Constrained compassion: An ethnography of compassion in the acute hospital setting

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What do we mean by compassion?

Complex, multifactorial phenomenon

Historical roots in a range of cultures, religions and disciplines

Research and debate complicated by lack of shared understanding - ongoing search for clarity/clinical applicability

A response to suffering, which includes both an engagement with suffering and a motivation to relieve it

(Gilbert, 2017, Germer and Barnhofer, 2017)

Increasing international significance - global 'compassion movement'

Healthcare professionals at the forefront of this

Nursing: compassion as 'essence' of nursing

UK nursing – a distinct discourse?

Image: adapted from an infographic by Robert Shelton

Study background

UK discourse result of:

- Long standing debate on nurse education & impact on compassion
- Series of care scandals in care homes & hospitals

Poor care largely the result of a lack of compassion

Much compassion research and scholarly discussion

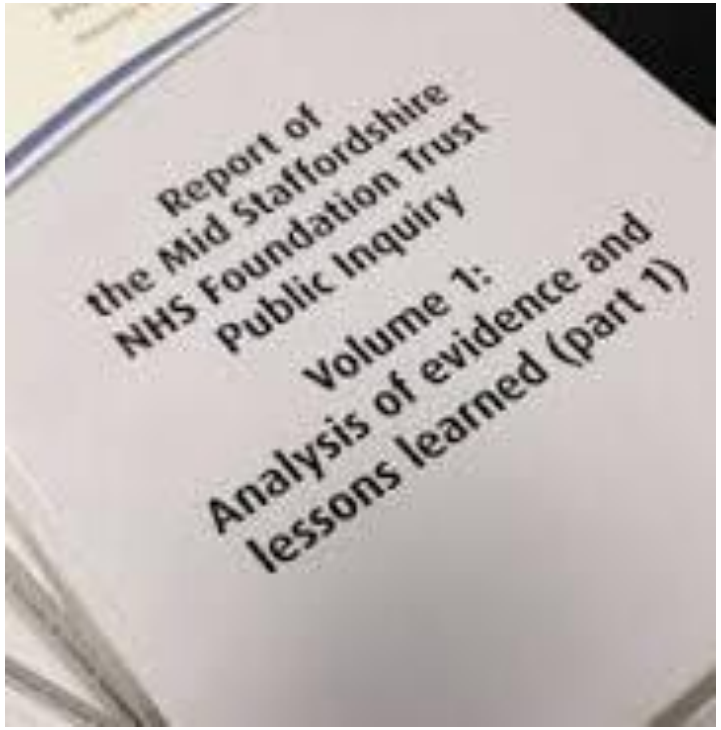
Predominant focus on individual values, little scrutiny of context

Current approach: values-based

Too simplistic? Too narrow?

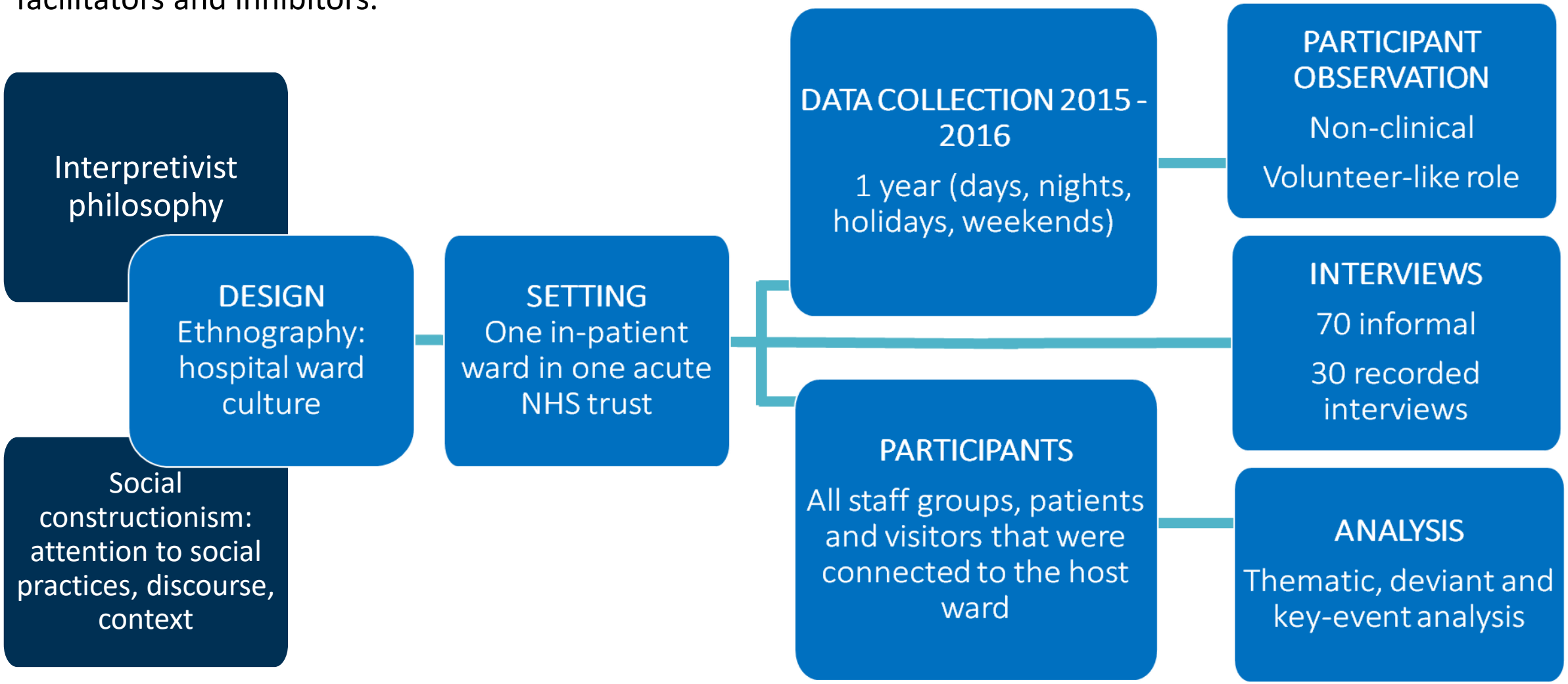
Shapes the response to poor care

- individualised, blaming, punitive



Study design and methods

Aim: To explore compassion in the context of a hospital setting, focusing on how it is demonstrated, its facilitators and inhibitors.



Findings overview

Compassion did not always look like the stock image – not always at bedside

Compassionate care was evident alongside poor care

The same staff who gave exemplary care are the same ones who gave poor care

Staff did not always recognise when they had given excellent care, often minimised

Context was key

Some conditions appeared to enable:

EOLC, dementia care, emergency care

Some conditions appeared to inhibit:

Discharges, patient flow

Enabling conditions: autonomy, clarity, support

When nurses had more autonomy to direct care

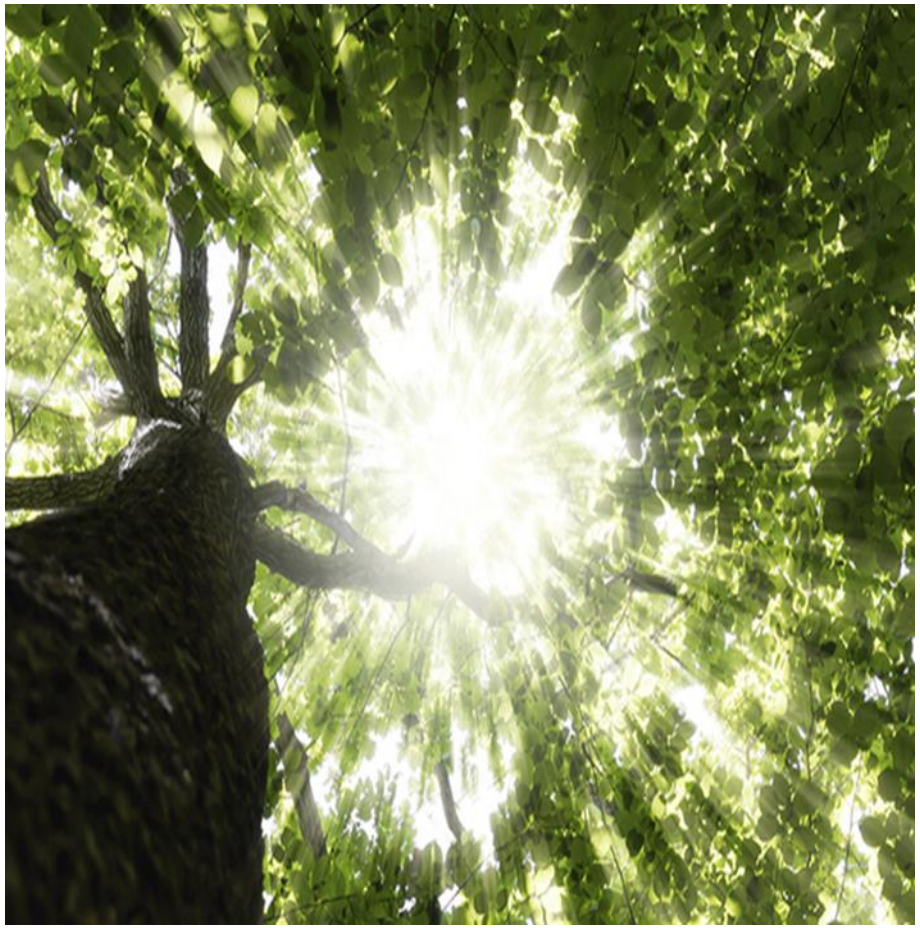
When care goals were clear and shared within the MDT

When staff felt the organisation explicitly prioritised compassionate care (eg over patient flow)

When practical support was provided (extra staff, expert staff, reduction of other workloads)

Most commonly seen in:

- End-of-life care
- Dementia care
- Emergency care



Enabling compassion to flourish

This HCA came up, and, immediately, she just knew what to do, she just soothed me right away. Oh, I was just so upset, I broke down, I just poured it all out to her. And she shared all this personal stuff even though I didn't know her. I told her, 'It's people like you that make this bearable.' She said, 'That's what we're here for', and I thought, good god, what a job (Patient Fiona, interview)

Everyone knows end-of-life care is top of the list for compassion, and it's OK for us to just give that. No one tells you off for sitting with a patient if they are end-of-life (Senior nurse Lucy, interview)

It's only when its an emergency that you're allowed to miss the other stuff. People can see then, and they help you so you can focus on the care (Junior nurse Alice, interview)

The nurses spent so long with that lady and afterwards she looked so refreshed, they pulled the curtains back and she had this huge smile! … I told them, bless you for that, darlings, what a fantastic thing you've done there! We have to remember to say thank you, no matter how small it seems, its still a gift from them to us (Patient Esther, interview)

Inhibiting conditions: sense of threat

Operational pressures *“relentless forward motion”*

Multiple and/or contradictory priorities –how to achieve?

‘Pressure points’ –times of overwhelming demand, staff aware of poor care but felt unable to improve

When staff were focused on defensive practices - *“Something bad is going to happen”*

Most commonly seen in:

- Discharge scenarios
- Patient flow felt to be the only priority

Inhibiting compassionate care

They come in, they go out, they've not got time to get to know you (Patient Sue, interview)

Inside, I just wanted to scream and shout. I'm not abrupt with [patients], but I'm, you know, if they start asking me questions while I'm doing the medication round, I'm like, 'Oh god, please don't ask me anything.' (Junior nurse Ellen, recorded interview)

That's why you get those nurses that just crack or burst into tears … or they're going to lose their temper. They're going to shut themselves somewhere where nobody can see them because they're absolutely at their wits' end. (Senior nurse Lucy, recorded interview)

We get told, 'Yeah, be compassionate, keep the flow going, make sure everything is clean, ooh, now you're on red alert, purple alert!' … We can't win! (Senior specialist nurse, informal interview)

You're not in control of the patient's care; however, you're accountable, and that's a very dangerous situation to be in. I've got no control! … However, the first person that the coroner will collar is me. (Consultant, interview)

We're just constantly pushed, like with emails and even screensavers saying … 'We are in the code red' or whatever it is, just totally over capacity … It's just constant, unceasing, all the time, and you can't fight against it. (Junior doctor Rob, interview)

When things go wrong they are often as a result of multiple failures … but … somebody always has to be made a scapegoat! And as a result of that, that is why there are so many [senior nursing] vacancies around the country … Someone is held accountable, and usually the response to that is too punitive (Corporate staff member, recorded interview)

Implications

Compassionate care in acute settings, like poor care, is the result of complex set of factors

Many are contextual & outside the control of front line staff

All these factors need to thoroughly examined and incorporated for effective strategies to be developed

(Compassionate) care is relational - staff and patient experience are entwined and both are critical

Focus on developing compassionate organisations/environments rather than people?

Supporting organisations to understand and build on what they do well, as well as the inhibiting conditions (local strategies)

Understanding more about the role of threat and how it can be decreased

- Safe spaces/time to discuss and offload
- Encouraging recognition of/reflection on emotional labour of care
- Locating pressure points and addressing

Further information

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PLANNED PUBLICATION SUBMISSION FOR MAIN FINDINGS, END OF 2019