up to provide an independent report in response to the question: ‘what essential features of pre-registration
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nursing education in the UK, and what types of support for newly registered practitioners are needed to create and maintain a workforce of competent, compassionate nurses fit to deliver future health and social care services? (Willis Commission 2012).

The DH and NHS Commissioning Board (2012) consultation document is centred on the 6 Cs of care, compassion, competence, communication, courage and commitment, to deliver high-quality, compassionate care and achieve excellent health and wellbeing outcomes. There is a focus on the resourcing of care, but also on ways of conceiving care, which needs to remain flexible and patient-centred in a period of rapid change within healthcare services. Compassionate care is defined as care that is delivered through relationships and is based on empathy, kindness, trust, respect and dignity (DH and NHS Commissioning Board 2012).

In this article, compassionate care is defined as that which meets the above standards, and which specifically allows a degree of individualisation. Patients’ experiences of illness or injury and personal health circumstances are understood as playing a mediating role in the design and delivery of nursing care. Insights into patients’ perceptions should be an important influence in adjusting standard treatment, enabling the nurse, patients and lay carers to establish trust that meets care requirements and sustains the reputation of nursing.

While the Willis Commission (2012) found that university education did focus appropriately on compassionate care, it was accepted that there would need to be a continuing focus on how best to organise and deliver education so that compassion remained central. In this article, three possible learning journeys are outlined, and readers are invited to debate whether these have a role in securing the objectives of the Willis Commission and furthering the work summarised in the DH and NHS Commissioning Board (2012) consultation document.

The term learning journey is used to denote the change that nurses individually and as a profession may have to undertake to ensure that future care is compassionate. Like all learning journeys, there is a need to take stock of the current position, determine what might be causing confusion or complacency and examine what might change. Moving from the familiar to the unfamiliar may prove uncomfortable and may be contested by others who assess the status of nursing care and education differently.

Readers of this article are invited to consider learning that might help nurses to access the experiences of patients and lay carers more effectively. Practice skills are also examined; while nurses may believe they have mastered these, it is argued that skill analysis can secure improvements in care. Finally, consideration is given to changes that may improve the quality of student learning in the clinical area, particularly in relation to the compassionate care relationship. Compassion, in this instance, may not simply be delivering care, but teaching patients in ways that help to develop their independence. It is not assumed that the patient is a passive consumer of care.

Experience as a basis of compassionate care

To conduct care in a compassionate way, it is vital that nurses use their experience of care giving and patients’ perceptions of care needs (Figure 1) (Needham 2012). Nurses achieve more insightful and sensitive care if they integrate an understanding of patients and lay carers’ experiences into the planning and delivery of care (Thompson 2011, Oldknow et al 2012). Nurses practise more strategically if they reflect on episodes that show how different components of a skill are integrated to convey concern for the patient (Winkelman et al 2012). In addition, nurses improve their teaching, in support of patients and students, where insights into learning and basic tenets of how to teach caring attitudes are included within the curriculum (Cross et al 2006, Stables 2012). Patient support is often based on teaching, and nurses helping patients to resume daily activities assist them in sustaining their independence (Williams 2012).

Learning journey one: working closely with patients and lay carers’ experiences

Nurses report a variety of challenges associated with getting to know patients well and individualising their care (Jangland et al 2011, Duff and Hurtley 2012, Gask and Coventry 2012). There is a perceived shortage of time to talk about patients’ problems and needs. The work environment is not always conducive to intimate conversations and this can make it difficult to arrange holistic care. The length of hospital stay is often short, making it difficult to develop a rapport with patients. The nature of services has also changed, with health care...
arguably viewed in more industrial terms, with the delivery of certain standardised commodities in ways that seem less flexible to healthcare practitioners (Allen 2001, Wells et al 2011).

Nurses wish to help define the services delivered using their insights from patients (Boev 2012). They also search for critical thinking managers who will help them develop an innovative practice environment (Zori et al 2010). However, managers may feel that they have limited scope to vary care provision. There is also less financial freedom to negotiate services. In light of the emphasis on health care as a commodity (something that is delivered or provided), nurses feel uneasy about how to broach conversations relating to patients’ experiences, especially if they are unsure whether the needs expressed can be met. They may fear that there is little scope to negotiate how care needs will be met (Durand et al 2012).

Nurses hope to propose solutions to dilemmas faced. In practice, however, this is sometimes unrealistic and patients and relatives retain some responsibilities relating to coping with illness. Healthcare services are finite and healthcare science is not omnipotent. Care might involve more than solely resolving the problem for patients (Silverman et al 2004). For example, the nurse might work with patients and relatives to help them adapt to change. In chronic illness, for example, the goal is often one of living well (Carrier 2009). Instead of solving a problem, nurses assist with the work that patients need to do to manage an emerging health situation (Sieber et al 2012).

Nonetheless, compassionate care attends to the perceived needs and situations of patients; it draws on their existing knowledge and experience, and includes nurse expertise. To conduct compassionate care, the nurse requires more efficient ways of understanding the experiences, concerns and expectations of patients and relatives or lay carers. Nurses need to ascertain what the patient, relative or lay carer expects of the care service (commodity) and what they are able to contribute. Compassionate communication with patients needs to:

- Demonstrate the nurse’s respect for, and interest in, the patient’s experiences.
- Explore with the patient what he or she means by coping, successful adaptation and a dignified way of living.
- Link the patient’s experiences to others’ experiences. The nurse may suggest to the patient what has worked well for other patients, without naming individuals or breaking confidences.
Gently remind the patient and relative or lay carer about what partnered care entails (shared and negotiated responsibilities).

**Complete time out activity 2**

The DH and NHS Commissioning Board (2012) consultation document recommends that care needs to help patients remain independent, maximise wellbeing and improve outcomes. It must promote a positive high-quality experience for patients, relatives, lay carers, practitioners, managers and healthcare service organisations. Good communication involves active listening, and compassionate care relies on empathy – a clear sense of concern for the situation of patients. It requires courage and commitment to gather insights of patients’ experiences and to represent them where appropriate to others in authority, as well as to recommend what the patient or relative can do for him or herself.

For these expectations to be met, nurses need to learn new ways to listen to and hear patients during care delivery (Hemsley et al 2012). It is argued that nurses need to hear the narratives (personal accounts) that patients and lay carers share and that may or may not fit well with the professional narratives that nurses and others are working with (Price 2011a). Narratives are stories used to explain what is happening, why it is happening and what an individual’s role entails. They are frequently articulated during the course of nursing interventions or procedures (Box 1).

While patients are often listened to with a view to understanding what they are asking for, they might not be listened to with regard to what they feel or are doing to make sense of their circumstances. Over a number of days, the patient’s narrative will develop, offering insights into his or her psychological state. A pattern of anxiety, hope, a search for a rational explanation of problems, increasing confidence or despair might emerge that the nurse should respond to. Discourses may then result between the nurse and patient, from which will emerge more habitual ways of conceiving what is happening (Schofield et al 2012). For example, the patient may develop expectations of the nurse and the nurse may develop expectations of the patient as part of negotiated care. If the discourse is not examined and the perceived basis of care revisited, both the patient and nurse may be dissatisfied with the role of the other.

Compassionate care involves recognising these narrative patterns, which signify difficulty, preferred ways of adapting and a successful or less successful coping strategy. Such pattern recognition is only possible when nurses communicate their observations to colleagues, sharing summaries of these at shift handover or in case report meetings.

**Complete time out activity 3**

Box 1 offers a short and simple illustration of a narrative in action; however, much narrative analysis can be complex. Patients are still making sense of their situation as care proceeds and their feelings about, and explanations of, their illness and care may change significantly with time (Pakenham 2008). It can sometimes take several days for a pattern to emerge and for nurses to determine what might seem most supportive. Patient narratives can be ambiguous, and sometimes these differ from lay carer narratives. Patients and relatives or lay carers may understand events quite differently.

It is important that narrative and discourse analysis should form a recurring theme in nurse education, helping to develop confidence in reading and working with patients and lay carers’ experiences. Analysing patient narratives that occur in practice, and those that are shared in role play or problem-based learning sessions, helps to develop confidence in identifying patients’ concerns. Where narratives are missed, where nurses and others have not understood the difference between what patients are experiencing and what healthcare staff think they are

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**TIME OUT**

2 Consider with colleagues how you have thought about conversations with patients. Has conversation been conceived largely in commodity terms (what you will provide) or as something that is much more collaborative (negotiated care)? Cite examples of these conversations. Are you using one type of conversation more than others? What are the implications of these types of conversation for compassionate care?

3 Study Box 1 to determine what you think Ruby’s narrative is about. What does this tell you about her chief concerns? Decide what sort of communication the nurse is using and if her narrative relates well to what Ruby is talking about. Determine whether you habitually hear the narratives that patients share during care episodes. If you do not, what is preventing this?

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**BOX 1**

**Ruby’s narrative**

A fungating wound on Ruby’s left breast is being cleaned and dressed. As the nurse conducts the dressing, Ruby muses aloud and the nurse responds.

Ruby: ‘You can come to hate your own breast you know – the smell of it when it has gone bad like this one has.’

Nurse: ‘We’ll clean the wound and put a nice clean dressing on and that should limit the unpleasant smell.’

Ruby: ‘Wounds are ugly, aren’t they… you can’t bear to look at some of them.’

Nurse: ‘Yes, some are difficult… I’ve dressed some difficult wounds, Ruby.’

Ruby: ‘I was wondering what Gordon [her husband] thinks of all this… it is difficult to talk about it sometimes.’

Nurse: ‘There, a clean dressing on top, we can dress you again now and that should help you feel presentable before visiting time.’
doing, there is a risk that care will seem insensitive and impersonal.

**Complete time out activity 4**

**Learning journey two: re-examining how skilful nurses are**

The DH and NHS Commissioning Board (2012) consultation document makes it clear that skills are central to competent practice and these skills are often represented through communication, for example listening, counselling, teaching and reassuring. However, there are several issues that might undermine practice skills in the pursuit of compassionate care. These include:

- Belief that skills are harnessed at the point of professional registration and need not be revisited in future practice or via educational courses.
- Misunderstandings about the contextual nature of skills – skills need to be exercised differently in different contexts.
- Confusion between skills, techniques and protocols.
- Difficulties discussing clinical skills as part of annual appraisals.

Clinical nursing skills are complex and combine work in several domains. The nurse should be dextrous (for example, be able to conduct catheterisation), have interpersonal skills (for example, be able to reassure the patient) and be professionally aware (work within appropriate ethical and protocol limits). Clinical nursing skills will be practised differently depending on the patient and the clinical situation, for example a child, a confused patient or an emergency procedure.

**Complete time out activity 5**

Price (2011b, 2012a, 2012b) argued that practice skills comprise several components that the nurse co-ordinates during the delivery of care. It is the arrangement of these components that distinguishes skill from technique. Skills comprise:

- The declarative component – outlines that which the nurse must be able to assert to proceed with confidence. In most practice circumstances, the declarative component relies on an understanding of patients and others’ expectations of the skill in use, and an appreciation of the nurses’ expectations of the skill, in a professional and ethical manner. To proceed with confidence, the nurse needs to know what patients and relatives think.

- The process component – determines how the skill is enacted; the sequencing of work, the dexterity of work, the ways in which psycho-motor and interpersonal care is combined, for example preparing the patient for a procedure, conducting the procedure and then checking that the patient is comfortable afterwards.

- The knowledge component – emphasises knowledge deemed relevant to care needs.

- The decision-making component – determines when, how and why to proceed in a given way, accepting that sometimes it is inappropriate to act.

Accepting the complexity of clinical skills is a first step to mandating their further analysis and development as part of care that will seem more compassionate to patients and relatives. Nurses who combine skill components in care delivery appear sensitive, patient-centred, empathetic and considerate. Instead of perceiving skills training as solely a way to learn certain skills, it is important to understand it as a process of exploration and critical examination of how the skill is deployed in different contexts. No skill is ever and perfected; instead each is refined, improved, augmented and adjusted in response to the circumstances and needs of health care.

In undergraduate education, the combining of skill components occurs when students examine episodes of care, practise during clinical placements or perform activities within the skills laboratory.

**Complete time out activity 6**

**Learning journey three: enhancing teaching in the clinical area**

The Willis Commission (2012) and the DH and NHS Commissioning Board (2012) consultation document make it clear that skill mix and staffing are central issues to be addressed if compassionate care is to be assured. This article does not address staffing, but attention focuses on the effects that staffing challenges may have on education. It is argued that teaching is important in developing compassionate care, for example helping patients become more independent through teaching (Falvo 2010), and enriching the learning experience of students who will join the caring professions (Gaberson and Oermann 2010). When patients are passive recipients of care and are not involved in improving their independence, criticisms of nursing care may prevail.

**Debate with colleagues the argument that a greater appreciation of narratives and understanding of the process of narrative analysis is important in making nursing care more compassionate. How much do you know about narratives and their analysis? If this is important as part of nurse education, how does it feature in the syllabus locally?**

**Describe examples of clinical skills in use. What distinguishes a skill from a technique? If a nurse simply used a technique, what might be missing from the care delivered?**

**If it is accepted that clinical skills involve the combination of components, and that skills in use need to be regularly revisited, what are the implications of this? What might mentors discuss with students? What might constitute practice improvement for nurses?**
Where formal teaching time in the clinical area is limited, opportunities need to be seized by the widest range of staff to contribute to teaching efforts overall for patients and students (Figure 2). Therefore, it may be necessary for a wider group of clinicians to become involved in teaching as part of a co-ordinated learning environment. In addition, the engagement of more staff in teaching allows a more balanced assessment of student performance (Price 2012c).

Often, individual mentors have felt it incumbent on them to conduct most of the teaching of learners in clinical areas. This can be problematic since students work with a variety of staff and on different shifts. Therefore, it seems wise to involve a number of different staff in the teaching of students. It is argued that teaching should be a standard skill among all nurses, and that it can be deployed with patients and students.

The principle that patients learn while in hospital is established in several areas, for example in asthma care (McCarty and Rogers 2012) and anti-coagulation therapy (Wilhelm and Petrovich 2011). This involves a change in healthcare practice norms; teaching should be considered essential to ensure successful and compassionate care as well as cost-effective services. If patients and families are to be assisted to become active partners in care, then adequate teaching is a prerequisite to success.

It is vital in modern health care that the nurse is clear when he or she is teaching the patient. If the patient only sees care in terms of help or support provided, and not in terms of learning, a vital message is missed and communication might be misconstrued. Some of the most successful practice-based teaching is strongly influenced by nurse experience (Falvo 2010), where the nurse draws on what other patients have noticed and what other students have discovered. Using experience in this way lends authority and authenticity to teaching.

Just how much education on teaching exists in the final stages of pre-registration nursing education is open to discussion and likely to vary from course to course. However, it is suggested that basic teaching skills include:

- Articulating the rationale for care activity, so that patients can understand why nurses proceed as they do, often in association with demonstrations of care activity.
- Representing conversations in teaching terms, making it clear that patients and others are invited to learn.
- Enquiring about what students are thinking as they deliver observed components of care-giving in order to judge reasoned care.
- Examining attitudes, values and agendas as care decisions and strategies are evaluated within the clinical setting.
- Contributing to judgements on the extent to which stated learning outcomes have been achieved by the student.

Complete time out activities 7 and 8.

**Conclusion**

Compassionate care relies on understanding patients’ narratives – the ways in which patients make sense of their circumstances and needs. Nurses need to learn how to identify patient narratives during care delivery and to be clear about their own narratives in relation to what they are trying to do. Care will seem more compassionate when nurses attend to what patients are feeling.

To work with narratives, it is necessary to revisit clinical practice skills and check whether these are as up to date and focused as nurses might imagine. Skills need to be reassessed regularly in terms of whether they fit well with care contexts. Identifying and
responding to patient narratives requires considerable interpersonal skills.

Compassionate care also relies on increasing the number of nurses who engage in teaching patients and students. Teaching has a central role in collaborative care. In addition to receiving care, patients learn from nurses how to care for themselves. If this does not occur, patients may continue to act as passive recipients of care and forget that in many instances, care is a collaborative venture. They may criticise the nurse for something not delivered, when in reality, a learning opportunity was missed. Clear conceptualisation and communication of the care activity is essential to ensure compassionate care. It involves helping patients and relatives to discover what they can do, as well as providing a considerate service.

As with most learning journeys, change entails effort and a re-consideration of what is done today. These journeys are only possible if other staffing and resourcing issues are addressed. Focusing more on patient narratives, clinical practice skills and perceiving teaching in a new way can make care more compassionate.