EXPERIENCES OF NURSING STUDENTS AT KAMUZU COLLEGE OF NURSING IN THE PROVISION OF COMPASSIONATE CARE, LILONGWE, MALAWI

MSc. (NURSING AND MIDWIFERY EDUCATION) THESIS

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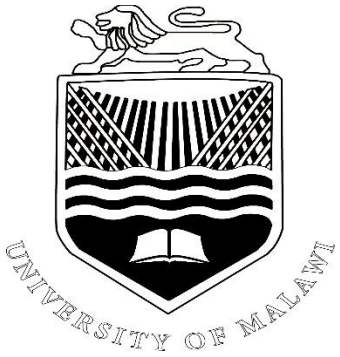
KAMUZU COLLEGE OF NURSING

JANUARY 2017



Kamuzu College of Nursing

Experiences of Nursing Students at Kamuzu College of Nursing in the Provision of Compassionate Care, Lilongwe, Malawi

MSc. (Nursing and Midwifery Education) Thesis

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Submitted to the Faculty of Nursing in Partial Fulfillment of the Requirements for the Degree of Master of Science (Nursing and Midwifery Education)

JANUARY 2017

Declaration

I, the undersigned, declare that this thesis titled “Experiences of Nursing Students at Kamuzu College of Nursing in the Provision of Compassionate Care, Lilongwe, Malawi” is entirely my own original work. This thesis has not been presented for any award at any University within or outside Africa. Where other peoples work has been used, acknowledgements have been made.

SQUAIKER ALICE BWANALI

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Signature

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Date

Certificate of Approval

We, the undersigned, certify that this thesis represents the student's own work and effort and has been submitted with our approval.

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Gladys Msiska, PhD (Senior Lecturer)

Main Supervisor

Signature_____ Date _____

Anthony Sefasi, MSc (Senior Lecturer)

Second Supervisor

Dedication

I dedicate this work to my dear parents Mr. and Mrs. J.T. Bwanali for their prayers and encouragement throughout the study period.

Acknowledgements

I would like to thank God for keeping me safe and in good health, for the blessings and intelligence throughout my study period which are not taken for granted.

I further extend my gratitude to Kamuzu College of nursing for providing me with ICAP/NEPI scholarship which enabled me to purse my studies. This gesture will go a long way in assisting me nurture future nurses to provide high quality compassionate care.

Lastly, my sincere thanks should go to the following people who have offered various forms of support during the period of writing my thesis:

- Dr. G. Msiska, my research supervisor for her time, inspiration, consistent encouragements, constructive criticism and expertise throughout the research process.
- Mr. A. Sefasi, my second supervisor for his constructive criticism and encouragement throughout the research process.
- Professor A. Malata, Principal for Kamuzu College of Nursing for granting me permission to conduct my research at the college.
- All informants who participated in this study.
- My husband Kapena, Children; Tadala and Aliko-Lingalathu remain my source of joy. You vastly contributed with your psychological support during the entire period of study.

Abstract

Over the recent years, there has been a general public concern that compassionate care is lacking in nursing, leading to poor health care outcomes. In response to the plethora of reported negative patient experiences relating to lack of compassionate care, professional drivers in nursing have been requested to re-endorse the concept of compassion as a core and underpinning philosophy, fundamental to the profession. Literature has shown that student nurses do provide compassionate care. However, this is not reflected in their practice when they qualify. The purpose of this study was to investigate the experiences of nursing students in providing compassionate care at KCN, Malawi. A qualitative narrative study was conducted among 3rd and 4th year undergraduate students at KCN, a constituent college of the University of Malawi. Purposive sampling method was used to recruit twelve participants for the study. Using a semi-structured interview guide, individual in-depth interviews were conducted to collect data while analysis was done using thematic analysis. Clearance from COMREC and consent from participants were obtained prior to data collection.

Findings revealed that there is lack of compassionate care in Malawian nursing practice, however, students are knowledgeable of the concept of compassionate care before graduating. Additionally, it was revealed that both theory and practice play a role in cultivating a culture of compassionate care. Furthermore, the study revealed that stories of lecturers caring experiences and working with positive role models in clinical practice facilitates development of compassionate care while lack of support systems in practice and harsh experiences during training hinders development and provision of compassionate care. This calls for professional drivers in nursing like nurse educators and managers to emphasize the need for compassion in nursing training and practice. Recommendations are made for nurse educators, curriculum planners, clinical staff and the regulatory body on their role in

promoting compassionate care. More studies need to be conducted on what compassionate care entails within Malawian culture and how it can be nurtured and measured in nursing education.

Keywords: compassion, cultivating compassion, nursing students, nursing education, barriers and enablers to compassionate care.

Table of Contents

List of Tables

List of Abbreviations and Acronyms

COMREC:	College of Medicine Research Ethics Committee
KCN:	Kamuzu College of Nursing
MCHS:	Malawi College of Health Sciences
NEPI:	Nursing Education Partnership Initiative
NMCM:	Nurses and Midwives Council of Malawi
TCA:	Thematic Content Analysis
5C's:	Confidence, Competence, Commitment, Conscience and Compassion.

CHAPTER 1

Introduction and Background

Introduction

Globally, there is growing concern within public and health care professional domains that the ability of health care practitioners including nurses to care compassionately is either; lost, eroded or compromised (Baillie & Black, 2015; Maben & Griffiths, 2008; Schantz, 2007). Similarly, over the recent years, there has been a general public concern in Malawi that compassionate care is lacking in nursing leading to poor health care outcomes (Bray et al., 2014; Kavinya, 2008; Msiska, Smith, & Fawcett, 2014; Simwaka, de Kok2, & Chilemba, 2014). Compassion is the 'emotion' that we feel in reaction to the suffering or misfortunes of others that motivates a desire to help (*Oxford Dictionary of English*, 2009)

Although, literature has shown that student nurses do provide compassionate care (Bray et al., 2014; Msiska, Smith, Fawcett, & Nyasulu, 2014), this is not reflected in their practice when they graduate. Additionally, literature has shown that the theoretical and clinical experiences which students undergo play a big role in developing compassionate practitioners (Bradshaw, 2014; Christiansen & Jensen, 2008; The Willis Commission Report, 2012; van der Cingel, 2014). Arguably, Adamson and Dewar (2011) stipulate that nurse educators are faced with challenges as they plan, develop and deliver a curriculum that seeks to equip nurses and midwives with the skills and knowledge required to deliver compassionate care.

Due to the plethora of reported negative patient experiences relating to lack of compassionate care, professional drivers have been requested to re-endorse the concept of

compassion in nursing as a core and underpinning philosophy, fundamental to the profession (Department of Health, 2010; Straughair, 2012; The Royal College of Nursing, 2010). However, there are debates as to whether compassion can be taught in nursing or not (Bramley & Matiti 2014). Chambers and Ryder (2009) suggest that developing patient-centered care skills in nursing students can consequently promote compassion in provision of care. Additionally, Curtis, Horton, and Smith (2012) assert that in order for student nurses to practice compassionately, they require professional socialization within environments where compassion can flourish.

On the other hand, many scholars have written on how nurse educators can enhance development of compassion in nursing students (Adamson & Dewar, 2011; Christiansen & Jensen, 2008; Rankin, 2013). However, there is scarcity of evidence based information on the experiences of students in learning and providing compassionate care. In order to facilitate development and implementation of compassionate care, it is imperative that nurse educators understand how compassion can be nurtured in nursing students for better nursing care (Msiska et al., 2014; Straughair, 2012). This research focused on students' experiences in providing compassionate care.

Background

Globally, there is growing concern within public and health care professional domains that the ability of health care practitioners including nurses to care compassionately is either; lost, eroded or compromised (Baillie & Black, 2015; Maben & Griffiths, 2008; Schantz, 2007). Compassionate practice is a public expectation and a core health professional value (Bray et al., 2014). Global anecdotal reports indicate that compassion is lacking in contemporary nursing care resulting to poor healthcare outcomes (Simwaka et al., 2014; The

Mid Staffordshire NHS Trust Foundation Inquiry, 2010a; The Parliamentary and Health Service Ombudsman, 2010; The Royal College of Nursing, 2010). Additionally, Chambers and Ryder (2009) stipulates that 'compassion' once seen as the essence of caring and therefore the essence of nursing is no longer always the central focus of current nursing practice. This has emphasized the need for the profession to re-endorse the concept of compassion (Department of Health, 2010; The Royal College of Nursing, 2010). Reacting to this call and in her Vision and Strategy on 'compassion in practice, Cummings (2012) included training of all care providers reflecting the six C's of caring as priority activities to assist bringing back compassionate care. The C's comprise of Competence, Commitment, Compassion, Conscience, Courage and Confidence. Furthermore, the author suggests that the 6 C's are relevant to all care providers and should be embedded throughout career pathways, including recruitment, education and training, organizational culture and appraisal and development of staff in order to improve health care outcomes.

The General Medical Council and the Nurses and Midwives Council in the United Kingdom (2012) jointly emphasize the need for health professionals to demonstrate compassion and kindness, as well as knowledge and skill in the profession. Indeed, the Nurses and Midwives Council of the United Kingdom (2010) identifies "safe, compassionate, person centered, evidence-based nursing that respects and maintain dignity and human rights'' as an essential skill and professional value that students must acquire before graduating. This concurs with the Nurses and Midwives Council of Malawi Pledge of Service (2008) which states that the nurse shall compassionately maintain dignity, respect and human rights in providing care.

In Malawi, there is evidence on lack of compassionate care through published study findings and media reports. There are increased cases of malpractice and negligence in

nursing practice. Some nurses mistreat patients communicatively by shouting at them without a valid reason. Nyasatimes Reporter (2011) reported that health care providers at Mwaiwathu Private Hospital were accused of negligence and lack of compassion by parents who lost their son due to sickle cell anemia. The parents felt that their son died a painful death despite seeking medical attention in time, and that the child could be saved if staff members compassionately cared for him. Similarly, the Nurses and Midwives Council of Malawi (NMCM) has withdrawn licenses from some practicing nurses on allegations like total negligence and malpractice (Pondani, 2013). Additionally, cases on nurses stealing drugs and hospital equipment are on the rise. A nurse in Karonga was caught selling stolen drugs (Nyasatimes Reporter, 2014). Recently, nurses at Zomba Central Hospital were shunning work for not receiving their allowances leaving patients suffering and dying unattended to (Mathews, 2014). Furthermore, another nurse was arrested at Nkhotakota District for attempted rape on a patient who went to collect drugs (Malenga, 2016). Such acts by nurses greatly compromises patient care and demonstrates lack of compassion. Compassion as portrayed in the definition, enables the nurse to be unselfish and feel for the suffering of others.

In their study on 'women's perceptions of nurses-midwives caring behaviors during perinatal loss', Simwaka et al. (2014) found that there was lack of compassion in nursing care rendered to mothers who had experienced perinatal loss and this emerged as one of the psychological aspects of care that mothers expressed concern on. This indicates total lack of compassion as negligence and malpractice cannot be done by nurses who are deep rooted in providing compassionate care. Compassion calls for the nurse to have self-awareness and feeling for others.

Whether or not compassionate care can be taught is often debated. However, in the context of concerns about poor health care outcomes, lack of compassion is emerging a potential factor leading to poor nursing care provision hence need to enhance its development in both qualified and student nurses (Adamson & Dewar, 2011). The most important question that scholars have asked is 'can compassionate care be taught?' Many scholars have written on how nurse educators can enhance development of compassion in nursing students. Van der Cingel (2014) suggested compassion is an intelligent judgement that can be gauged and perhaps, taught. This builds on the work of Eason (2009) and Heffernan et al. (2010) who identified the need for emotional intelligence and self-compassion. However, there is paucity of studies conducted in Malawi to explore the experiences of nursing students in developing and providing compassionate care.

In their study on 'emotional learning within the framework of nursing education' Christiansen and Jensen (2008) found that role-play is a suitable teaching strategy for enhancing communication that expresses a professional, compassionate concern. This implies the teaching methods which nurse educators employ in teaching nursing students play a role in developing compassionate care providers. Furthermore, Middleton (2010) suggests being an excellent role model for nursing students can assist them know how to act with patients and what kind of approaches to care they should take to provide compassionate care.

Arguably, Adamson and Dewar (2011) stipulate that nurse educators are faced with challenges as they plan, develop and deliver a curriculum that seeks to equip nurses and midwives with the knowledge and skills required to render compassionate care. Davison and Williams (2009) suggested it is not possible to be compassionate without self-compassion and that, ultimately, self-dissatisfaction may affect care provision.

von Dietze and Orb (2000) have described compassion as a moral dimension of nursing and a central characteristic that nurses are expected to show. Straughair (2012a) states that the origin of compassion in nursing is firmly rooted in religious ideologies. Florence Nightingale who is the founder of nursing profession was a Christian and translated her ideals into the characterization of the professional nurse. The nurse was regarded as a ministering angel, performing the work of God. This is evident in Nightingale's notes on nursing: it is said that;

> the nurse must be a religious and devoted person; he/she must have respect for own calling, because God's precious gift of life is often literally placed in his/her hands… she should bring the best she has, whatever she has, to the work of God's world (Nightingale, 1859: p.49 &53 cited by Straughair, 2012).

Although compassion is a public expectation from all health care providers, this study focuses on nursing education.

Problem Statement

Although compassionate practice is a public expectation from healthcare providers, there is a general public concern in Malawi that compassionate care is lacking in current healthcare systems (including nursing) leading to poor health care outcomes (Bray et al., 2014; Kavinya, 2008; G. Msiska et al., 2014a; Simwaka et al., 2014). Literature has shown that the theoretical and clinical nursing education experience that undergraduate students undergo play a role in developing compassionate practitioners (Christiansen & Jensen, 2008; Middleton, 2010; and Willis Commission Report, 2012). However, nurse educators are faced with challenges as they plan, develop and deliver a curriculum that seeks to equip nurses and

midwives with the knowledge and skills required to practice compassionate care (Adamson & Dewar, 2011). There is also limited literature on the experiences of nursing students in learning and providing compassionate care in Malawi. As such, it is imperative to explore the experiences of students in developing and providing compassionate care.

Justification of the Study

Caring is the core business of nurses and without compassion nurses cannot be caring (Fingeld-Connett, 2008). Literature has shown that nursing students join the nursing profession with passion to provide quality care (Baughan & Smith, 2008; Eley, Eley, & Rogers-Clark, 2010; Maben, Cornwell, & Sweeney, 2010) however, when they qualify, some do not provide compassionate care (Kavinya, 2008; Simwaka et al., 2014). Furthermore, nurse educators and qualified clinical nurses pray a vital role in socializing nursing students in the profession. In the face of growing public and professional unease about lack of compassion in nursing care, it is essential that the role of education in developing compassionate practitioners is fully understood. Locally, there is paucity of literature on experiences of students in providing compassionate care. This has made the researcher to set a formal enquiry from the nursing students' perspective so to learn from them what assists them to develop and provide compassionate care, and explore factors affecting provision of compassionate care in practice. Findings will bring to light some salient issues which may assist nurse educators identify and plan learning needs on how compassion can be nurtured in undergraduate nursing students hence improving quality in nursing care and consequently health care outcomes may improve. Furthermore, some barriers to provision of compassionate care in practice will be uncovered hence easing the job of concerned stakeholders to finding solutions to the problem.

Study Objectives

Aim of the study.

To investigate experiences of nursing students in providing compassionate nursing care at Kamuzu College of Nursing.

Specific Objectives.

1. To explore how nursing students conceptualize compassionate care.

2. To describe how nursing students develop compassionate care.

3. To establish factors that enable, or hinder the provision of compassionate care.

Conclusion

In this chapter, an introduction and background to the study on experiences of nursing students in providing compassionate care at Kamuzu College of Nursing in Malawi has been discussed. The aim of the study is to investigate students' experiences in the provision of compassionate care. The findings of the study will contribute to the body of knowledge in nursing and midwifery education in cultivating compassionate care hence improving nurse and midwifery education and practice in general.

CHAPTER 2

Literature Review

Introduction

This chapter presents a review of studies done on compassionate nursing care at national and international level with particular attention on nursing education. However, locally there seem to be scanty information and literature on compassionate nursing care focusing on our national health system. The review of the literature has been organized in accordance with the study objectives. The review included articles and books published in English from 2005 to date to make the search more manageable and to ensure quality and sound evidence relevant to current practice (Harvard, 2007).

The following databases were used for the literature search: PubMed, CINAHL, EBSCOHOST, Google Scholar, and HINARI. The following search terms were used: compassionate care, nursing, cultivating compassionate nurses, nursing students and compassionate care and nursing education.

Compassion in Nursing

The term ‘compassion’ is derived from Latin and its original form means “with suffering”. In nursing, Chambers and Ryder (2009) described compassion as a profound feeling, triggered by witnessing the pain and distress of others, which can be demonstrated by acting in a way that you would like others to act towards you.

Compassion in nursing is not a new concept, but is derived from ancient theological ideals that were translated by Florence Nightingale into the very essence of professional

nursing (Straughair, 2012a). Compassion, remains an underpinning philosophy that permeates the moral codes and value statements of nursing today and as such it should be regarded as fundamental. The American Code of Nursing Ethics (2014) stipulates that 'the nurse in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and personal attributes of every person, without prejudice.'

Whilst it is agreed internationally that compassionate care is important for health care professionals like nurses, elements within the concept remain contested (Curtis et al., 2012). Schantz (2007) asserts that as the nursing profession has evolved, there has been an increasing emphasis on developing the quality of clinical care and, as a result, the value of compassion has seemingly been eroded to such a degree that it could be considered an optional component of nursing practice. Johnson and Black (2008) argues that using computers and doing administrative tasks are part of modern nurses' daily routine activities and these have distracted nurses from being compassionate.

Negative patient experiences have highlighted lack of compassion in nursing and consequently, professional drivers have been asked to re-endorse the concept (Department of Health, 2010; The Royal college of Nursing, 2010). Similarly, Price (2013) agrees that nurses' ability to provide compassionate care has come under increasing scrutiny in the light of reports criticizing shortfalls in care. Therefore, such practice can influence students negatively through role modeling. This concurs with Christiansen and Jensen (2008) who assert that in nursing education, students' ability to cultivate emotional qualities in caring like 'compassion' is usually associated with their experience in relationship to patients. Furthermore, the authors suggest three learning journeys that may encourage compassionate care in students. The learning journeys include; addressing issues relating to the conceptualization of care and related learning, revising clinical skills and diversifying the mix

of staff engaged in teaching hence increasing opportunities for students to examine the nature of compassionate care and emphasizing that the care relationship is also a teaching relationship, with patients often required to self-care.

Can Compassion Care be taught to Nursing Students?

Chambers and Ryder (2009) asserts that compassion, in its many manifestations, is the key to rediscovering what lies at the heart of nursing practice all over the world and it is absolutely essential that nurses start to revisit compassion as a central focus for nursing practice. They suggest that developing patient-centered care skills in nursing students can consequently promote compassion in provision of care. In their study on compassionate care, Bray et al. (2014) found that there was clear consensus from qualified health professionals that training was necessary to provide compassionate care.

Compassion is often considered to be an essential component of nursing care; however, it is difficult to identify what exactly comprises compassionate care (von Dietze & Orb, 2000). There's evidence that Nursing students join the nursing profession with passion to care, but once they qualify, this is not reflected in their practice in their work place (Maben et al., 2010). Concurringly, Baughan and Smith (2008) assert that students enter the nursing profession because they want to deliver high-quality compassionate care. Additionally, Eley et al. (2010) support this assertion through their study in Australia which demonstrated that students and qualified nurses identified the key influencing factor driving their decision to enter nursing profession as the motivation to care for others. Furthermore, Lemonidou et al. (2004) and Msiska et al. (2014) found that student nurses did provide compassionate care as they demonstrated to have emotional engagement, moral awareness and empathy with their patients when rendering care.

However, Rankin (2013) argues that in times of economic austerity, students are likely to persevere with programs of study because of limited alternatives. It is therefore difficult for such students to provide compassionate care when they qualify. Supporting his argument, (Cho, Jung, & Jang, 2010) showed that of 40 student nurses in Korea who had chosen to join the nursing profession, none identified the altruistic quality of desiring to care as a motivating factor; citing salary and job security instead.

To ensure that nurses are able to deliver high-quality compassionate care, they need to be supported by embedding the concept of compassion throughout training. This ensures that nurses and midwives are equipped with the necessary knowledge and skills required to practice compassionately (Adamson & Dewar, 2011). Additionally, Straughair (2012b) suggests effective role modeling in clinical practice facilitates compassionate behaviors. Furthermore, Corder (2014) recommends development of recruitment strategies which consider specific values and attitudes to ensure that the most appropriate students enter the nursing profession.

Similarly, in relation to students' development of compassionate care, Bray et al. (2014) asserts that the impact of the practice environment in which students learn and work should not be underestimated. Nursing students in Malawi practice in clinical settings characterized by severe nursing shortage and gross lack of supplies (Msiska, Smith, & Fawcett, 2014b). The nurse/patient ratio is 38 nurses per 100,000 population (Ministry of Health, 2012). Additionally, evidence has shown that most nurses in Malawian clinical settings do not practice compassionate care due to burnout (Msiska et al., 2014; Simwaka et al., 2014; and Kavinya, 2008). These organization environmental factors can negatively impact on students' development of compassionate care.

Contrary to the above assertions, Whitehead (2013) found that compassion cannot be taught, but it can be unlocked. The author argues that one cannot teach compassion but can only teach students its importance and how best the student can allow compassion to guide his/her conduct in the profession. This left him wondering that if we cannot teach it, what else are we to do to combat the problem of nurses that are qualified and working but have no empathy and compassion?

Effects of Compassionate Care

Compassion is one of the most important principles or moral virtues in the ethics of nursing (Armstrong, 2006). It is important to be compassionate towards a patient because health care completely relies on compassion. This is because compassion is one of the most valuable ways of treating a person who has ill health. Nurses must be compassionate caretakers of their patients and they should perform their duties with full diligence. They should not harm the dignity as well as safety of the individual in any way. Often considered the mother of modern nursing, English nurse Florence Nightingale became famous for her courage to show compassion for wounded patients on the battlefield during the Crimean War. Many World War II nurses lost their own lives while compassionately caring for GIs. Today's nurses continue the legacy of compassion, and understand the many benefits this trait provides to patients and their families (Boykin & Dunphy, 2002).

Compassion unites people during times of suffering and distress. Furthermore, compassion brings peace of mind in those Patients who are shown compassion by the nurses who care for them are more likely to be comfortable in times of illness, pain and mental stress. Whether preparing for surgery, recovering from an injury or fighting a disease, compassion can help make pain more tolerable and ease the minds of nervous patients.

Compassionate care gives patients support and confidence when they need it most, hence fundamental in the caring profession (Bramley & Matiti, 2014).

On the other hand, Pearson 2006; Kim and Flaskrud 2007 and Youngson (2008) assert that not only does compassionate nursing care benefit patients, it also has a profound effect on the nurses who practice this vital trait. Nurses who feel a sense of concern for their patient's well-being typically enjoy their jobs more than those who focus less on the emotional side of the profession. They are more aware of the pain and distress patients go through, which gives them a sense of connection to their careers. The ability to relate to patients on a deeper level increases compassionate feelings and gives nurses who practice their profession in this manner self-gratification for provided emotional support.

In her study, 'Compassion in care' van der Cingel (2014) found that compassion is a valuable process which motivates patients as well as nurses to cooperate in achieving relevant outcomes of care.

What Promotes Development of Compassion in Nursing Students?

Studies on how students cultivate caring and compassionate conduct in relation to patients have shown that through social interaction students learn to fashion their emotions in accordance with the norms of the group or what Hochschild (1983) cited by Christiansen and Jensen (2008) terms as 'feeling rules' of a given culture . In this case the nursing profession culture. These rules not only influence the expression of feeling, but the actual feelings we hold as well. Hochschild extricates two ways of fashioning emotions as surface and deep. In the first way, we try to change our outward appearance and he calls this *surface acting.* As a nurse, one sometimes has to disguise one's own feelings, for instance when one is unpleasantly affected by specific sights, odor and noise. Although separating the display of

the feeling from the actual feeling is hard to maintain over long periods, in surface acting we deceive others about what we really feel, but we do not deceive ourselves. In deep acting, the performer actually feels that which is communicated. Deep acting is what Hochschild recommends for nurses. Supporting his notion, Christiansen and Jensen (2008) assert that grief and suffering in the field of nursing involve a wide range of emotional challenges which require deep acting: the nurse projecting self into the position of the patient, comprehending reactions in a professional way as well as drawing on similar memories as a source of compassion.

Additionally, in their study of caring about caring, Dewar and Nolan (2013) found that engaging in 'appreciative caring conversations' promotes compassionate, relationship-centered care but that these conversations involve practitioners taking risks. Furthermore, Christiansen and Jensen (2008) found that peer learning in form of role-play as a formal teaching strategy can promote emotional learning. They suggest that role-playing may offer the students an opportunity to learn from each other, because it gives them considerably more practice than traditional teaching and learning methods. In nursing, role playing aims to make students intellectually, emotionally and behaviorally involved in their own learning. Supporting these assertions, Askland (2007) explains role-playing as a medium for building competencies as it integrates knowledge, skills and attitudes.

Furthermore, Christiansen et al. (2015) found that there are a number of enabling factors that enhance a culture conducive to providing compassionate care. These include leaders who act as positive role models, good relationship between team members and focus on staff wellbeing. Their findings are supported with study assertions by Firth-Cozens and Cornwell (2009) who advocated that acting as a role model for the delivery of compassionate

care will demonstrate its importance as a fundamental value to students and less experienced staff.

What Hinders Provision of Compassionate Care?

Through literature review, the importance of providing compassionate care is well established. While compassionate care can be understood as an individual's response to others suffering and pain Maben et al. (2010) it is acknowledged that health care environments can impact significantly on this aspect of practice. Literature has shown that hindering factors to compassionate care can be at individual, organizational and leadership level (Christiansen et al., 2015).

In their study on enabling compassionate care, Firth-Cozens and Cornwell (2009) identified stress and burnout as key factors in reducing the occurrence of compassionate care, as these can cause nurses to depersonalize patients. They championed the need to provide access to support groups and educational workshops, with a view to promoting strategies for preventing stress at individual level. Burnout is a psychological term for the negative response to chronic job-related emotional stress, and this result in impaired performance, negative attitudes, absenteeism in nurses (Thornsen, Teten Tharp, & Meguid, 2011).

Additionally, lack of role models in compassionate care also hinders its occurrence. This is why Firth-Cozens and Cornwell (2009) advocate the need to place more emphasis on the need to act as role model to others, in terms of delivering high-quality compassionate nursing care. Schon (1983) cited by Straughair (2012) identified that, when student nurses work with a mentor in the clinical environment, they reflect on and internalize the behavior patterns observed. Illingworth (2006) suggested that student nurses undergo a process of professional socialization, involving the transfer of values, attitudes and beliefs from

experienced nurse to less experienced nurse. Role models can best demonstrate to student nurses that compassion is a core behavior by showing their own commitment to the concept. These assertions are supported by Firth-Cozens and Cornwell who purports that acting as a role model for the delivery of compassionate care will demonstrate its importance as a fundamental value to students and less experienced nurses.

Furthermore, embedding compassion as a core value through leadership is a key consideration. Straughair (2012) purports that nurse leaders need to ensure that nurses are afforded the opportunity to reflect on their practice and maintain ongoing personal and professional development in relation to compassion in nursing. Bryant (2010) highlighted the importance of clinical supervision as a vehicle to support this. Youngson (2008) identified modernization of services and fragmentation of care as key factors affecting compassion.

Conclusion

Based on literature review, there is paucity of research on compassionate care in Malawi. However, evidence has demonstrated that both theoretical and practical training that student nurses undergo play a role in the development of compassionate care (Bray et al, 2013; Horsburgh & Ross, 2012; and Msiska, Smith & Fawcett, 2014). Evidence has also shown that nurse educators and clinical nurses have an important role to play as role models in ensuring that compassionate care is nurtured in nursing students (Adamson & Dewar, 2011; Bray et al., 2013). However, most of the studies were conducted outside Malawi and as such there is little that is known on experiences of undergraduate nursing students in developing and providing compassionate care in the country. It is therefore imperative that this study be conducted in Malawi. The next chapter will focus on the study methodology.

CHAPTER 3

Methodology

Introduction

This chapter introduces the concepts of research design, setting, population, sample size, sampling method, data collection method, data analysis, and ethical considerations. The chapter also discusses plan for dissemination of study results and limitations to the study methodology.

Study Design

Research design is considered as the architectural backbone or plan of how a researcher intends to conduct the study which includes methods and procedures for collecting, analyzing and interpreting data (Polit & Beck, 2011). The design selected for research should be the one most suited so as to find an answer to the proposed research questions (Parahoo, 2006). This study utilized a narrative qualitative approach to collect and analyze data. Literature has shown that we can understand people better through narrative. Asking a person 'what is your story?' will provide more knowledge about persons than asking 'how are you?' (Clandinin & Connelly, 2000). Narratives have been central to nursing and will continue to be so because through narrative inquiry, you can gain access to personal experiences of the story teller who frames, articulates' and reveals life as experienced.

Based on literature search done by the researcher, there was limited literature on experiences of nursing students in relation to compassionate care. A qualitative approach was considered appropriate in this study in order to explore and describe the experiences of the student nurses. Qualitative research is a systematic, subjective approach used to describe life

experiences and give them significance, whereas quantitative research is a formal, systematic approach which incorporates numerical data to obtain information about the world and this would not be suitable to gain information required in this study (Burns & Grove, 2009). The views and experiences of nursing students in this study were very important because it gave first-hand information in the context of their experience in providing compassionate care. The study used semi-structured interview guide to data collection. This gave participants opportunity to fully and freely describe their experiences and raise their views.

Study Setting

Setting is the physical location where individuals of interest live, experience life and where the data collection takes place (Polit & Beck, 2010). The study was conducted at Kamuzu College of Nursing (KCN) in Malawi. This is one of the leading Nursing Colleges in Malawi which trains registered nurses from degree level and above.

Kamuzu College of Nursing was chosen because students at this college mostly do their clinical practice in central hospitals where they mix and practice with quite a large number of qualified nurses whose practice is classified as lacking compassion (Simwaka, de kok2, & Chilemba 2014; Msiska, Smith & Fawcett, 2014).

Study Population

Target population is referred to as 'the entire population in which a researcher is interested and to which the researcher would generalise the results' (Polit & Beck, 2010, p.569). The study population involved all generic third and fourth year students at Kamuzu College of Nursing. Students at this level are expected to have acquired enough theoretical and practical knowledge in nursing; they have undergone various clinical experiences which

put them at a better position to narrate their experiences in clinical learning and compassionate nursing care provision.

Sampling and Sample Size

Sampling refers to the selection of a group of people that are representative of the population being studied (Burns & Grove, 2009). This study used purposive sampling. Purposive sampling is defined as a non-probability sampling method in which the researcher selects the participants based on personal judgment about who will be most representative or informative for the purposes of the study (Polit & Beck, 2010; Wiersma & Jurs, 2009). Concurringly, Streubert and Carpenter (2011, p.28) asserts that in this method of sampling, 'individuals are sampled for the information they can provide about a specific phenomenon'. Furthermore, literature has shown that study participants in qualitative research are selected for the purpose of describing an experience in which they have participated.

Additionally, Holloway and Wheeler, (2010) recommend that a purposive sample is chosen on the basis of personal knowledge of the person selected about the phenomenon under study. In this study, consenting students who have had experience on compassionate care and were willing to narrate their stories were recruited as study participants. Hence, study participants were purposively recruited after a briefing session of the study and its purpose. This method was chosen in order to select the specific participants who were third or fourth year undergraduate students who had an experience to share in terms of providing compassionate nursing care. This was done to collect the rich data that is needed to gain insights and discover new meaning in the area of study (Burns & Grove, 2009).

The initial sample plan was to recruit 20 participants. However, a sample of 12 participants was used because data had saturated. Saturation was achieved with a sample of

10 because the participants were good informants who were able to reflect on their experiences and communicate effectively (Polit & Beck, 2011). Two More participants were interviewed just to be sure if data saturation was reached. Saturation refers to repetition of discovered information and confirmation of previously collected data (Speziale & Carpenter, 2007). Thus it was known that saturation had been reached when the ideas surfacing in the dialogue were the ones previously heard from other participants (LoBiondo-Wood & Huber, 2014).

Holloway and Wheeler (2010) assert that larger samples are rarely necessary in qualitative research because it might compromise depth and richness of study findings. Concurringly, Polit and Beck (2010) state that if participants are good informants; who are able to reflect on their experiences and communicate effectively, saturation can be achieved with a relatively small sample. Furthermore, Todres, Galvin, and Richardson (2005) purports that even a sample of one can be meaningful in qualitative inquiry. Concurringly, Creswell (2008, p.217) recommend a sample range of '2 to 30' as adequate. As the researcher intended to acquire a purposive sample, there were some inclusion and exclusion criteria requirements.

Inclusion criteria.

Inclusion criteria refer to the criteria that specify the characteristics that delimit the study population (Polit & Beck, 2010). The inclusion criteria were all third and fourth year undergraduate students who:

1. Had a story to narrate on compassionate nursing care.
2. Were students at Kamuzu College of Nursing.
3. Had consented to take part in the study.

Exclusion criteria.

Exclusion criteria refer to the criteria specifying the characteristics that participants do not have (Polit & Beck, 2010). The exclusion criteria were all third and fourth year generic students who:

1. Did not have a story to narrate on compassionate care.
2. Were not from Kamuzu college of Nursing.
3. Did not consent to take part in the study.

Recruitment Process

After approval from COMREC (Appendix 4) and permission from the Principal of Kamuzu College of nursing (Appendix 4) were obtained, the Dean of students at the college was briefed about the study and the dates when the interviews were to be conducted. During the period of data collection, students were doing their clinical practices hence consent to withdraw students was sought from the Nurse-in-charges who were in the designated clinical placement sites. The researcher held an audience with the target population and briefed them about the study and its purpose. Details of the study were explained in English and it was communicated to the potential participants that their participation in the study was voluntary. For those students who met the inclusion criteria and were willing to participate in the study, a convenient interview schedule was developed in collaboration with the researcher within a specified data collection period. Phone numbers of the participating students were taken by the researcher to confirm their participation. All the participants met the researcher in a quiet room within the college library where detailed explanation about the study was given prior to signing of the consent and interview.

Data Collection Tool

A data collection tool refers to a device used to collect data (Polit & Beck, 2010). In this study, data were collected using a semi structured interview guide. The Semi structured interview guide allowed the researcher to guide the participants towards an area of focus, but at the same time allowed participants to freely express a full range of experiences in terms of compassionate nursing care provision (Polit & Beck, 2006, p.59).

The semi-structured interview guide (Appendix 3) was developed in English by the researcher and it was administered as such. The interview guide had two sections; the first part contained questions which aided in collecting demographic data for participants' identification while the second part had an interview guide which contained an interview prompt/ grand tour question accompanied by an aide memoir. This aided in the collection of data that allowed the researcher to achieve the study objectives.

Pretesting of the Data Collection Tool

Pre-testing is a trial run to determine whether the tool is useful in generating desired information (Polit & Beck, 2010). The interview guide was pretested at Malawi College of Health Sciences, Blantyre Campus (Appendix 4). The interview guide was pretested to eliminate and refine the questions that seemed vague to the participants. This exercise was done soon after permission to conduct the study was granted (Appendix 4).

Data Collection Process

After approval from the relevant authorities and obtaining consent from the participants, individual face to face in depth narrative interviews were done to explore the experiences. The interviews were structured around an open question which acted as an interview prompt inviting participants to narrate their experiences on compassionate care. In

this case the interview prompt acted as a stimulus or reminder to provide trigger for a story (Holloway & Wheeler, 2010). Some probes or questions were instituted when the narrative was completed so to develop the story by including the words of the participant. This concurs with Neuman (2011, p.475) who asserts that in narrative inquiry, 'the inquirer and the participant co-participate in creating/gathering data and in reflecting on it'.

Data was collected in a quiet environment within the libraries of the college because participants were in a familiar environment. A familiar environment allows participants to freely express themselves (Marshall & Rossman, 2011). Data collection and transcription was done by the researcher and member checking followed up to avoid researcher's biasness. The interviews were audio recorded and field notes were taken to serve as a backup when recording fails and help to capture nonverbal information during the interviews. The interview guides, transcripts, field notes, and consent forms were put in a place only accessible by the researcher to ensure confidentiality. The interviews lasted between 22 - 50 minutes.

Data Management and Analysis

The purpose of data analysis is to organize, provide structure to, and elicit meaning from research data. The researcher dwells with and becomes immersed in the data (Polit & Beck, 2010). Data which were collected through in depth interviews was analysed manually using thematic analysis. Thematic analysis is a qualitative analytic method for identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes data set in rich detail (Braun & Clark, 2006). Data was presented thematically using the following 6 steps as explained by Braun and Clarke (2006).

Step 1: Becoming familiar with the data

The researcher conducted the in-depth individual interviews with all the participants. Data collection and analysis was done concurrently where the audio recorded interviews were listened to and transcribed verbatim. Field notes were included in the transcripts. Each transcript was re-read and the data was reflected upon to get the meaning behind some words before starting coding. All these assisted the researcher to get immersed in the data hence becoming familiar with the depth and breadth of the data content.

Step 2: Generating initial codes

At this stage, codes were generated inductively by directly examining the data. The researcher used personal judgement to identify broad subject areas under which the data was categorized (Harding, 2013). Charmaz (2006, p. 45) suggests that 'coding is a process of selecting, separating and sorting data; identifying categories is a major part of the separating and sorting'. Data was segmented/ organized into meaningful groups (Tuckett, 2005). Segments of data were then marked by descriptive words carrying a category name for example; conceptualization, hindering factor, development, recommendation etc. Codes were both theoretical (a priori codes) and data driven (in vivo codes). A priori codes are codes which are developed before examining the data. A priori codes were used in this study as the researcher had specific questions in mind that she wished to code around and this is acceptable in qualitative analysis (Johnson & Christensen, 2014). For example, 'how do nursing students conceptualize compassionate care? Hence, an example of a priori code in this study is 'students' conceptualization' of compassionate care.' In vivo codes are codes that use the words of the research participants. In this study an example is 'empathy,' a word which most participants used to describe compassionate care (Johnson & Christensen, 2014).

Step 3: Searching for themes

At this stage, the coded data were put together to identify similar or different data. Similar ideas or issues that emerged from the results were grouped together to form categories. The researcher sorted out the different codes and combined codes with similar meaning to form an overarching theme. Brief description of each code were placed in a table. Some initial codes went on to form main themes for example 'conceptualization of compassionate care', whereas some formed subthemes for example 'empathy'. Codes which did not seem to belong anywhere formed miscellaneous themes for example, a subtheme of routine care (Braun & Clarke, 2006). All the themes came from the data. However, after sorting out the different codes assigned to the categories, the overarching/major themes did not differ much with the study objectives.

Step 4: Reviewing themes

The grouped texts were read several times to get the significant words and their meaning. Meanings from the grouped data were identified and highlighted which became the themes. Themes and subthemes were generated with reference to relevance to research questions and objectives. For example, participants in this study gave different explanations on how they conceptualize compassionate care. When the researcher reflected on the explanations, empathy was one of the significant words which became a sub theme under a major theme of students' conceptualization of compassionate care.

Themes were discovered by looking at repetition of ideas in the data. Though this is not an exhaustive method on how to discover themes. Ryan and Bernard (2003, p. 89) alluded that 'repetition is one of the easiest way to identify themes'. The authors stipulate that the more the same concept occurs in a text, the more likely it is a theme. Another way which

was used to identify themes was looking for terms that sounded unfamiliar, indigenous typologies or categories for example ‘routine care’, a word which participants indicated as a barrier to provision of compassionate care in current nursing.

Step 5: Defining and naming themes

The themes were then defined and ranked as major themes (those which are overarching) and subthemes (those falling under the overarching themes) accordingly. The themes have been presented in the study results section with data extracts for each theme and accompanying narrative. A summary of the themes and subthemes that emerged from data analysis are presented in the results chapter in a table.

Step 6: Producing report

Both major and subthemes have been reported as results in narration format and some direct quotes have been used for scientific rigor and to highlight important points which were raised by the participants in the results section. Demographic data have been summarized and presented in a table.

Presentation of Results

The results have been presented in themes and discussed in a narrative descriptive form. The demographic information has also been presented to show sample characteristics.

Dissemination of Results

The report will be submitted to Kamuzu College of Nursing post graduate Academic Committee as a requirement for Master of Science in nursing and Midwifery Education dissertation. The results will be presented in nursing education forums and will also be published in nursing and midwifery education journals. A copy of the final report shall be

submitted to each of the following: the Kamuzu College of Nursing Library, the College of Medicine Research and Ethics Committee, and the University Research and Publications Committee (URPC) through COMREC secretariat. Publications will be prepared for scientific journals.

Trustworthiness of Data

Trustworthiness is a way of demonstrating plausibility, credibility and integrity of the qualitative research process (Moule & Goodman, 2009). It also relates to the degree of confidence readers can have in the study findings (Schmidt & Brown, 2012, p.354). This was done to help in ensuring that findings on the ground reflected the experiences and to ensure accuracy and honesty of the data. Trustworthiness of data was achieved by evaluating the credibility, dependability, confirmability, and transferability of the data as suggested by Lincoln and Guba (1985) cited by Polit and Beck (2010). These have been elaborated in the following paragraphs.

Credibility.

Credibility refers to 'the confidence in the truth of the data and their interpretation' (Polit & Beck, 2010, p.106). Credibility was achieved by prolonged engagement with the participant in-order to have an in-depth understanding of their experiences, hence probes were instituted where the researcher felt the information given was inadequate, or not clear. Field notes were taken and good rapport with the participants was built prior to data collection. The tape recorded data was listened to several times for scrutiny to search for meaning and deeper understanding, and member checking was done where deemed necessary to avoid researcher's biasness by validating the findings with the participants from whom data was collected (Lincoln & Guba, 1985).

Dependability.

Dependability refers to stability of the data over time and over conditions (Polit & Beck, 2010). To assess dependability, the researcher determines the extent to which another investigator, with similar methodological training, rapport with the participants and knowledge of the field would make the same observations (Polit & Beck, 2010). In this study, dependability was achieved by audio recording the interviews, field notes taking, and having an interview guide for data collection. The data was analyzed using Braun & Clark, (2006)analysis method. In addition to this, the participants were probed for more information and clarification if their narratives were not clear.

Confirmability.

Confirmability refers to objectivity, that is; 'the potential for congruency between two or more independent people about data's accuracy, relevance or meaning' (Polit & Beck, 2010, p.492). Confirmability was achieved by recording all the words spoken by participants and the researcher in order to distinguish the participants' data from the researcher's view. Raw data in form of literal statements and quotations of participants have been included in the results section. The study findings were also reviewed together with the research supervisors.

Transferability.

Transferability is the extent to which qualitative findings can be transferred or have applicability to other settings or groups (Polit & Beck, 2010). Transferability was achieved by provision of a rich, thorough description of the research transactions, report and processes observed during the study.

Ethical Consideration

A study should ensure that participants are treated with justice and that they are protected from any form of harm (Polit & Beck, 2011). Prior to undertaking research, it is imperative to ensure ethical research practice. The involvement of student nurses as participants required special consideration as they could be vulnerable to coercion and may already feel under duress. The study adhered to the principles of veracity and autonomy, non-maleficence, beneficence and justice. As all ethical requirements were met, favourable approval was provided by Ethics Committee (COMREC) at the researcher's university and the participants' college (KCN) prior to data collection to ensure participants protection.

An information letter (Appendix 1) was formulated and given to the participants to explain the purpose of the study, risks, benefits, and confidentiality issues to the participants. The letter also contained information regarding the investigator and COMREC chairperson including their phone numbers and contact addresses. Furthermore, participants were asked to sign a consent form (Appendix 2) after having an explanation on the purpose, risks, benefits, and confidentiality issues prior to interviews.

Participants were assured that their participation in the study was voluntary and that they could withdraw from the study at any point. Furthermore, participants were assured of confidentiality and anonymity of information in that no identifying information obtained from them was to be made public and by publishing the information in a way that would not relate to the participants. Anonymity was achieved by using numbers and pseudonyms on the interview guides. Participants were assured that their recorded information will be destroyed upon completion of the study. Additionally, interviews were conducted in a quiet, private, rocked room where people could not hear the conversation.

The probable risks in this study included psychological risks in terms of making the students recall some sad moments where they witnessed lack of compassion in nursing care and the participants might have been uncomfortable with some of the questions about compassionate nursing care provision. These risks were minimised by establishing a good rapport with the participants, asking them to freely express their experiences both positive and negative. The participants were also assured not to answer questions they were not comfortable with. The information given by the participants was kept secret.

Conclusion

This chapter has presented a description of the study design, setting, study population, sample size, instrument, the strength and limitations of the study. It has also given an overview of the methodology and procedures which were followed to collect manage and analyze data for this study. Furthermore, it has highlighted the ethical considerations that were followed to ensure that neither the study participants nor the principal investigator were harmed in anyway. The next chapter presents the findings of the study.

CHAPTER 4

Presentation of Results

Introduction

This chapter presents results from the study on experiences of nursing students at Kamuzu College of Nursing in providing compassionate care. The results presented include demographic characteristics and the emerging themes which are: participants' conceptualization of compassionate care, factors influencing development of compassionate care, facilitating and hindering factors on compassionate care. The data were analysed using thematic analysis by Braun and Clarke (2006).

Demographic Characteristics

Data were collected from 12 participants whose ages ranged from 19 to 33 years. All the participants had a religious affiliation and they were all Christians. The participants had spent not less than three years of nursing training. The majority of the participants were females (9 out of 12). More fourth year students were interviewed than the third years (7 out of 12).

The following table summarizes the demographic findings;

Table 1: Demographic data summary

Year 3		**Year 4**	
	Females	**Males**	**Females**
	PT.1.F.3	**PT.5.M.4**	**PT.7.F.4**
	PT.2.F.3	**PT.6.M.4**	**PT.8.F.4**
	PT.3.F.3	**PT.10.M.4**	**PT.9.F.4**
	PT.4.F.3	**PT.12.M.4**	
	PT.11.F.3		
TOTAL	**5**	**4**	**3**
SUBTOTAL	**5**	**7**	
GRAND TOTAL	**12**		

KEY: PT.3.F.3 [Participant (PT) number (3), Gender (F), Year of study (3)]

Qualitative Data

Data from narrative interviews were analyzed using thematic analysis. This method of qualitative data analysis, data were transcribed verbatim followed by line by line coding and then words and sentences with relevant information related to the study objectives were

highlighted leading to development of categories. The categories were reduced to form significant words and themes developed from the coded data.

Emerging Themes

Table 2: Themes and subthemes

Themes	**Subthemes**
❖ Conceptualization of compassionate care.	• Individualized care • Empathy • Love • Compassionate care viewed as altruism • Not shouting at patients • Understanding and considerate • Risk taking for a greater good
❖ Factors influencing development of compassionate care	• Role modeling. • Caring concepts taught in class. • Stories of lecturers experiences of caring. • Community socialization.

❖ Factors enabling compassionate care	• Recognition • Commitment. • Learning from past mistakes.
❖ Factors hindering compassionate care.	• Negative personal attitude. • Working environment. • Routine nursing care. • Harsh experience during training.
❖ Compassionate nurses	

Conceptualization of Compassionate Nursing Care

The theme of conceptualization of compassionate nursing care refers to participants' understanding of what compassionate care is. The findings reflect the participants' meanings of the concept and what a compassionate nurse should do. Seven subthemes emerged under this major theme and they included; empathy, individualized care, love, compassionate care viewed as altruism, not shouting at patients, understanding and risk taking for a greater good.

Empathy.

The results revealed empathy as a constant theme as participants reiterated that compassionate care is characterized by empathetic acts. One participant described her experience as follows:

> Ok, empathy is one of the characters (of compassionate care). Aah..., putting yourself in the shoes of the patients, assuming that you are not a nurse and then you had come to the hospital as a patient, and then what care would you expect to receive from nurses? The same care that you would wish to receive should be given to patients. So you have to put the patients in your own shoes. (PT.3.F.3)

Similarly, another participant described compassionate care as follows:

> I think also putting yourself in the patient's shoes (*being empathetic*). Like labor and delivery, I think it's a very painful experience, the nurses I think they have to be understanding that someone in pain may have bad behavior (*screaming or crying)*, so may be understanding that the woman is behaving like that because of the pain that she is feeling, yaaa! (PT.5.M.4).

Individualized care.

The study also revealed that participants regard nurses who provide individualized care as being compassionate. According to participants' narratives, a nurse who provides individualized care meets a patient needs in totality. This is how one participant described a compassionate nurse;

> I think a compassionate nurse always knows that she is there in the ward for the patients, and she always makes sure that every patients bed is clean, every patient has received drugs, every patient is eating, the patient is just fine, whenever the patient is in pain she is concerned and she makes sure that the patient is not in pain. She makes sure that the patient is happy and well until she is discharged (*meets individual patient's needs*). (PT.1.F.3)

Love.

The study findings also revealed that some participants likened compassionate care to love. Love that is characterized by passion for people and work. This is what one participant said:

> a compassionate nurse to me; 1: he has to have love, you need to have love, love of what you are doing, love that we develop towards other people, love of your work, because you love your work then you will do without problems. (PT. 6.M.4).

Similarly, another participant said a compassionate nurse:

> Should be loving, caring and understanding. Should not ignore other people's subjective feelings like pain, or any other complaint. The first thing nurse should assess the patient holistically and then see what is happening to the patient. (PT.7.F.4).

Compassionate care viewed as altruism.

The study also revealed that compassionate care goes beyond the routine care in nursing. It requires self-sacrifice on the side of the nurse. This is how some participants expressed their sentiments:

> My understanding of compassionate care is that somebody has to be willing to provide care beyond the limit of just providing care. That is to say, she has to be touched with the condition of the patient, should forget self and put herself in the condition that the patient is in, and should be willing to even take some risks to say that would benefit the patient. (PT.6.M.4)

Similarly, another participant justified the care she provided to one of her patients as being compassionate because she felt she risked her health for the sake of the patient; this is how she narrated her experience:

> I felt I gave compassionate care because had it been that I listened to the sister (*qualified nurse on duty*) to say if you get sick again, because you are asthmatic, because of the stinking, you will not go home! You will continue working because I have told you not to do it. You can find other things to do……..I didn't listen to that, I continued up to the state of the patient being able to speak, able to turn, able to smile, able to talk with a loud voice……I sacrificed! For my own health. To say, ok I will do this. I know I have medication at home. I will do this because even if I leave it, am still not comfortable. (PT.8.F.4).

Furthermore, another participant felt compassion moved her to take care of neglected patients due to striking nurses. She said she risked her nursing training by practicing in the

absence of qualified nurses, and she received threats from a senior nurse (*matron*) but that did not move her to provide care, this is how she narrated her experience:

> I feel the care was compassionately given because 1. I found the patients in a messed up situation and I did not follow what the majority did that day…. My focus was on the patients. I took the risk to say if anything happens I will still take care of the patients because I wanted them to get better, I saw that I did a good thing, even though I worked without a license, without owners of the ward being there, the patients appreciated the care I provided. (PT.7.F.4).

Not shouting at patients.

Some health care workers do shout at patients without a valid reason. The study revealed that shouting at patients shows lack of compassion as some participants characterized a compassionate nurse as one who does not shout at patients, and this is how one participant described compassionate care:

> not shouting at patients whenever they are misbehaving, at least asking them what the problem is and understanding the patient's condition, not acting before understanding the patient's condition and the other thing is speaking at a low voice when dealing with the patients, maybe the patients are misbehaving(*screaming/ crying or not taking instructions by the midwife while in labor*), I think speaking at a low voice the patients also can be able to tell you what their problems are and then you see the way forward on how to solve their problem. (PT.5.M.4).

Similarly, another participant equated a nurse who shout at patients as one who lacks compassion and this is how she narrated her negative experience:

> … Like what happens in labor ward. Of course sometimes you see that a woman is crying because of the contractions in labor, and you see this other nurse talking to this patient like 'aah Amayiinu! Bwanjimukungosokosa? Eeh! Chani-chani!zimkakomatu!' [*(aah! Woman! Why are you making a lot of noise? Shouting this and that. The sexual intercourse was sweet!) (the nurse shouting at the woman in labor*)] Something like that, which is not good. (PT.9.F.4).

Furthermore, another participant qualified her care as being compassionate by the following sentiments:

> So, I felt I provided compassionate care to the woman since I did not shout at her as she was failing to push effectively. I was able to understand that she was not taught how to bear down and the woman thanked me after the baby was born. She thanked me for not shouting at her and for teaching her how to bear down. Yea. (PT.5.M.4)

Understanding and being considerate.

The findings also revealed that some participants characterized compassionate care as being understanding and considerate on a patient's condition. This is what another participant said:

> …the nurses I think they have to be understanding that someone in pain may have bad behavior (*screaming or crying),* so may be understanding that the

> woman (in labor) is behaving like that because of the pain that she is feeling, yaaa! (PT.5.M.4)

Similarly, another participant said:

> I think I provided compassionate care because …..I was able to understand that she was not taught how to bear down and the woman thanked me after the baby was born. (PT.5.M.4)

Risk taking for a greater good.

The study findings also revealed that some participants characterized compassionate care as care which involves risk taking for a greater good to both the patient and the nurse. This is what another participant said:

> ….the nurse should be willing to even take some risks to say that would benefit the patient. (PT.6.M.4)

Factors Influencing Development of Compassion

In-depth interviews revealed that development of compassion in nursing students is associated with their background and experiences during training. Four subthemes emerged under this major theme. The subthemes include; role modeling, caring concepts taught in class, stories of lecturers' experience of caring, and community socialization.

Role modeling.

The study findings revealed that most participants attribute their ability to provide compassionate care to their role models in practice during training. The role models comprise lecturers, clinical instructors, and qualified nurses in the clinical area and their relations back

home (who are nurses). This is what one participant narrated when asked to share what has assisted him to be compassionate when rendering nursing care:

> I am telling you to say this nursery nurse at ….. (*the name of the health facility*), because of the way she was working, and I was observing how compassionate she was, that has done something to me, and not only to me, but to many who have worked with her. So I believe that if we can have nurses who have good skills in the wards 'who are compassionate in care provision' that would force even the young ones to develop the same compassion. Apart from that, the juniors of those people will also have compassion because they will be following leaders. (PT.6.M.4).

Similarly, when another participant was asked to share what has assisted her to be compassionate, this is what she said:

> I am coming from a family where my grandmother is a nurse and some of my aunts are nurses. Some of them could come home very late when on day duty (around 7 or 8 pm) because they had a patient whom they felt they had to care for till was stable, and they used to tell us stories on how they meet very sick patients, how they used to care for them. We couldn't understand because we were too young to understand, but she still gave us an idea of being in a position to help and being able to use that opportunity (*of being a nurse*) to help other people. (PT.2.F.3).

Furthermore, another participant attributed her ability to provide compassionate care to her lecturer, and this is what she narrated:

> Academically, I would say personally I have been privileged to work under clinical supervisors (lecturers) who work hand in hand with us and the nursing staff, to care for the patients compassionately…., so that we learn and we observe, and we have the necessary skills.

Caring concepts taught in class.

The study also revealed that the theoretical knowledge which students acquire during training assist them to develop compassion for their patients. Some participants said:

> Understanding the values that we are taught in nursing. We are taught that nurses have to be compassionate. It just happens that may be some nurses are not, but we are taught in class to be loving to the women, putting ourselves in the women's shoes, like if it was my mother, what I could have done, yeah. That made me to be compassionate. (PT.5.M.4).

> We learnt and I believe that nursing is a calling, so I feel that in this profession, aah.., when I am providing care, if I provide care to someone, and that someone says 'thank you!' to me thus a blessing (from God). (PT.3.F.3).

Stories of lecturers experience of caring.

The study findings also revealed that some participants attributed their ability to develop compassionate care to their lecturers' stories of caring, and this is what one of the participants said:

> It's also the stories which our lecturers narrate in our classes. Most of the lecturers have stories that show that they gave compassionate care at one point

> in time. So those stories motivate us a lot. I feel those stories motivated me. (*To develop and provide compassionate care*) (PT.1.F.3).

Community socialization.

The study findings also revealed that the cultural and religious socialization which take place in the community prior to training assist the undergraduate nurses to be compassionate. One participant said:

> …it's the value for life that I have, and the value itself is mostly built not only on cultural background, but also religious background. I am a Christian though my friend is a Muslim, but because of our beliefs we could have respect for that life. We could say this one is also a living person, if anything else I would attribute it to our religious background. That we value life and that value for life made us to say though she is in a dying condition, but she is still somebody who needs our care. So I would attribute it to the religious and cultural background that I have (PT.6.M.4).

Factors Affecting Compassionate Care

This theme captures some factors which can affect compassionate care either positively or negatively. Most factors affect compassionate care provision in both students and qualified nurses, while a few affect students only. Three subthemes emerged under factors that facilitate compassionate care provision and they include: recognition, commitment and past caring experience. On factors that hinder compassionate nursing care provision, five subthemes emerged and they include; negative personal attitude, working environment, harsh experience during training, incompetence and routine nursing care.

Factors enabling compassionate care.

Recognition.

The interviews revealed that compassionate care provision can be promoted by recognition. Some participants indicated that compassionate care provision is a behavior that can be reinforced by recognizing those practicing it. This is what one of the participants said:

> on the part of the students, being congratulated by the lecturers or being appreciated by your colleagues, even the qualified nurses motivates you to say if they say I did well on this patient, let me carry on. Even when you are being awarded good marks that motivates you to go on to provide good care to the patients. On the part of qualified nurses, I have seen in some of the hospitals they have the nurse of the month or may be nurse of the year, those things though they are not really directly connected to providing compassionate nursing care, it promotes compassionate care because those nurses are doing that having the aim that I will be awarded nurse of the month but then that also helps. (PT.3.F.3).

Similarly. Another participant said:

> …even your fellow workmates, they also like promote you, maybe by just praising you that you are doing good that makes you feel happy and continue providing compassionate care, maybe the patients themselves praising you even the guardian that makes you feel that you are providing compassionate care. (PT.4.F.3).

Commitment and hard work.

According to participants' narratives, a nurse who upholds nursing professional values is committed to his/her work, and pursues his/her pledge of service in nursing profession. He/she upholds nursing professional values and standards like being faithful, trustworthy, hardworking, valuing people's lives under his/her care, and taking nursing as a calling, just to mention a few. This is how another participant characterized a compassionate nurse:

> On the other hand you have to have the spirit of faithfulness, be faithful because that is one of the virtues in the nurses pledge, if I am not wrong; but then when we recite the pledge we say I will be faithful, so sticking to what you pledged or the oath that we make is also a character that a compassionate nurse should have. (PT.3.F.3).

Learning from past mistakes (reflective practice).

Findings in this study also revealed that compassionate care can also be learnt through past caring mistakes. A word mostly used is 'learning it in a hard way,' or 'once beaten, twice shy.' It was learnt in the findings that some nurses become compassionate because they had a bad experience of caring because they did not provide compassionate care. This makes them improve on care provision because they don't want to re-embrace that experience. This is how one participant narrated her experience:

> Past experience, for example you had a patient, you did not do something that was supposed to be done. For example, the patient died or had some other complications. If you were touched that time to say this thing has happened

> because of me, you don't want it to happen again. Definitely you give compassionate care. You give as much care as you can to this patient because you don't want the same scenario to occur. (PT.7.F.4).

Factors hindering compassionate care.

Negative personal attitude.

Participants reiterated that negative personal attitude that some nurses have towards their profession, patients and patient's medical conditions hinder their ability to care compassionately. One participant said:

> ….. But if the condition (patient's illness) is that which can even risk their life, then their compassion does not endure. That is how I can analyze it because they could do well with other clients, even the qualified ones could do well with other clients, but with this client (suspected TB case) they would not because you could see that the other clients were receiving their medication except this client. They did not care whether this client had received medication or not. So I can deduce that compassionate care provision in most people depends on the condition that the person is in, from that experience. (PT.6.M.4)

Some participants felt that some nurses have poor attitude for their profession as such they cannot deliver compassionate care. One participant said:

> First I would say attitude, personal attitude. There are some people who are in this profession because they truly feel they have to serve as nurses. Some people came to the profession just for the job, they are not exactly interested but because they are there and they are doing the job. So, personal attitude has made

> some other people disregard how other people feel, disregard how people are feeling, or forgotten the main aim, or the main principles in nursing when rendering care to the sick, so because of negative personal attitude people cannot give compassionate care (PT.2.F.3)

Harsh experience during nursing training.

In-depth interviews also revealed that the nurses' ability to provide compassionate care also depends on their past experiences during training. This is what some participants said:

> The other factor that contributes to nurses that they should be harsh to patients is the kind of treatment that they received from lecturers/ preceptors in the wards/ clinical area. So I feel that if the compassion can begin with the lecturers/ preceptors towards the students, they will instill that spirit of being compassionate, and in turn the students will be compassionate towards their patients.(PT. 3.F.3)

Similarly another participant said:

> I can suggest to say if compassion is lacking in students and most of the people, then the problem starts with the nurse educators, because the educators the way they treat the students, the way they handle them, that builds compassion for this profession. Because if may be they are being ill-treated, they are not being taught exactly what they are supposed to do, they are being shouted at, may be instead of skills being demonstrated to them, they just come to the ward to police them and doing this and that, that also builds lack of compassion in the young ones (*nursing students*). (PT.6.M.4)

Working environment.

Findings also revealed that the ability of nurses to provide compassionate care largely depends on their working environment. Some of the environmental factors which came out clearly include; resource availability, workload, supervision, and peer pressure. These factors can either positively or negatively affect compassionate care provision. This is what some participants said:

> I would say nurse-patient ratio is too big, I have been in wards like …(*Name of ward*), where on duty we would have only two nurses against eighty patients which is impossible for someone to give out patients all the care that they need, by the time they feel that they are tired, they leave it there…. So because of the large numbers we have in the hospital, it is difficult for somebody to provide compassionate care (PT.1.F.3).

Additionally, the findings also revealed that the type of socialization that the newly qualified nurses receive from their experienced peers also affect their ability to provide compassionate care. This is what another participant narrated:

> what I have noted is when people are students, most students provide compassionate care, but when they qualify, when they go to practice, they see their friends (*those that have been there for a long time*) they are not providing the care that is needed, so they emulate them, they do what their friends are doing. They say, I can't be working alone, something like that. (PT.9.F.4).

Similarly, another participant said:

> I think we must also not copy from the other nurses who are not compassionate. It may happen that in a ward there are seven nurses and you are the only one who is compassionate and you may end up copying the other bad behaviors and the compassionate nurse must stick to his good behavior so that maybe with time, the other nurses may copy from the compassionate nurse. (PT.5.M.4)

On the other hand, hospital environments in Malawi are characterized by critical shortage of essential drugs and supplies. Findings in this study reflect that such working environments hinders compassionate care. This is how another participant narrated her sentiments:

> If you don't have materials, compassionate care is mostly not given properly. May be what happens is just to say some words to the patient although you could have done something that could be good to the patient. For example,a patient who is on palliative care may have pain, a lot of pain, and you don't have Morphine and you just talk to the patient, I don't think that patient can concentrate on what you are saying because their pain is severe, beyond our imagination, so without having that morphine to give to that patient, I don't think that patient can appreciate for you to go there and start talking and smiling. So other situations will still need the materials to give compassionate care (PT.7.F.4).

Furthermore, lack of supervision in the clinical environment to ensure compassionate care also emerged as a hindering factor to compassionate care provision. This is what another participant said:

> Some people work when they know that they are being followed by someone, who will come to see them, so they are being followed up. Like what we do with our supervisors, they come and ask us about our patients, what is their history? What are we doing for the patient? Why we are doing that for the patient? And how we are working with other teams to provide care? So because we know sometimes the matron does not come to the ward for a week, sometimes two weeks, she is not there to monitor what kind of care is given.., and what! What!.., so it's difficult for people to follow standards, they become relaxed and say aah!, it's not like anyone is coming to see what we are doing and ask me about the care that I am providing (PT.2.F.3).

Routine nursing care.

The study findings also revealed that most practicing nurses in Malawi are used to routine nursing care, hence this compromises their ability to care compassionately. This is what another participant narrated:

> The other thing (*that hinders to provide compassionate care*) can be they are just used to routine care. They don't provide individualized care. They just do like drug administration and the like. yaah. They don't assess the patients and see what is so special in the patient, yeah. (PT.6.M.4)

Compassionate Nurses

Although the findings in this study portray that most of the participants are of the opinion that there is lack of compassion in Malawian nursing basing on their clinical

experiences, some participants reported that some nurses demonstrate commitment and compassion. One participant narrated his experience as follows:

> Through my learning experience, I can assure you that there are some nurses who are providing compassionate care. In my studies I have met one nurse at …..(*name of the hospital*) nursery ward. I have seen that, that nurse is providing compassionate care that she would not just accept to say this neonate is dying. For her to accept that let this life die, it means something has really happened, but she provides care to the maximum, so through that encounter I have also noticed that there are some nurses that are providing compassionate care.

Another participant also gave similar sentiments as evidence of the presence of compassionate nurses in current nursing and that patients do recognize compassionate nurses, this is what she narrated:

> .. like in gynecological ward, there is a certain nurse, she is old, and most of the patients like saying about her, they usually say; that nurse is really good, they say she is very old amongst you all but she doesn't care who she is talking to, whenever we call her to assist us may be the patient is in pain she always come, even when she is sleeping when we go to call her she doesn't complain, she is nice. Thus what most of the patients say; about the compassionate nurse (PT.8.F.4).

Conclusion

This chapter focused on the description of research findings. The themes and subthemes were described. The main themes include conceptualizing compassion, factors

influencing development of compassionate care, enabling factors to compassionate care and hindering factors to compassionate care. Each of the themes was described with its subthemes. The findings have been discussed in chapter 5.

CHAPTER 5

Discussion of Study Results

Introduction

This chapter discusses the results in chapter 4, and presents recommendations for nurse educators, curriculum planners, clinical staff and the nursing regulatory body. The chapter also presents implications as well as limitations of the study. The discussion focuses on key findings and the themes included in the discussion are participants' conceptualization of compassionate care, factors influencing development of compassion, enabling and hindering factors to compassionate care provision.

Participants Conceptualization of Compassionate Care

This section discusses participants' conceptualization of compassionate care in order to know their understanding of this vital concept in nursing profession. The essence of compassion in nursing care is evident in the International Council of Nurses (ICN) professional standards (2006) and the Pledge of nursing service which call for nurses to practice with compassion. It was encouraging to learn that all the participants were knowledgeable of this indispensable nursing profession concept (Msiska, Smith & Fawcett, 2014). However, the participants viewed compassionate care as a multidimensional entity. This concurs with Von Dietze and Orb (2000) who asserts that it is difficult to identify what exactly comprises compassionate care in nursing practice. This is so because what matters to the nurse as being compassionate, may not matter to the patient. To this end, Adamson and Dewar (2011) suggest knowing the things that matter to patients and responding accordingly is one way of ensuring compassionate care.

The analyzed narratives indicate a high level consensus in relation to participants' conceptualization of compassionate care. The common subthemes which emerged when participants were explaining their conceptualization of compassionate care included: individualized nursing care, empathy, love and commitment

Martin and McFerran (2008) defines individualized care as care planned to meet the particular needs of one patient, as opposed to a routine applied to all patients suffering from the same disease. Individualized care is considered an important indicator of quality nursing care (Suhonen, Valimaki, & Leino-kilpi, 2005). Individualization is considered a particularly important feature of nursing care by nurses, patients and their families, and by health care administrators. Descriptions in the literature suggest that individualized care requires some background knowledge of the patient, which nurses use to devise care plans that treat each patient as unique.

The participants conceptualized 'compassionate care' as delivering 'individualized care' because individualized care leaves no stone unturned as long as patient care is concerned. This is because one of the characteristics of individualized care is meeting the physical, psychological, emotional, spiritual and cultural needs of the patient as a unique being. The participants' conceptualization concurs with Potter & Perry (2009) who describes compassion in nursing as demonstrating to patients that they matter as individuals, which links to the Scottish Government's (2010) statement which partly states that 'compassion is a response of humanity and kindness to all individuals in pain, distress, anxiety or need.'

Furthermore, the findings correspond with Bray et al. (2014) study findings which revealed that respondents understood compassionate care as care which involves patients in their care, and providing individualized care. This necessitates the importance of teaching undergraduate nursing students the 'Nursing Process'; a nursing profession tool based on

Jean Orlando's Nursing Process Theory. The nursing process acts as a guide to provision of individualized care by assisting the nurse to identify a patient's health care status, actual and potential health problems, establish plans to meet the identified needs and deliver specific nursing interventions to address those needs (Levy-Malmberg, 2014).

The current study findings revealed that students recognize empathy as one character which nurses are expected to have in order to provide compassionate care. This concurs with Bray et al (2014) findings which indicate that acting with empathy, warmth and respect was the highly rated attribute of compassionate care by qualified professionals and pre-registered students at Edge Hill University in the United Kingdom. *The Mosby Dictionary of Medicine, Nursing & Health professions* (2010) describes empathy as a vital component of therapeutic relationship involving having awareness of, and insight into the biopsychosocial experiences of another person.

Similarly, Roach (2007) analyses compassionate care in nursing as care which requires immersion into the pain, brokenness, fear, and anguish of another, even when that person is a stranger. Empathy is known to increase prosocial (helping) behaviors (Brooker, 2010). Furthermore, Von Dietze and Orb (2000) stipulates that empathy is viewed as the 'hook' into another person's emotions and it enables nurses to interpret the feelings, thoughts or perceptions of another person so as to provide professional care.

Additionally, Baumal (2004, p.833) asserts that empathy begins with gaining an insight into the patients concerns, feelings and sources of distress. In other ways, knowing what matters to the patient. In turn, this produces compassion, that is; a feeling of discomfort produced by the distress of another person. Compassion leads to a desire to remove the cause of distress or at least to alleviate it. Compassion is therefore a reaction to empathy. This indicates that without 'empathy' nurses cannot practice compassionate care. No wonder that

studies on compassionate nursing care have shown that empathy is indispensable in the provision of compassionate nursing care (Curtis et al., 2012; Msiska et al., 2014).

The study results also characterized compassionate care as care that is built on love; love for the nursing profession and love for the patients. From the participants' narratives, it was clearly exposed that majority of the qualified nurses in the clinical area lack love when providing care. This was evident when some participants described some nurses as heartless, rude, do not love their job and patients, some joined the profession because they had no options, just to mention a few. This concurs with Rankin (2013) who argues that in times of economic austerity, students are likely to persevere with programs of study because of limited alternatives. It is therefore difficult for such students to provide compassionate care when they qualify. Supporting his argument, Cho, Jung, and Jang (2010) revealed that of 40 student nurses in Korea who had chosen to join the nursing profession, none identified the altruistic quality of desiring to care as a motivating factor; but cited salary and job security instead. It is for this reason that the researcher challenges the nurse educators to be critical when recruiting nursing students. Additionally, Corder (2014) advocates for values-based recruitment in nursing training to ensure the right people enter the profession.

Nursing profession literature clearly indicates that nursing is about caring. Love adds beauty, joy and satisfaction to the practice of nursing and also to the caring process (Emakpor & Nyback, 2010). Ericksson (2001) stipulates that one reason for suffering is the lack of care, and the motive for caring is love. Lack of love can therefore be concluded to be the reason for the lack of care. His assertions are supported by Jean Watson's Theory of Human Caring which puts caring and love together for a new form of deep, transpersonal caring (Watson, 2006).

Furthermore, study findings revealed that some students conceptualize compassionate care as altruism. Altruism means selflessness, or can be understood as having the scope to transcend the religious and spiritual sphere as being based upon relatively contemporary humanistic ideas (Carter, 2014). This is consistent with Nouwen et al. (1982) who assert that compassion means 'full immersion into the condition of being human'. Nursing profession literature has shown that the core function of nurses is caring. Nursing offers humanity services which require some emotional investment as well as the capacity to align one's emotions to the norms and values of the profession (Christiansen & Jensen, 2008).

Caring in nursing is defined as 'the mental, emotional and physical effort involved in looking after, responding to, and supporting others' (Baines et al. cited by Msiska, Smith & Fawcett, 2014). More often, the emotional effort is neglected. However, emotional effort and concern in the suffering of others is crucial in providing compassionate care (Msiska et al., 2014). Johnson et al (2007) suggest that the value of altruism has been eroded over the past decades owing this to an overall decline in altruism in society. Additionally, Firth-Cozens and Cornwell (2009) suggest that a variety of reasons may be responsible for the decline in altruism, and cited evolving role of the nurse, high levels of stress and burnout, organizational issues related to the dynamic nature of modern day health care and the influence of nurse education as some factors along with general decline that are potentially affecting levels of compassionate activity.

In their study on 'emotional learning within the framework of nursing education,' Christiansen and Jensen found that peer learning in form of role-play can facilitate emotional qualities in student nurses hence facilitating cultivation of caring and compassionate conduct in relation with patients.

Factors Influencing Development of Compassionate Care

There has been discussion regarding the role of health professional education in influencing the development of compassionate practice (Bray et al., 2014, p.481). Therefore, the second aim of the study was to learn how nursing students develop compassionate care. The study findings reveal that development of compassion in nursing students is associated with their background in community socialization and experiences during training. The practice environment in which students learn should also not be underestimated as this is where professional socialization occurs (Bray, et al. 2014).

In the current study, most participants attributed their ability to develop and provide compassionate nursing care to their role models during training. These findings are consistent with Straughair (2012) who asserts that role models can best show students that compassion is a fundamental behavior by demonstrating their own commitment to the concept. The role models comprise lecturers, clinical instructors and qualified nurses in the clinical area. Given the pivotal role of mentors to students development of compassionate care, Bray et al. (2014) suggest it is essential that nursing training institutions and health institutions where nursing students do their clinical practice work together to ensure that mentors are effectively prepared, supported and developed to allow compassionate care to flourish in practice.

Additionally, Role modeling is one of the advocated innovative teaching strategy in nursing education. Firth-Cozens and Cornwell (2009) advocated that acting as a role model for the delivery of compassionate care will demonstrate its importance as a fundamental value to students and less experienced staff. Similarly, Loveday (2012) noted that for a vision to be communicated, it must be apparent in everything you do; consequently, the responsibility for clinical nurses and lecturers to act as appropriate role models remains crucial. Supporting these assertions, Bradshaw (2014) maintains that in a quickly changing

environment, it is not enough for nurse leaders/educators in the nursing profession to "talk the walk" they also need to "walk the walk" to understand and recognize their staff's/students challenges and achievements.

However, the study results have indicated that despite participants citing role modelling as a way that facilitates their development of compassionate care; it was evident in the study findings that students are observing more negative models than positive ones in their training. This is dangerous and degrading to the nursing profession in terms of developing compassionate care givers. Bandura's (1977) social learning theory states that individuals learn in the social environment through the observation of others actions. Alain (1989) cited by Straughair (2011) asserted that, when learners are unable to discriminate positive from negative role modeling in practice, there is a risk they may perpetuate negative behaviors. This is why Bray et al. (2014) state that the impact of the practice environment should never be underestimated in relation to students' development of compassionate care.

Additionally, all the participants narrated a story in which they feel they rendered compassionate care despite being given the opportunity to narrate any experience in which they feel a patient received compassionate care. Only two participants narrated their experience with compassionate nurses. This indicates that compassionate nurses are a rare species in the clinical setting, henceforth proving the 'lack of compassion in current nursing' notion true. This agrees with study findings which indicate that there is lack of compassion in current nursing (The Patients Association, 2009; Mid Staffordshire NHS Foundation Trust Inquiry, 2010a; b; Parliamentary and Health Services Ombudsman, 2011; Simwaka et al., 2014). This is further supported by Chambers and Rider (2009) assertion that 'compassion' once seen as the essence of caring and therefore the essence of nursing is no longer always the central focus of nursing practice. Despite all sentiments about lack of compassionate care,

compassion remains a fundamental and essential moral value of the caring role (Von Dietze & Orb. 2000; Bray et al., 2014).

The study results also indicate that caring concepts taught in class assist students to deliver compassionate care. This indicates the importance of theory in cultivating compassionate care. Knowledge assist students to make informed decisions to achieve quality compassionate care. Roach (1985) cited by Costello and Haggart (2012) suggests 5 Cs of caring concepts and they include: compassion, competence, confidence, conscience and competence. It is therefore the role of nursing education to ensure that curricula is designed in a way that the learner understands such concepts and develops relevant skills to provide compassionate care before graduating. Brown (2011) and McLean (2012) cites a caring or values-based curriculum as a fundamental approach to enable learners to develop the person-centered values needed to become more effective compassionate practitioners. In their mixed methods study on exploring the perceptions of health professionals and pre-registration students, Bray et al. (2014) found that although compassion was seen to impact on all aspects of care, being a knowledgeable, safe and experienced practitioner was of higher importance in nursing.

Furthermore, stories of lecturers caring experience also emerged as a factor that contributes to students' development of compassionate care. One theory in educational research holds that humans are storytelling organisms who, individually and socially, lead storied lives (Connelly & Clandinin, 2014). Stories are teachings of the heart. Huber et al. (2013) stipulate that throughout the ages and across cultures story continues to express the fundamental nature of humanity. Stories carry and inspire significant obligations and responsibilities: they are at the heart of how we make meaning of our experiences of the world. This entails nursing as a culture/discipline the possibility of transferring the essence of

caring through stories. These findings inform nurse educators the importance of sharing compassionate caring experiences with students as a teaching strategy for promoting compassionate care development.

Additionally, study findings indicate that community socialization in form of cultural and religious values and beliefs assist student nurses as individuals to develop compassion for a fellow human being who is suffering. Through socialization one learns value for life, spiritual and cultural foundations laid early in one's life instill the culture and conviction of valuing life up to the end. It was evident in some participants' narratives that culture and religion informs their perception of the service of humanity. It has been argued that the representation of the compassionate God in scripture and the message to followers to practice this moral virtue underpins the core value of compassion in nursing today (Kapelli, 2008). The author claims that the Holy Bible illustrates examples of a compassionate God, who provides moral direction to followers of the faith. Furthermore, the author also discusses the parable of a Good Samaritan and highlights its influence in teaching Christians to be compassionate in their actions.

Similarly, Arbuckle (2007) argues that the inherent message of the Good Samaritan is that compassion should be the universal standard. Armstrong (2011) further elaborates this key message and highlights the principle of the Golden Rule as the key philosophical message of Christian scripture: *'always treat others as you would wish to be treated yourself'* (Armstrong, 2011). These assertions are supported by nursing profession literature which reflects the value Nightingale placed on compassion. Additionally, various nursing professionals have highlighted the moral virtues of the professional nurse: kind, compassionate and technically competent (Bradshaw, 2011). This challenges nurse educators

to recruit students with a religious affiliation to ensure that appropriate people to practice compassionate care enter the nursing profession. However, this provokes another debate.

Despite students' experiences of the challenging clinical practice environment, it was calming to note that participants in the study were able to discriminate compassionate care from care which lacked compassion. This indicates that students learn and understand the concept of compassion before graduating. Illington (2006) suggested that nursing students undergo a process of professional socialization, involving the transfer of attitudes, values and beliefs from experienced nurse to less experienced nurse. This is why Firth-Cozens & Cornwell (2009) advocated that acting as role model for the delivery of compassionate care will demonstrate its importance as a fundamental value to students and less experienced nurses. Hence there is need to emphasize the need to act as role models to others, in terms of developing and delivering high-quality compassionate care.

Factors Enabling Compassionate Care

The study findings indicate that compassionate care practice is a nursing profession behavior that can be reinforced by recognizing those practicing it. This concurs with Dewar and Nolan (2013) who assert that compassionate-centered care should be valued and accorded status as it involves risk taking by those practicing it. Although literature has shown that compassion does not only benefit the recipient of care, but it also benefits the care provider as it gives the nurses who practice their profession in this manner self-gratification for the provided emotional support. Morris (2006) stipulates that caring is emotionally rewarding. It is believed that nurses who feel a sense of concern for their patient's well-being typically enjoy their jobs more than those who focus less on the emotional side of the profession. In her study, 'Compassion in care' Van der Cingel (2011) found that compassion

is a valuable process which motivates patients as well as nurses to cooperate in achieving relevant outcomes of care. Additionally, participants in the current study recommend that nurses who are practicing compassionate care should be recognized by giving them awards or by giving them titles like nurse of the month/ nurse of the year like what some hospitals are already doing. In this case, recognition will act as a reinforcer for the delivery of compassionate care.

Commitment also surfaced in the study findings as a means of achieving compassionate care. This issue was closely linked to the pledge of service which nurses recite when commencing training and upon qualifying for the noble course of serving human kind. Other participants discussed that nurses who are committed to caring cling to what they pledged and this assist them to deliver compassionate care as compassion is one of the virtues in the nurses' pledge. From the participants' narratives, it was revealed that despite the challenging working environment in terms of shortage of staff and lack of essential drugs and supplies, some nurses could still care. This demonstrates commitment to their job of caring.

Additionally, study findings indicate that incidents of bad past caring practices or experiences facilitate provision of compassionate care as nurses do not want to re-embrace similar experiences. Other participants narrated that some nurses learn to practice compassionate care in a hard way. The participants argued that when there are bad health care outcomes because the nurse failed to deliver compassionate care, guilt builds in that nurse and he/she does not want to re-embrace that experience hence he/she changes his approach to caring by becoming more compassionate with patients. Some authors have termed this 'once beaten, twice shy.'

According to the current study findings, delivering compassionate care in Malawian clinical settings is challenging as the hindering factors outweigh the enabling factors. The hindering factors on compassionate care have been discussed in the sequel heading.

Hindrances to Compassionate Care

The study findings also exposed some challenges associated with compassionate care provision in most clinical settings in Malawi. Study participants mentioned lack of support systems in the clinical environment like supplies and resources, role models, and clinical supervision as some factors hindering provision of compassionate care.

The clinical environment in Malawi is characterized by nursing shortage and lack of equipment and supplies (Msiska, Smith & Fawcett, 2014). According to the current study findings, these challenges impact on nurses' provision of compassionate care. Some study participants indicated that the working environment for nurses has more workload to the extent that nurses cannot manage to meet all patients' needs in a compassionate manner as they are overwhelmed with work. Consequently, nurses usually resolve this by providing routine care which does not meet individual patient's needs. This supports study findings by Msiska, Smith and Fawcett (2013) who assert that the performance of clinical nurses in Malawi is adversely affected by excess workload imposed on them due to shortage of nurses and gross lack of resources. This consequently hinders provision of optimal, effective and compassionate care to patients.

Additionally, working in such environments leads to substantial workforce burnout, impaired performance and negative attitudes. Burnout is a psychological term for the negative response to chronic job-related emotional stress (Thorsen, Tharp & Meguid, 2011). Similarly, Firth-Cozens and Cornwell (2009) identified stress and burnout as key factors in

reducing the occurrence of compassionate care as these can cause nurses to depersonalize patients. To this end, the current study findings have shown that such challenging working environments and other related factors like lack of supervision and peer pressure contribute to low morale for nurses to deliver compassionate care.

Lack of supervision in the clinical setting was another factor which came out in the study as a contributing factor to lack of compassionate care in practice. The participants clearly indicated that nurses know that they are expected to provide compassionate care, but they deliberately choose not to be compassionate because there is no supervision. This is why it is recommended in literature that appropriate support systems must be in place to enable compassionate practice flourish in nursing care (Straughair, 2012; Dewar & Nolan, 2013).

Some participants indicated that performance is enhanced when one is supervised. According to participants' narratives this supervision should not be policing type of supervision, but it should be supportive supervision. Bradley et al. (2013) found that the current supervision paradigm in Malawi is centered on inspection and control. Such supervision was observed to be problematic by health workers as its language was couched in terms of fault-finding, poor performance and weakness. It was therefore recommended by study participants that there is need to move to supportive supervision as this will help health workers address the challenges they are facing and acknowledge the good work that they do, hence moving from the inspection and control paradigm (policing type of supervision) to support and improvement paradigm.

Study Recommendations

The recommendations for this study have been drawn from the findings of the current study and from other studies which were utilized in the literature review and discussion of the

study findings. The recommendations have been made to nurse educators, curriculum planners, nursing regulatory body and clinical staff who are the main players in ensuring that students are equipped with the necessary skills, attitudes and competences in providing compassionate care. It is hoped that the recommendations will be implemented and the study will have positive implications for nursing education, nursing research and nursing practice.

Nurse Educators

Nurse educators as core mentors of nursing students need to act as role models in providing compassionate care. Nurse educators should demonstrate caring behaviors to students. In the current study, it was revealed that some nurse educators are harsh to students and this indicates lack of compassion. Firth-Cozens and Cornwell (2009) advocate that acting as a role model for the delivery of compassionate care will demonstrate its importance as a fundamental value to students and less experienced staff.

Additionally, Nurse Educators should ensure that students are learning within clinical environments where compassion can flourish. This can be achieved through proper scouting and collaboration between educational institutions and health institutions. This recommendation draws on the work of Msiska (2012) who posits that the preparation of nursing students for their role as future nurses is a shared responsibility between teaching institutions and health care institutions. Furthermore, Christiansen et al. (2015) found that an optimistic environment characterized by leaders who act as role models is one of the key enablers to compassionate care practice.

Furthermore, nurse educators should design educational and assessment tools and methods that will help nurses effectively deliver compassionate care. For example, by employing innovative teaching strategies which promote reflective practice. Christiansen and

Jensen (2008) consider role-play a good teaching strategy which provides opportunity for students to verbalize experiences, and to comment and reflect on each other's performance. This is believed to promote caring and compassionate conduct.

Curriculum Planners

We share the recommendation by Adamson and Dewar (2011) who stipulate that the nursing curriculum should be developed in a manner that can assist students to develop compassionate caring knowledge and skills.

Clinical Staff

The study findings indicate that the clinical environment in Malawian health institutions leaves a lot to be desired in as far as efforts to deliver compassionate care are concerned. However, hope is not lost as findings also indicated that there are still some nurses who are caring compassionately despite all the outlined barriers in practice. It is therefore recommended that clinical nurses should act as role models to students. This is crucial as students professional socialization mainly occur in the clinical setting (Msiska, Smith & Fawcett, 2014).

According to Straughair (2012) appropriate support systems must be in place to enable nurses demonstrate compassionate behaviors. It is therefore recommended that nurses in managerial positions in the clinical area should ensure that adequate support is provided for compassionate care to flourish and be a norm in practice. This can be achieved by conducting in-service training on compassionate care, ensuring that essential drugs and supplies are available and providing supportive supervision.

Furthermore, it is recommended from the study findings that those practicing compassionate care should be recognized. In this case, recognition will reinforce compassionate behaviors. This concurs with Dewar & Nolan (2013) who assert that compassionate-centered care should be valued and accorded status as it involves risk taking by those practicing it.

Nursing Regulatory Body

Loveday (2012) noted that for a vision to be communicated, it must be apparent in everything we do. Therefore, apart from nurse educators, curriculum planners and clinical nurses' role of promoting compassionate care, there is need for the Nurses and Midwives Council of Malawi to incorporate the concept of compassion in their licensure examinations and the routine quality assessment exercises for nursing education institutions and health care institutions. This will emphasize the need for compassion in nursing practice.

Implications of the Study

Nursing Education

The findings of this research study have shed light on the impact of education in developing compassionate nurses. As the public is crying for compassionate nursing care, it is recommended that active role modeling by nurse educators and clinical nurses may be a potent tool for nurturing compassion in students and clinical staff. This will promote the quality of nursing education.

Nursing Research

The study can be replicated in other nursing training institutions to make transferability of the findings possible. Some hypotheses can be formulated from the findings and be tested to add to the body of knowledge in nursing education.

Nursing Practice

Compassion is considered one of the qualities of an exemplary nurse and understanding the meaning of compassion is important to nursing professionals. In the conclusion of her concept analysis of compassion, Schantz (2007) stated "…. Nothing less than compassion can empower nursing to assume major roles in solving or preventing problems afflicting the global community." Nursing practice will benefit from this study in that the recommendations will emphasize the need for compassionate care. As a result, nurses will become more compassionate in care provision hence providing quality care to the public which will consequently lead to better health care outcomes. As Youngson (2008, p.4) suggested, "Investing time up front to check a patients need (for compassion) increases efficiency, safety and patient satisfaction."

Areas for Further Study

The current study has touched on many important issues that could not be investigated within the scope of this study. In this section, recommendations for further research are based on insights from the current study. This study investigated the experiences of nursing students in developing and providing compassionate care. However, there are other groups of people like nurse educators, clinical staff and care recipients whose side of the story is worth investigating in order to have a feel of their understanding and how best they feel we can

improve and imbed the culture of compassionate care in the healthcare delivery system. The researcher therefore recommends further research on the following areas:

- Exploratory study to establish what compassionate care entails within a Malawian culture.
- Exploratory study on how compassion can be taught and measured, as well as the notion and effects of compassion satisfaction and compassion fatigue, before nurse educators can be sure of designing education tools and methods that will help nurses effectively deliver compassionate care in practice.
- Experiences of nurse educators in teaching compassionate care.
- Exploratory study on compassionate care provision in the perspective of qualified nurses' experiences.

Study Strength

Literature search did not yield much relevant information on how nursing students develop compassion in Malawi. Therefore, it is apparent that this study emerges to be the first study to be conducted in a Malawian setting. This will help provide a basis for future research regarding developing compassionate care in nursing students.

Study Limitations

Time was a major constraint as the study was done whilst the researcher was doing other assignments and it had to be done within a time line. The study was conducted at KCN Lilongwe and Blantyre campuses only and involvement of more nursing training institutions is needed in future research as the sample used in current research may not truly be

representative of all nursing students' population. However, the findings are significant and provide the whole valuable insight into issues affecting compassionate care development and provision in nursing in Malawi. It was difficult to find relevant related literature on compassionate care in Africa because most studies were done outside Africa. Scanty literature on compassionate care exist in Malawian studies.

Conclusion

The findings in this study portrays how nursing students at KCN conceptualize compassionate care. Significantly, the study has revealed that stories of lecturers caring experiences can be a useful tool in helping students develop compassionate care behaviors while harsh treatment which students get from their lecturers hinders compassionate care development.

Additionally, some findings in the current study are consistent with research findings in various developed countries like America and England. Lack of compassionate care is indeed a global concern which has not spared the nursing practice in Malawi. Role modeling is the most advocated means of developing compassionate care behaviors in students and less experienced nurses.

Furthermore, the findings have also uncovered some salient issues that enable and hinder compassionate care provision in Malawi. Some elements which may assist nurse educators improve on how classroom instruction should be given to promote compassionate care are discussed. The results have been discussed with relevant literature and recommendation for nurse educators, curriculum planners, nurse practitioners and the regulatory body have been made. Implications for nursing education, practice and research have also been discussed. This will consequently improve quality of care.

Reference

Adamson, E., & Dewar, B. (2011). Compassion in the nursing curriculum: Making it more explicit. *Journal of Holistic Healthcare, 8*(3), 42–45.

Armstrong, A. E. (2006). Towards a strong virtue ethics for nursing practice. *Nursing Philosophy*, *7*(3), 110–124.

Baillie, L., & Black, S. (2015). *Professional values in nursing*. Boca Raton, FL: CRC Press.

Baughan, J., & Smith, A. (2008). *Caring in nursing practice*. Harlow: Pearson Education.

Boykin, A., & Dunphy, L. (2002). Justice making: Nursing's call. *Policy, Politics & Nursing Practice, 3*(1), 14–19.

Bradley, S., Kamwendo, F., Masanja, H., de Pinho, H., Waxman, R., Boostrom, C., & McAuliffe, E. (2013). District health managers perceptions of supervision in Malawi and Tanzania. *BioMed Central, 11*(43). **Doi:** 10.1186/1478-4491-11-43

Bradshaw, A. (2014). Relink education with practice to restore compassion to nursing. *British Medical Journal, 348*(22), 7965. **doi: http://dx.doi.org/10.1136/bmj.g3310**

Bramley, L., & Matiti, M. (2014). How does it really feel to be in my shoes? Patients experiences of compassion within nursing care and their perceptions of developing compassionate nurses. *Journal of Clinical Nursing, 348*(19-20), 2790–2799.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Bray, L., O'Brien, M. R., Kirton, J., & Zubairu K. et al. (2014). The role of professional education in developing compassionate practitioners: A mixed methods study exploring the perceptions of health professionals and pre-registration students. *Nurse Education Today, 34*(2014), 480–486.

Brown, L. P. (2011). Revisiting our roots: Caring in nursing curriculum. *Nurse Education in Practice*, *11*(6), 360–364. https://doi.org/http://dx.doi.org/10.1016/j.nepr.2011.03.007

Burns, N., & Grove, S. K. (2009). *The practice of nursing research, appraisal, synthesis and generation of evidence* (6th ed.). St. Louis: Saunders Elsevier.

Carter, M. (2014). Vocation and altruism in nursing: The habits of practice. *Nursing Ethics*, *21*(6), 695–706. https://doi.org/10.1177/0969733013516159

Chambers, C., & Ryder, E. (2009). *Compassion and caring in nursing*. Oxford: Radcliffe Publishing.

Cho, S., Jung, S., & Jang, S. (2010). Who enters nursing schools and why do they choose nursing? A comparison with female non nursing students using longitudinal data. *Nurse Education Today*, *30*(2), 180–186.

Christiansen, A., O'Brien, M. R., Kirton, J. A., Zubairu, K., & Bray, L. (2015). Delivering compassionate care: The enablers and barriers. *British Journal of Nursing. 24 (16),* 833-837.

Christiansen, B., & Jensen, K. (2008). Emotional learning within the framework of nursing education. *Nurse Education in Practice*, *8*(5), 328–334.

Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry: Experience and story in qualitative research.* San Francisco: Jossy-Bass Publishers.

Corder, K. (2014). How to recruit caring and compassionate HCAs. *Nursing Times*, *110*(13), 20–22.

Cummings, J. (2012). *Compassion in practice. Nursing, Midwifery and Care Staff. Our Vision and Strategy. NHS Commissioning Board.* Available at: http://www. england. nhs. uk/wp-content/uploads/2012/12/compassion-in-practice. pdf [accessed 5 May 2016].

Curtis, K., Horton, K., & Smith, P. (2012). Student nurse socialization in compassionate practice; A Grounded Theory Study. *Nurse Education Today*, *32*(7), 790–795.

Davison, N., & Williams, K. (2009). Compassion in nursing: Defining, identifying and measuring in this essential quality. *Nursing Times*, *105*(36), 16–18.

Department of Health. (2012). *Patients first and foremost: The initial government response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (Vol. 8576). London: The Stationery Office.

Dewar, B., & Nolan, M. (2013). Caring about caring: Developing a model to implement compassionate relationship centered care in an older people care setting. *International Journal of Nursing Studies*, *50*(9), 1247–1258.

Eason, T. (2009). Emotional intelligence and nursing leadership; A successful combination. *Creative Nursing*, *15*(4), 184–185.

Eley, R., Eley, D., & Rogers-Clark, C. (2010). Reasons for entering and leaving nursing: an Australian regional study. *Journal of Advanced Nursing*, *28*(1), 6–12.

Fingeld-Connett, D. (2008). Meta-sythesis of caring in nursing. *Journal of Clinical Nursing*, *17*(2), 196–204.

Heffernan, M., Quinn Griffin, M. T., McNulty, S. R., & Fitzpatrick, J. J. (2010). Self-compassion and emotional intelligence in nurses. *International Journal of Nursing Practice*, *16*(4), 366–373.

Holloway, I., & Wheeler, S. (2010). *Qualitative research in nursing and healthcare* (3rd ed.). Chichester: Wiley-Blackwell.

Kavinya, T. (2008). Do you think doctors are practicing compassionate medical ethics? *Malawi Medical Journal*, *20*(2), 71.

Lemonidou, C., Papathanassoglou, E., Giannakopoulou, M., Patiraki, E., & Papadatou, D. (2004). Moral professional personhood: ethical reflections during initial clinical encounters in nursing education. *Nursing Ethics*, *11*(2), *122-137*.

LoBiondo-Wood, G., & Huber, J. (2014). *Nursing research: methods and critical appraisal for evidence-based practice* (8th ed.). St. Louis: Elsevier.

Maben, J., Cornwell, J., & Sweeney, K. (2010). In praise of compassion. *Journal of Research in Nursing*, *15*(1), 9–13.

Maben, J., & Griffiths. (2008). *Nurses in society: Starting the debate*. London: Kings College.

Malenga, B. (2016 July 10). *Malawian nurse arrested for attempted rape on a patient*. Retrieved from https://malawi24.com/2016/07/10/malawian-nurse-arrested-attempted-rape-patient/

Marshall, C., & Rossman, G. B. (2011). *Designing qualitative research* (5th ed.). Los Angeles: Sage.

Martin, E., & McFerran, T. (2008). *A Dictionary of Nursing*. Oxford: Oxford University Press,

McLean, C. (2012). The yellow brick road: A values based curriculum model. *Nurse Education in Practice*, *12*(3), 159–163.

Morris, P. (2006). *Want a rewarding and challenging career? Then try social care.* London Borough of Hounslow. Retrieved from http://www.hounslow.gov.uk/22_feb_rewarding_challenging_career.htm

Mosby, (2010). *Mosby's Dictionary of Medicine, Nursing & Health Professions.* London: Elsevier Health Sciences.

Moule, P., & Goodman, M. (2009). *Nursing research: An introduction*. London: Sage.

Msiska, G., Smith, P., & Fawcett, T. (2014). Emotive responses to ethical challenges in caring; A Malawian perspective. *Nursing Ethics*, *21*(1), 97–107.

Msiska, G., Smith, P., & Fawcett, T. (2014). Exposing emotional labour experienced by nursing students during their clinical learning experience: A Malawian perspective. *International Journal of Africa Nursing Sciences*, 1(2014), 43–50.

Msiska, G., Smith, P., Fawcett, T., & Nyasulu, B. M. (2014). Emotional labor and compassionate care: What's the Relationship? *Nurse Education Today, 34(9), 1246-1252.*

Neuman, W.L. 2011. *Social research methods: qualitative and quantitative approaches*.7th ed. Boston: Allyn & Bacon.

Nurses and Midwives Council of Malawi. (2008). Nurses pledge of service. Lilongwe: Malawi

Nyasa Times Reporter (2011, October, 10). Parents accuse Mwaiwathu of medical negligence for child's death. *Nyasatimes*. Retrived October 20, 2014 from http://www.nyasatimes.com/parents-accuse-mwaiwathu-of-medical-negligence-for-childs-death/

Nyasa Times Reporter (2014, July, 24). Nurse Arrested for Stealing Drugs in Karonga. *Nyasatimes.* Retrived October 18, 2014 from http://www.nyasatimes.com/nurse-arrested-for-stealing-drugs-in-karonga/

Oxford Dictionary of English. (2009): Oxford: Oxford University Press.

Parahoo, K. (2006). *Nursing research: principles, process and issues*.2nd ed. London: Palgrave Macmillan.

Polit, D., & Beck, C. (2010). *Essentials of nursing research: appraising evidence for nursing practice* (7th ed.). Philadelphia: Lippincott Williams & Wilkins.

Polit, D. F., & Beck, C. T. (2011). *Essentials of nursing research : Appraising evidence for nursing practice* (7th ed.). Philadelphia: Lippincott Williams & Wilkins.

Pondani, M. (2013, November, 4). Council for better nursing standards in Malawi. *Bnltimes*. Retrieved from http://timesmediamw.com/council-for-better-nursing-standards-in-malawi/

Potter, P. A., & Perry, A. G. (2009). *Fundamentals of nursing* (7th ed.). Mosby: Elsevier.

Price, B. (2013). Promoting compassionate care through learning journey. *Nursing Standard, 27*(48), 51–57.

Rankin, B. (2013). Emotional intelligence: Enhancing values-based practice and compassionate care in nursing. *Journal of Advanced Nursing*, *69*(12), 2717–2725.

Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes. *Field Methods*, *15*(1), 85–109.

Schantz, M. (2007). Compassion: a concept analysis. *Nursing Forum, 42*(2), 48–55.

Schmidt, N. A., & Brown, J. M. (2012). *Evidence based practice for nurses: appraisal and application of research* (2nd ed.). Ontario: Jones & Bartlett Learning.

Simwaka, A. N. ., de Kok2, B., & Chilemba, W. (2014). The women's perceptions of Nurses-Midwives caring behaviors during perinatal loss in Lilongwe, Malawi: An exploratory study. *Malawi Medical Journal*. *26*(1), 8-11.

Speziale, H. J. S., & Carpenter, D. R. (2007). *Qualitative research in nursing*. Philadelphia: J.B. Lippincott Company.

Straughair, C. (2012). Exploring Compassion: Implications for contemporary nursing. Part 1. *British Journal of Nursing*, *21*(3), *70-74*.

Straughair, C. (2012). Exploring Compassion: Implications for contemporary nursing. Part 2. *British Journal of Nursing, 21*(4), *93-97.*

Streubert, H. J., & Carpenter, D. R. (2011). *Qualitative research in nursing: Advancing the humanistic imperative*. Philadelphia: Wolters Kluwer.

Suhonen, R., Valimaki, M., & Leino-kilpi, H. (2005). Individualized care, quality of life and satisfaction with nursing care. *Journal of Advanced Nursing*, *50*(3), 283–292.

The Mid Staffordshire NHS Trust Foundation Inquiry. (2010). *Independent inquiry into care provision by Mid Staffordshire NHS Foundation Trust. January 2005-March 2009. Vol 1. Chaired by Robert Francis QC*. London: The Stationery Office.

The Parliamentary and Health Service Ombudsman. (2010). *Care and Compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people*. London: The Stationery Office.

The Royal College of Nursing. (2010). *Principles of nursing practice: Principles and measures consultation summary report for nurse leaders*. London: RCN.

The Willis Commission Report. (2012). *Quality with compassion*. London: Kings College.

Thornsen, V., Teten Tharp, A., & Meguid, T. (2011). High rates of Burnout among maternal health staff at a referral Hospital in Malawi: A cross-sectional study. *BioMed Central Nursing, 10*(9). Retrieved from http://www.biomedcentral.com/1472-6955/10/9

Van der Cingel, M. (2014). Compassion: The missing link in quality of care. *Nurse Education Today*, *34*(9), 1253–1257.

Von Dietze, E., & Orb, A. (2000). Compassionate care: A moral dimension of nursing. *Nursing Inquiry*, *7*, 166–174.

Watson, J. (2006). Caring theory as an ethical guide to administrative and clinical practice. *Nursing Administration Quartery*, *30*(1), 48–55.

Wiersma, W., & Jurs, S. G. (2009). *Research methods in education: An introduction* (9th ed.). Boston: Pearson.

Appendices

Appendix 1: Students information letter on 'Providing compassionate nursing care; Experiences of nursing students at Kamuzu College of Nursing: Malawi.

Dear participant,

My name is Squaiker Alice Bwanali and I am currently registered as a student here at Kamuzu College of Nursing for the degree of Master of Science in Nursing Education. I am conducting a research project on the study mentioned above**.**

The aim of the study is to explore students' experiences in providing compassionate nursing care in Malawi: therefore, those willing to participate should have a story to narrate about a patient who they feel they cared for '**compassionately.'**

Please be aware that participation in the study is entirely voluntary. You may choose to participate or withdraw from the study at any time, which will not have any effects on your studies or academic performance. The study does not have any foreseeable physical harm (risks) to you as participants. However, in cases of any emotional or psychological harm you may forward your concerns and complaints to the researcher at Kamuzu College of Nursing.

I appreciate that you will derive no benefit from participating in the study. However, it is hoped that the completed study will clarify nurse educators understanding on how best compassion can be developed or promoted in nursing students, hence improving approaches to unlocking this important attribute in caring and furthermore improving quality of nursing care in Malawi. No reports in this study will identify you in any way and results of the study will be given to you should you so wish. The interviews will be tape recorded but the recordings will be handled with confidentiality.

Should you agree to participate, I will ask you to sign a consent form on the space provided to indicate that you have accepted to be interviewed. It is anticipated that the interview will take 40 minutes to 1 hour of your time and the interview will be conducted at a time that is most suitable and convenient to you in a quiet environment to ensure privacy and to avoid any disturbances.

The study has been approved by College of Medicine Research Ethics Committee (COMREC) and the Principal for your college has approved the study and its procedures.

Thank you for taking time to read this information letter. Should you require any further information regarding the study or your rights as study participant you are free to contact me on the following numbers: 0888516548 or 0882641822? Or, the chairperson, COMREC Secretariat, P/Bag 360, Chichiri, Blantyre 3 or you may call on 01989766.

Appendix 2: Participant's Informed Consent Form.

Instructions: Please read and sign the form if you are taking part in this study.

I…… (Name), voluntarily give permission to participate in the study.

I have read and understood the contents of the information letter and I have understood the purpose of the study. I have also been given the opportunity to ask questions, where deemed necessary, about the study and its procedures.

I understand that the interviews will be recorded and the information I have given will be kept confidential and will only be accessed by the researcher and/or those people who are directly concerned with the study

I know that I do not have to suffer any harm during the research process and the information that I will give to the researcher should not be used against me in future.

Participant's Signature Date

....

Researcher's Signature Date

…….. …….

Appendix 3: Interview guide

Below is the interview guide for a study on 'Providing compassionate nursing care; Experiences of nursing students at Kamuzu College of Nursing, Lilongwe, Malawi.

Date ……. Participant Code: ...…….

Part A: Demographic data

1. Age group in years

15 - 20	
21 – 25	
26 – 30	
Above 30	

2. Sex

Male	
Female	

3. Marital status

Single	
Married	
Divorced	
Widowed	

4. Religion

Christianity	
Islam	
Other	

5. Year of study

Three	
Four	

PART B: interview guide prompt: Participants experiences in providing compassionate nursing care.

Can you share one memorable encounter with your patients/clients in which you feel you delivered nursing care compassionately?

Aide Memoir

How do you feel about the experience?

What makes you feel the care was compassionately provided?

Did you get any support from fellow students or qualified nurses in this experience?

Is there any social or academic support which has assisted you to develop such attributes to care?

From your experience can you share some practical issues which promote or hinder provision of compassionate care in nursing practice?

Do you have suggestions as to how nurse educators can promote development of compassion in nursing students?

Appendix 4: Letter Seeking Permission to Test Research Instrument

Kamuzu College of Nursing

P/Bag 1,

Lilongwe.

16/3/15

The Campus Director Approved

Malawi College of Health Sciences (Blantyre Campus)

P / Bag 396,

Blantyre.

TOPIC: REQUEST FOR PERMISSION TO TEST RESEARCH INSTRUMENT

I am a postgraduate student pursuing a master degree in nursing education at Kamuzu College of Nursing and I write to seek permission to test my research instrument at your college. The study is one of the requirements for the program I am studying and the study topic is 'providing compassionate nursing care; experiences of nursing students at Kamuzu College of Nursing, Lilongwe. Malawi.'

This study will therefore explore the lived experiences of nursing students in learning and providing compassionate care. The study will assist nurse educators understand students' conceptualization of compassionate care and identify strategies that can be put in place in nursing education to facilitate development of compassion in nursing students.

I look forward to your favorable response.

Yours faithfully,

..Bwanali..

Squaiker Alice Bwanali Salema (Mrs.)

0888 516 548

Appendix 5: Letter Seeking Permission to Conduct a Study

University of Malawi

Kamuzu College of Nursing

P/Bag 1.

Lilongwe

University of Malawi
Kamuzu College of Nursing
2015 -01- 26
PRINCIPAL
Private Bag 1, Lilongwe

Attention: The Principal

Kamuzu College of Nursing

P/Bag 1.

Lilongwe.

Dear Madam,

TOPIC: PERMISSION TO CONDUCT A RESEARCH STUDY

I am a Master of Science Degree in Nursing Education student at your institution. In partial fulfillment for the degree, I am required to carry out a research study related to nursing education practice on a topic of my choice. The title of my research project is "providing compassionate nursing care; experiences of nursing students at Kamuzu College of Nursing, Malawi".

I therefore write to seek permission to allow me conduct this study at your institution. The study will be conducted between the months of February and March, 2015.

I am looking forward to your favorable response.

Yours Faithfully,

Bwanali.....

Squaiker Alice Bwanali.

0888 516 548

Approved

A. Malava

27/1/15

Appendix 6: Budget

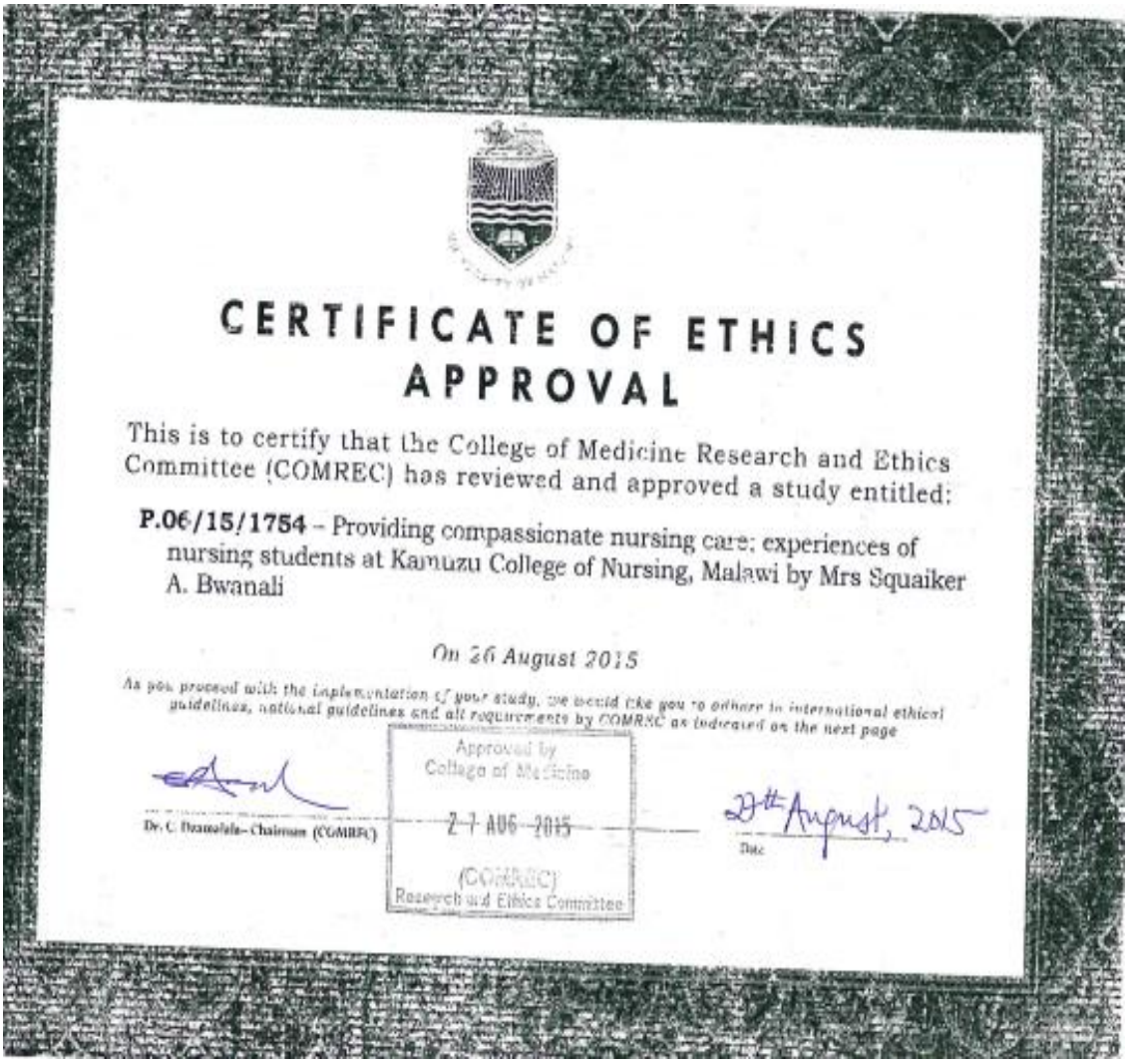
The study required an estimated amount of money worth K160, 000.00 to be used for stationery, food and travelling costs for the investigator and secretarial services, (see Table 3). However, the amount of money sponsored for the research project by NEPI was K75, 000. 00 which is less than half of the total estimated budget. The remainder was footed by the researcher.

Table 3

ITEM	**COST PER ITEM**	**TOTAL COST**
Stationery		
3 Reams of plain papers (A4)	K1,500.00	K4,500.00
4 pens	K100.00	K400.00
5 large envelops	K100.00	K500.00
5 medium envelops	K50.00	K250.00
Recorder		K30,000.00
Secretarial Services		
Printing and Binding of research proposal and letters.		K15,000.00
Printing and binding of thesis		K20,000.00

Allowances		
Payment for the approval of research proposal		K50,000.00
Airtime		K5,000.00
Transport and lunch		K20,000.00
10% of the proposed budget contingency		K14,565.00
GRAND TOTAL		**K160,215.00**

Appendix 7: Certificate of Approval



CERTIFICATE OF ETHICS APPROVAL

This is to certify that the College of Medicine Research and Ethics Committee (COMREC) has reviewed and approved a study entitled:

P.06/15/1754 – Providing compassionate nursing care: experiences of nursing students at Kamuzu College of Nursing, Malawi by Mrs Squaiker A. Bwanali

On 26 August 2015

As you proceed with the implementation of your study, we would like you to adhere to international ethical guidelines, national guidelines and all requirements by COMREC as indicated on the next page

Approved by College of Medicine
27 AUG 2015
(COMREC) Research and Ethics Committee

Dr. C. Dzamalala– Chairman (COMREC)

27th August, 2015
Date