

# Development and Evaluation of Tool to Assess Compassionate Care in Clinical Nursing Practice – A Protocol Review

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## Abstract

**Aim:** The objective of the study is to develop a tool to assess compassionate care in clinical nursing practice.

**Materials and Method:** A mixed-method approach was adopted for the study. The study will be conducted in three phases. Phase 1 includes conceptualization and item generation through theoretical and fieldwork. Phase 2 is the preliminary evaluation of items through pretest, face validity, and content validity. Phase 3 includes the scale refinement, final validation, and comparing the scale items with Jean Watson's 10 carative factors. Data analysis will include the sociodemographic information, Noblit, and Hares' step process in qualitative data analysis, content validity index, and reliability tests.

**Results:** A valid and reliable tool was to measure compassionate care in clinical nursing practice in the Indian setting.

**Conclusion:** Compassionate care is an important aspect of nursing. It is vital for the provision of quality care. No tools have been developed to assess the construct of compassion in nursing practice. The study will yield a finally validated tool for measuring compassionate care in nursing practice.

**Keywords:** Compassion, development, empathy, nursing

## INTRODUCTION

Over the time, the way patients are treated and cared for has been put under limelight. A lot of concerns about poor care, lack of humanity, dignity, value for human life, and failure to treat people with compassion has been noticed.<sup>[1-4]</sup> This has influenced public perceptions that a lack of compassion exists within the general context of nursing. The word "compassion" is derived from the Latin com (together with) and pati (to suffer).

Compassion might then be defined as "suffering with." It is understood to involve emotion, such as empathy or sympathy, and a rational understanding of the suffering that enables identification with it; for example, the ability to deliberately and altruistically participate in another's suffering.<sup>[5]</sup> Empathy begins with gaining an insight into the patients concerns, feelings, and source of distress. 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 to alleviate it. Compassion is therefore a reaction to empathy.<sup>[6]</sup> If compassionate care is routine in health-care delivery models, nursing behaviors and actions that exemplify compassion ought to be easily identifiable to patients. A better understanding of the patient must be reached for the nurse to care for the patient in an effective meaningful way.

The complexities of compassion, its effect on patient care, and the historical roots of the compassion need to be explored.

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Current understanding of compassion predominantly arises from professional perspectives, with limited insight from the perceptions of individuals who have experienced nursing care. Professional standards call for nurses to practice with compassion (e.g., American Nurses Association [ANA] Code of Ethics, International Council of Nurses), and innumerable hospital mission and vision statements include compassion as an essential purpose and directive. Provision 1 in the ANA (2001) Code of Ethics expresses nursing's commitment to patients and the community, stating "The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems." Despite the importance of compassion and increasing interest from researchers, clinicians, teachers, and other professionals, there is a lack of consensus on its definition and a paucity of psychometrically robust measurement tools. Without these, scientific enquiry is greatly impeded – we need consensus on a definition and valid and reliable measurement tools to assess compassion in empirical research. The present study has been undertaken to develop a tool for compassion considering the multidimensional aspects of the particular concept.

Many studies have been undertaken to understand the construct of compassion in clinical practice but there seems to be a paucity of Indian literature in the current concept. A study by Lori Burnell in 2013 to develop a compassion care assessment tool is the only available tool in nursing practice in the global scenario. The various attributes identified were meaningful connection, patient expectation, caring attributes, and capable practitioner.<sup>[7]</sup> Nurses embody and enact compassion through behaviors such as spending time with patients and communicating effectively with patients. Patients experience compassion through a sense of togetherness with nurses<sup>[8,9]</sup> A study by Papadopoulos *et al.* (2016) to explore the nurses' views and experiences of a number of compassion-related issues in nursing and at an international level had the findings such as: The majority of participants (59.5%) defined compassion as "Deep awareness of the suffering of others and wish to alleviate it" but definitions of compassion varied by country. Of the participants, 69.6% thought compassion was very important in nursing and more than half (59.6%) of them argued that compassion could be taught. However, only 26.8% reported that the correct amount and level of teaching is provided. The majority of the participants (82.6%) stated that their patients prefer knowledgeable nurses with good interpersonal skills. Only 4.3% noted that they are receiving compassion from their managers. A significant relationship was found between nurses' experiences of compassion and their views about teaching of compassion.<sup>[10]</sup> A study by Zamanzadeh to identify factors facilitating nurses to deliver compassionate care found the personal system of values and beliefs-personal interest, spiritual/religious beliefs, family upbringing, and altruistic motives; patient experience-patients experience by nurses, patient experience in nurses family; and positive role models and teachers as role models.<sup>[11]</sup>

The process of tool development is logical, systematic, structured, and iterative (Rattray and Jones, 2007)<sup>[12]</sup> labor intensive and lengthy process demanding a fair amount of statistical sophistication. It is because, the developed measure requires to internalize the characteristics namely, conceptual clarity, reliability, validity, responsiveness or sensitivity, interpretability, and adaptability to language and culture (Maloney and Chaiken, 1999).<sup>[15]</sup>

DeVellis (1991)<sup>[14]</sup> in his book on scale development outlined the general guidelines for the development of measurement scales, namely, (1) clarity of phenomenon to be measured, (2) generation of item pool, (3) choice of a measure (format of measurement), (4) review of initial item pool by experts, (5) validation of items, (6) administration of items to a development sample, (7) evaluation of items, and (8) optimization of scale length.

Polit and Beck (2012)<sup>[15]</sup> in their book on nursing research described five stages in the process of development of self-report scales, namely, (1) conceptualization and generation of items; (2) evaluation of items through internal and external review; (3) preliminary assessment by administering to a development sample; (4) analysis of scale development data: item analysis or factor analysis; and (5) scale refinement and validation including establishment of cut off points, norms and the manual.

## Objectives of study

### Primary objectives

The primary objectives of the study are as follows:

1. To develop an instrument to measure compassionate care delivered by nurses from patients' perspective
2. To test the reliability and validity of the scale and compare it with the gold standard tool.

### Secondary objective

The secondary objective of the study was to compare the concepts of Jean Watson's Theory of caring with the construct derived from compassionate care.

### Hypothesis

The compassionate care in nursing practice can be identified, observed, and measured.

### Ethical approval

Ethical approval has been obtained from the ethics committee of BMHRC, Bhopal.

## MATERIAL AND METHODS

### Research design

Non-experimental research design is used.

### Research approach

A mixed method will be used for the study as it is the most suitable method for the development of items for compassionate care in the study.

## Population

### Target population

Patients and nurses.

### The setting of study

The proposed study will be carried out at BMHRC Hospital, Bhopal Madhya Pradesh.

### Accessible population

Patients and registered nurses in BMHRC hospital will be the accessible population.

## Criteria for sample selection

### Inclusion criteria

The following criteria were included in the study:

- Registered nurses with 15 years of experience in a clinical setting
- Patients who have experienced at least three hospitalizations.

### Exclusion criteria

The following criteria were excluded from the study:

- Critically ill patients
- Maternity patients/and patients with primary psychiatric diagnoses.

## Sampling size and technique

The probability, purposive sampling technique will be used for the study.

The various tools used for the study include a sociodemographic data sheet, a focused group discussion guide, and a compassion care assessment tool.

## Methods of data collection

### First phase

1. Defining the construct compassion – “Compassion is the ability to understand the suffering of a patient and able to take steps to alleviate the suffering by the nurse”
2. Developing test items for the construct of compassion.
  - a. Comprehensive review of literature-(Existing research, theories from different databases)
  - b. Personal interview with patients and staff nurses.
  - c. Analyzing the data obtained through personal interviews to deduct various items
  - d. Development of a pilot tool with the help of items generated through a and c
  - e. Expert rating of the items in the pilot tool by evaluating each item on a 4-point scale (4 = Highly Relevant; 3 = Quite Relevant/Highly Relevant but Needs Rewording; 2 = Somewhat Relevant; and 1= Not Relevant). Then, the CVR is calculated using the following formula to evaluate the ratings:

$$CVR = (ne - N/2) / N/2$$

- f. Development of draft tool by adding or deleting items as per content validity ratio.

### Second phase

The draft tool will be piloted among 100 patients asking patients to rate elements representing compassionate care from two perspectives – the importance of each item personally and the degree to which their nurses made these elements apparent during current hospitalization. The strength of the response is measured by assigning a value to each statement from not important to extremely important (1–4). Reliability will be checked by inter-item and item-total correlation.

### Third phase

The tool developed will be given to patients along with the compassionate care assessment tool. The concurrent validity will be assessed by correlations between the scales and norms for interpreting compassion will be determined. Factor analysis will be used to test the variability among survey items to look for patterns and relationships.

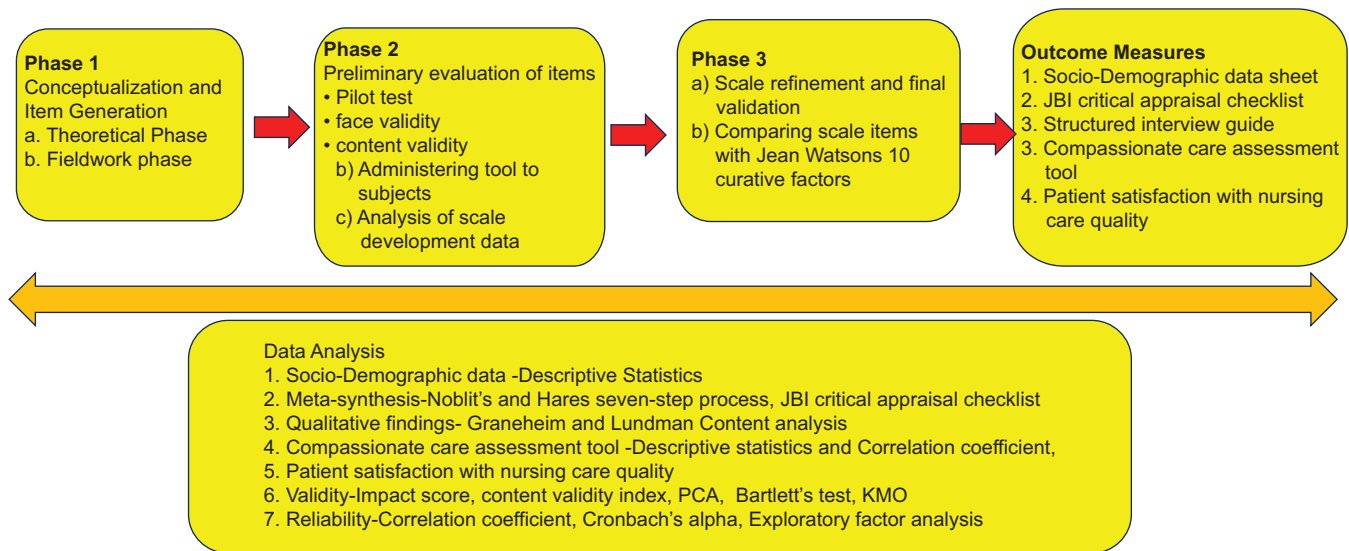
The items in the tool will be compared with Jean Watson’s Theory of Caring which includes the following 10 components.

1. Practicing loving-kindness and equanimity within the context of caring consciousness.
2. Being authentically present and enabling, and sustaining the deep belief system and subjective life world of self and one being cared for.
3. Cultivating one’s own spiritual practices and transpersonal self, going beyond ego self.
4. Developing and sustaining a helping-trusting, authentic caring relationship.
5. Being present to, and supportive of the expression of positive and negative feelings.
6. Creatively using self and all ways of knowing as part of the caring process; engaging in artistry of caring-healing practices.
7. Engaging in genuine teaching-learning experience that attends to wholeness and meaning, attempting to stay within other’s frame of reference.
8. Creating healing environment at all levels, whereby wholeness, beauty, comfort, dignity, and peace are potentiated.
9. Assisting with basic needs, with an intentional caring consciousness, administering “human care essentials,” which potentiate alignment of mind-body-spirit, wholeness in all aspects of care.
10. Opening and attending to mysterious dimensions of one’s life-death; soul care for self and the one being cared for; “allowing and being open to miracles.”

The entire phases of the study are depicted in Figure 1.

## Data analysis

The data will be subjected to qualitative and quantitative analysis throughout the different phases of the study. Descriptive and inferential statistics will be used for the data analysis with the use of a statistical program – IBM’s Statistical Package for the Social Sciences. A statistical significance of 0.05 ( $P < 0.05$ ) will be adopted throughout the study.



**Figure 1:** Schematic representation of research design<sup>[13,15]</sup>

## DISCUSSION

There are operational issues in the identification of multiple items for compassionate care in the Indian setting as many of the attributes seem to be overlapped with the broad concept of caring. No studies are in the Indian context exploring the concept of compassion from the perspective of nurses and patients.

## CONCLUSION

The study findings will generate a tool to measure compassionate care in clinical nursing practice in the Indian setup. The assessment tool will help nurses to get an insight into the attributes of compassion and, in turn, improve the quality of nursing care.

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## CONFLICTS OF INTEREST

There are no conflicts of interest.

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