Black and minority ethnic (BME) nurses and the provision of compassionate care in an acute hospital: A pilot study

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PROJECT REPORT

RESEARCH TEAM

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1. EXECUTIVE SUMMARY

Background

A good deal of attention has been focused on black and minority ethnic nurses (BME) in relation to their transition to working in healthcare settings in the United Kingdom. Research in the 1990's and early 2000s focused primarily on the isolation, discrimination and marginalisation BME nurses experienced, which can make service delivery challenging for them. More recently, discussion has focused on the value of BME nurses at a time of increasing global scarcity of nurses, on ethical aspects of global migration and on UK changing immigration legislation. The result from the recent Brexit referendum is also likely to impact on nurses who self-define as BME and are from Europe and further afield.

Recent media attention to deficits in care has raised questions about the relationship between patients' experiences and nurses' responsibility for compassionate care. There has also been some scepticism as to whether care deficits are due to a lack of nurses' compassion or due to other reasons such as cognitive dissonance and organizational factors. This is an area that needs to be researched further and aspects of compassionate care have not previously been explored. There is a gap in the research literature regarding the impact of the cultural background of nurses on perceptions of compassionate care. Most particularly, little is known about any differences in the delivery of such care amongst those nurses who self-identify as members of BME communities and those who self-identify as non-BME.

This project is timely as it is in keeping with the recommendations of the recently published *NHS Workforce Race Equality Standard:*

> We know that care is far more likely to meet the needs of all the patients we're here to serve when NHS leadership is drawn from diverse communities across the country, and when all our frontline staff are themselves free from discrimination. These new mandatory standards will help NHS organisations to achieve these important goals (Simon Stevens, Chief Executive of NHS England 2014).

Research aims

The overall aim of this pilot project was to explore the perceived relationship between the cultural diversity of nurses (to include midwives and healthcare assistants) and its impact on compassionate care. Objectives included investigating BME and non-BME nurses perspectives on compassionate care, what enables and inhibits compassionate care and on evidence from NHS documentation of patients, relatives' and staff' views as to what enables and undermines good care.

Project design

The project was initially planned to be of three months duration. However, this was extended due to delay with ethical review and challenges with recruitment during an exceptionally busy period in the NHS. The project had three components: a

literature review; qualitative interviews with nurses, midwives and healthcare assistants and a review of Trust documents. Focus groups with other members of staff were planned but were not possible due to Trust care demands and staffing challenges.

Ethical considerations

The project proposal and accompanying documents (Participant Information Sheet, Consent form and adverts) were submitted to the University of Surrey Ethics Committee and a favourable ethical opinion was granted. They additionally received approval from Ashford and St Peter's Hospital NHS Foundation Trust Research and Development committee.

Methods

Semi-structured individual interviews were conducted with 16 nurses, midwives and healthcare assistants from 4 departments. Four self-identified as White British, 11 as BME or White non-British and one self-identified as mixed-race.

Findings

Four key themes with sub-themes were identified from the analysis of the 16 qualitative interviews. The themes are (i) *elements of compassionate care* which involves: treating people as individuals; the provision of fundamental care; care of the family; and the demonstration of empathy and sympathy (ii) *enablers of compassionate care* which include: good teamwork; staff development opportunities; and a positive organisational culture (iii) *challenges regarding compassionate care* which include: staffing levels and workload; patient challenges and expectations; bullying and discrimination; and organisational culture and (iv) *perceptions of impact of nurses' culture on compassionate care* which relates to: the influence of nurses' culture; and the impact of the cultural background of the nurse on compassionate care.

Discussion, Conclusion and Recommendations

Our findings are in accord with recent research relating to compassion in care. Given the small number of participants and limited number of documents accessed, it is impossible to make claims about the relationship between staff diversity and compassionate care. We propose 3 areas of recommendations:

Healthcare practice –We recommend that Trusts pay particular attention to staff induction and welcome/hospitality events to enable new staff to integrate more fully. We recommend also initiatives such as buddying.

Staff education – We recommend that staff utilise existing educational resources such as the Cultivating Compassion toolkit and that time and space is made in everyday practice for discussion of ethical and professional practice more generally.

Future research – We propose a large scale study to investigate the significance of cultural identity and also to ask participants to speculate as to the causes of, and most effective responses, to compassion challenges in the UK

2. ACKNOWLEDGEMENTS

We would like to thank The Burdett Trust for Nursing who funded this pilot study through the Trust's Small Grants Scheme. We are also grateful to staff at Ashford & St Peter's NHS Foundation Trust who hosted the study. Most particularly, we owe a debt of gratitude to Martha Wrigley, along with her Research and Development (R&D) team who all assisted with recruitment and room bookings. We would also like to thank Kit Tapson who conducted the original literature review and assisted in preparing the project for ethical review. We also owe a debt of gratitude to Catherine Koch who edited the final version of the report.

Without study participants, the research would not have been possible. We are grateful to the nurses and healthcare assistants who participated in the project. They kindly agreed to be interviewed taking precious time out of a busy work schedule. They have given generously of their views and experiences regarding cultural diversity and compassionate care.

3. INTRODUCTION, RESEARCH AIM AND RESEARCH DESIGN

This report details findings from a pilot study on the theme of cultural diversity and perceptions of compassionate care relating to a sample of nurses, midwives and health care assistants in Surrey. The study included a literature review, qualitative interviews and a review of Trust documents.

The pilot study activities enabled the research team to gain some appreciation of what is understood by the concept of 'culture' from the perspective of nurses, midwives and health care assistants. This suggests the influence this might have on the provision of compassionate care. The pilot study also provided the opportunity to explore the understanding of compassionate care held by nursing and midwifery staff and healthcare assistants. It was also possible to draw some conclusions about the perspectives of patients and their families on compassionate care from literature and on perceptions of good care from documentary analysis of Trust data [this was not identified explicitly as 'compassionate']. The study suggests factors that enable and challenge the delivery of compassionate care and possible strategies which could contribute further to supporting compassionate care.

Research aims and research design

The pilot project **aim** was to explore the perceived relationship between the cultural diversity of nurses (to include midwives and healthcare assistants) and its impact on compassionate care. **Objectives** were: to investigate BME and non-BME nurses perspectives on compassionate care; what enables and inhibits compassionate care; and on what can be learnt from evidence of NHS documentation of patients, relatives' and staff' views as to what enables and undermines good care. The focus was on the cultural background of individual nurses, their views of compassionate care and on how cultural background may impact on relationships with patients, families, colleagues and hospital leadership.

The project was initially planned to be of three months duration. However, this was extended due to delay with ethical review and challenges with recruitment during an exceptionally busy period in the Trust.

Following receipt of a favourable ethical opinion from the University of Surrey Ethics Committee and research and development approval from Ashford & St Peter's Hospitals NHS Foundation Trust (ASPH,) an advert was inserted in the Trust newsletter inviting those interested to contact researchers for further information about the project. Those interested were sent a Participant Information Sheet (PIS). In addition, members of the research team visited the orthopaedic, elderly care, paediatrics and maternity departments. These four departments, identified to participate in the project, were introduced to the research face-to-face during visits by members of the research team and by supplying Participant Information Sheets.

The project had **three components**: a literature review; qualitative interviews a review of Trust documents; and. The **literature review** generated research questions relating to the meaning of compassionate care, the influences, if any, that culture has on the provision of compassionate care, what inhibits and facilitates this, and strategies to ensure the delivery of compassionate care (See **Section 4** of this report).

Semi-structured individual interviews were conducted with 16 nurses and healthcare assistants. Four self-identified as White British (one said she had Romany background), 11 as BME or White non-British and one self-identified as mixed-race
Questions asked of study participants, supported by the literature review, were as follows:

- What led you to work in care? Describe your journey.

- What is your understanding of 'compassionate care'? Please give examples from your practice of i) situations where you or a colleague delivered compassionate care? And ii) times when you were on the receiving end of compassionate care?

- Can you think of an example from your experience when either you or a colleague failed to give compassionate care? Why do you think that this was?

- What do you understand by 'culture'?

- What influence, if any, does culture have on the provision of compassionate care? Please give examples from your practice.

- What, if anything, helps you to deliver compassionate care? What makes it challenging?

- In addition to compassion, what values underpin your practice?

- What, do you think, do ASPH and other NHS Trusts need to do to ensure that compassionate care is delivered and received at all times?

- What barriers do this and other Trusts face in trying to achieve the delivery of compassionate care at all times?

A semi-structured approach to interviewing allows the researcher to '[…] engage in dialogue whereby initial questions are modified in the light of the participants' responses and the investigator is able to probe interesting and important areas which arise' (Smith & Osborn, 2003, p. 57). This provides flexibility, for although the interview is based upon a number of pre-prepared questions, these are intended only as guidance, freeing the researcher to pose questions in any order whilst also recognising the participant as 'experiential expert' (Smith & Osborn, p.59). In other words, areas considered important by the participant, but which were not predicted by the researcher can surface, facilitating rich description and yielding in-depth accounts of participants' experiences (Di-Cicco-Bloom & Crabtree, 2006; Lambert & Loiselle, 2008). Data were analysed thematically using the framework of Braun and Clarke (2006).

The t**hird component of the research involved documentary analysis of Trust documentation** such as patient and family website feedback; patient and family feedback questionnaires; Trust's annual report; Staff Forum Comments; Quality report; Equality and Diversity report; and complaints data.

The next section presents findings from the literature review.

4. LITERATURE REVIEW

4.1 Introduction

In this literature review, the following search terms were used: Black and minority ethnic nurses; Black and minority ethnic patients; internationally recruited nurses, compassionate care; and compassion. The electronic databases searched were: BNI; CINAHL; ProQuest Nursing and Allied Health; Pubmed; and The King's Fund. The inclusion criteria were: English language; peer reviewed; national; and international journal papers, and government reports, medical reports and policy documents, dating from 1975 to 2015. The focus of the literature and policy was the UK. We focus on a discussion of more recent literature**.**

4.2 Background

For the last 50 years, black and minority ethnic (BME) nurses have been employed in the United Kingdom (UK) nursing workforce (Alexis & Vydelingum, 2005). A recent report from the Royal College of Nursing (RCN 2015) summarises trends regarding the initial registrations on the NMC register of internationally recruited nurses EEA and Non-EEA nurses. The report states that the last peak in the international recruitment of nurses was in the early 2000's with over 16,000 nurses registering with the NMC. The majority of these were from outside the European Union. After a decrease from 2003, numbers are again rising. The report states that:

> In 2014-15, a total of 8,183 internationally recruited nurses joined the NMC register to work in the UK; 7,518 from within the EEA (European Economic Area) and 665 from outside the EEA (RCN 2015 p.2).

With cuts in the number of places for student nurses in the UK and increasing demand on health and social care services, UK employers are likely to struggle with recruitment and retention of nurses. This is a global phenomenon with data from the World Bank confirming that, in 2014, there was a shortage of 2.4 million nurses. By 2015, it was reported that by 2025 there will be a shortfall of 10,000 nurses due to migration to the Middle East, the US and other regions. There is a shortage of nurses also in the United States, Australia, Canada and Japan. It has been estimated that there will be a shortfall of approximately 600,000 nurses in the European Union by 2020 (See RCN 2015).

NHS Chief Executive, Simon Stevens (Merrifield 2016), for example, said that:

> We've got about 130,000 European Union nurses, doctors and care workers in the NHS, and in care homes, and we would surely miss the effect, the impact, the benefit they would bring were some of them to choose to leave.

In addition, amendment to the immigration rules in 2012 state that a nurse who entered the UK after April 6th 2011 on a tier 2 visa will have to earn £35,000 to apply for indefinite leave to remain. Under the new rules a nurse may only remain in the UK for a maximum of 6 years if the high income threshold is not satisfied.'(RCN 2015 p.3). The impact of these immigration changes and of Brexit remain to be seen but it seems likely that there will be consequences for health and social care in terms of ongoing challenges of recruitment and retention for employers and opportunities available for local and overseas nurses.

4.3 The experiences of black and minority ethnic nurses working in the United Kingdom

Research relating to the experience of BME nurses in the UK in the 1990's and 2000s focused their negative experiences of marginalisation, discrimination and exploitation (see for example, Allan & Larsen, 2003; Allan et al., 2003; Alexis & Vydelingum, 2005; Withers & Snowball, 2003, DiCicco-Bloom, 2004; Matiti & Taylor, 2005). Attempts at integration were hampered by language barriers, which not only inhibited the forming of social connections, but also the effectiveness and efficiency of care delivery, a disadvantage also perceived as a shortcoming by some members of the healthcare team (Alexis & Vydelingum, 2005). In extreme cases, patients refused care, simply because of the BME nurse's inability to create a mutual understanding (Lopez, 1990). Amongst Asian nurses, such events were taken personally, partly because of their cultural socialisation, but also, because of the cognitive dissonance with their self-perception as compassionate and competent professionals (Yi, 1993). Such conflict frequently left the nurses frustrated, stressed and deeply saddened by feelings of inadequacy (Alexis & Vydelingum, 2005). According to Buchan (2003) confidence was further undermined by the allocation of duties that were not appropriate for the qualifications of BME nurses, data corroborated by Larsen (2007), who found that BME nurses with

advanced qualifications and experience, are allocated positions as healthcare assistants, with little opportunity for professional development. Managers were often passive in the face of complaints about unfair treatment, fearing to unsettle the equilibrium, a reaction referred to by Puwar (2001) as the 'latent character' of racism. Other examples include infantalisation, when a black person is wrongly assumed to be a junior and receives a lack of recognition for their hard work, but also, the assumption that black nurses will assimilate to the values and behaviour of the dominant white culture (Puwar, 2001).

In addition, data from the study by Larsen (2007) highlighted the increased likelihood for nurses recruited from overseas to be the subject of disciplinary action since their professional skills were being constantly questioned. According to Pope (2012), if managers' model discriminatory behaviour by disciplining nurses from overseas, such attitudes could become the norm, and are difficult to change once integrated into the culture.

The Race Equality Action Plan of 2004 (DH 2004) stated that:

> The NHS and Department of Health must give even greater prominence to race equality as part of [their] drive to improve health (Kline, 2014, p.6).

A survey of the leadership of NHS Trusts in London reports that 41% of staff and 45% of the population are from black and minority ethnic backgrounds and suggests that little or no progress has been made in meeting these goals (Kline, 2014). It is claimed that London's BME NHS staff are discriminated against in recruitment and promotion, that they are disproportionately found in lower grades, disadvantaged with bonus payments and more likely to face disciplinary action. The latter is a problem which Kline attributes in large part to their under-representation at senior managerial level. For example, the proportion of Chairs and Chief executives of the Trusts who responded to Kline's survey and who are BME, is strikingly low (see table 1), such that any discussion of equality is already inequitable (Kline, 2014).

Table 1: Survey on Board Membership in London: findings.

	White	BME	Unknown	Total	% BME
Chair	39	1	0	40	2.5
Chief Executive	38	1	1	40	2.5
Executive Members	197	16	3	216	7.4
Non-executive Members	190	22	5	217	10.4
Board total	464	40	9	513	7.9

There is some evidence that BME nurses do not always react negatively to deleterious working conditions (see for example, Allan & Larsen, 2003; Larsen, 2007; Alexis & Vydelingum, 2005; MORI, 2002). Whereas for some, the experiences of discrimination and the constant undermining of professional values can prove draining, others use this as a springboard to progress, by reasoning exploitative treatment as the product of their UK colleagues' professional incompetence (Larsen, 2007). The reason for this alternative response was originally attributed to the theory of social suffering, a notion suggesting that economic, social and interpersonal disadvantage are embodied to impact an

individual's way of being (Charlesworth, 2005). For example, feelings of hopelessness and lack of confidence experienced by some BME nurses may be amplified by the violent nature of their country of origin (Larsen, 2007). By internalising their life expectations, individuals unwittingly accept social and institutionalised disadvantage, adjusting their expectations accordingly (Bourdieu, 1977, 1991). Such thinking represents the phenomenological precepts of lived experience as inseparable from our physical and social world (Smith, 2008), and is important as it supplements perspectives on organisational power and the affect upon employees (Jackson 2005, p. xi).

It has been suggested that how individuals respond to their life circumstances may be considered in terms of self-compassion, describing a non-judgmental attitude to self, where thoughts and actions are reflected upon without guilt or shame (Heffernan et al., 2010). However, before this topic is developed, the subject of compassion in care is considered in more detail.

4.4 Compassionate care

In 2010, the Government published the NHS Constitution (2010a), which aimed to establish the principles and values underpinning the health service and identify the rights of patients. In relation to compassion, the constitution claimed:

> […] we respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for those we serve and work alongside. We do not wait to be asked, because we care (DH, 2010a: 12).

Less than 3 years later, however, reports by Francis (2013), into the failings at the Mid Staffordshire Foundation Trust and by Keogh (2013), into urgent and emergency care revealed serious deficits in the provision of healthcare, such negative evidence bringing a lens to bear on compassionate care. As a result, political and professional drivers for compassion in contemporary nursing have taken on increased significance, placing the healthcare professions under scrutiny (Straughair, 2012).

Although the Prime Minister's Commission on the Future of Nursing and Midwifery in England (DH, 2010b) had also identified compassion as key to healthcare delivery, it was considered to lack clear definition as to what compassion in nursing really entailed. The Department of Health stipulated that '[…] compassion required the highest levels of skills and professionalism' (DH, 2010b: 3). However, researchers recognised that, because of its subjective nature (Davison & Williams, 2009; Harrison, 2009; Dewar et al, 2011) the competent, values-based care necessary to effect respect and dignity for patients, compassion was complex. It is important to recognise that compassion and whilst it is necessary, it is not sufficient to respond adequately to the complexity of holistic care in an ever-changing health and social care context.

4.5 What is compassion?

Compassion is not a new concept and has been discussed in Buddhist and Christian writings, for example, for millennia. It has been described and debated as both a religious and a secular value and virtue, as an emotion, a psychological process, a political phenomenon, as a core value in professional writing and as a topic of

empirical research for some time. The word ‘compassion’ comes from the Latin ‘co-suffering’ or ‘to suffer together with’ (Austin et al 2013). It is said to capture two different ideas: one that involves recognition of, and identification with, the suffering of others; and a second involving a motivation to help, that is, to respond to relieve the suffering.

Von Dietzea and Orbb (2000) suggest that confusion regarding the theoretical and practical dimensions of compassion is due to lack of clarity as to how compassion is distinct from concepts such as empathy and sympathy. The latter two concepts are distinct from each other. Empathy is usually understood as being aware of the feelings and emotions of others, and experiencing them for ourselves through the power of imagination (Olsen 1991). In the context of healthcare delivery, this translates as the ability to interpret the feelings, thoughts, or perceptions of the patient so as to provide professional care (Olsen, 1991). The subtle difference with sympathy is the capacity to be affected with the same feeling as another, and therefore, an association with pity differentiating the passive nature of sympathy from the more active notion of empathy (von Dietzea & Orbb, 2000). Of importance, Schwaber (cited in Olsen 1991, p. 64), identifies that neither empathy nor sympathy imply good care in or of themselves. The needs of the patient and responses to those needs make claims upon a nurse’s motivation or behaviour (Northouse, 1991).

Compassion implies a more participative stance, communicated as the deliberate involvement in another person’s suffering. In other words ‘not merely identification of the suffering but identification *with* it’. It is this emphasis upon agency and action which differentiates compassion from empathy and sympathy and its moral value within nursing (von Dietzea & Orbb, 2000, p. 168). Neff (cited in Heffernan et al., 2010), continues this theme by suggesting that:

> Compassion is the ability to acknowledge and be moved by the suffering of others; it encompasses a desire to help the suffering person and a willingness to be non-judgmental (p.367).

Nef then turns the focus of the discourse to the individual, with his opinion of self-compassion as having the *same* ability (Neff, 2003). In fact, for Neff, the dialogue of compassion is almost inseparable from self-compassion. To attain the former is challenging in the absence of the latter. To achieve self-compassion necessitates that the individual has an objective and non-judgmental awareness of their emotions, which encompasses an understanding and self-kindness when feeling inadequate or when suffering (Heffernan et al., (2010). Heffernan et al., (2010) consider a possible solution to be the screening of nurses to identify low-self-compassion. This intervention could enable this population to benefit from specific training.

This is of particular significance in relation to BME nurses. Cole-King and Gilbert (2011) write that:

> Being able to bear distress and cope with it, allows us to be *with* distress, actively remaining present to listen and feel able to work out with the other person what might be helpful for them (p.31).

Earlier research, previously referred to above, detailed BME nurses experiences of marginalisation, discrimination and isolation have induced frustration, stress,

sadness and feelings of inadequacy (Alexis & Vydelingum, 2005). It seems possible that self-compassion may be challenging in these circumstances which could undermine their compassion. However, a search of the literature revealed no previous research explicitly asking BME nurses about their understanding and experience of compassionate care.

The term compassion is frequently used in conjunction with other concepts and values relating to nursing care (Pearson 1991; Downie & Calman 1994), and is conceived as a means to address the patient's holistic needs. As suggested above, it is important to contextualise compassion within a broader ethical framework.

4.6 Patients' attitudes about compassionate care

Cornwell & Goodrich (2009) state that:

> Anecdotally, it is the presence or absence of compassion that often marks the lasting and vivid memories patients and family members retain about the overall experience of care in hospital and other settings (p.1).

Improving levels of compassion represents a significant goal in key policy documents (DoH, 2008). This objective is of particular relevance as research suggests that effective compassion positively affects treatment outcomes, since patients are more inclined to communicate their symptoms whereby aiding a diagnosis (Epstein et al, 2005). Additionally, with anxiety known to delay healing (Cole-King and Harding, 2001), and compassionate caring found to reduce anxiety (Gilbert and Procter, 2006), compassion is likewise linked with an ability to heal. However, there is worldwide concern of failing levels of compassionate care (Youngson, 2008) and also concerns patients' experiences of compassion with the care they receive (Darzi, 2008; DoH, 2012).

In a qualitative study by Bramley and Matiti (2014), a purposive sample of 10 hospital inpatients took part in semi-structured interviews, with the aim of understanding how patients experience compassion, and ways in which compassionate nursing could be developed. Findings revealed that for the participants, caring was synonymous with compassion, where providing time with patients, given acknowledgement of busy ward environments, assumed significance as a precious commodity. Despite Hayter's (2010) recognition of the time needed to establish a compassionate relationship, patients iterated that a fleeting association was sufficient to establish a connection. Overwhelmingly, the patients wanted the nurses to understand what it felt like to be them, citing empathy as key in pursuit of this goal and of particular relevance when nursing behaviour was perceived as uncompassionate (Bramley & Matiti, 2014).

Dewar and Nolan's (2013) narrative synthesis of the extant literature on compassionate care found no consensus as to the definition of compassion, nor a model as to how it could be achieved in practice. They explored the relational processes and practices that support compassion, as part of a three year project called the 'Leadership in Compassionate Care' project (Edinburgh Napier and NHS Lothian, 2012). Appreciative enquiry was the project approach and involves a four phase process starting with a discovery phase to identify 'the best of what already exists', and culminating in the destiny phase, experimenting with 'what can be'

(Moore, 2008, cited in Dewar & Nolan, 2013, p.1249). Central to its creation, is an 'enriched environment', cultivating a collectivist attitude which facilitates staff, families, carers and patients in working together to shape the way things are done (Dewar et al, 2011).

In the study by Dewar and Nolan (2013), staff, families and patients undertook appreciative caring conversations as to the behaviours needed to encourage compassion, revealing that for patients, being known and understood represented the basis of compassion. For staff, recognition of their hard work epitomised compassion. The findings concluded that making these connections had played an important part in establishing relationships, where staff subsequently challenged engrained practice, developing a questioning culture to effect individualised care.

Not all outcomes using appreciative enquiry have yielded such positive findings however. The cultivating compassion project (Ramage et al 2015) developed a cultivating compassion toolkit, where the activities included were founded on the premise of celebrating compassionate acts. The intention was that designated trainers would communicate the insights to compassion leads who, in turn, would then cascade the strategies to their wider teams across NHS organisations. The findings revealed that, despite the enthusiasm of some participants, the project had initially been met with scepticism by others who felt that they already understood compassion, an attitude that instigated resistance. In addition, integrating the toolkit activities within existing mandatory training initiatives proved challenging unless supported by more senior leaders, such as ward managers. These staff had the authority to negotiate time slots where compassion activities could be *"squeezed in*" (CCP, 2015, p.5), and without whose influence, attempts at generating interest often floundered.

Patients also acknowledged that their own negative attitudes towards nurses could be instrumental in inhibiting a compassionate dyad, with the ward culture an additional influence in changing compassionate behaviour (Bramley & Matiti, 2014). The patients recognised communication as central to the compassionate relationship, a requirement also acknowledged in policy (DoH, 2012). Above all, it was personalised care that patients identified as central to compassionate nursing, where entering into the patient experience introduced an ethical element, reinforcing the moral dimension of compassion previously eluded to by Von Dietze and Orbb (2000, p.8).

Given the diverse needs of patients in relation to compassionate care, a question of significance is whether, or how, cultural heritage influences such needs, a topic developed in the following section.

4.7 Ethnicity and its relationship to compassionate care

It has been suggested that a culture contains sets of values, beliefs, and habits learned during development and socialisation, shaping the behaviour and decision making which motivates individuals' actions (Doswell & Erlen, 1998; Wros et al., 2004) Equally, these criteria characterise the nature of carers, and therefore, the caring interaction. And yet, nurses providing care to BME patients are found to consider them a homogeny (Vydelingum 2000), whereas, as Balarajan & Raleigh

(1993) point out, BME populations have a varied language, religion and lifestyle that differs, not only from the majority white population but also from each other, thereby effecting how they experience compassion.

An early UK report into dementia care for BME groups, found that BME individuals and their carers were not accessing services in the same numbers as others and were thus marginalised (Badger et al., 1988). This is a problem that Moriarty et al., (2011) consider to originate with their low levels of awareness about the disease. In fact, when afflicted with dementia, BME groups often attributed their symptoms to 'going mad', partly as there is no term in some BME languages for dementia (All-Party Parliamentary Group on Dementia, 2013 p.24). Such myths create significant stigma about dementia, further alienating BME groups from seeking care (Moriarty et al, 2011). When they did access services, BME patients often discerned the support available as inappropriate for their faith or culture, and as with BME cancer patients, language barriers prevented coherent exploration of their case, a situation hampered since many interventions and support groups were talking therapies (All-Party Parliamentary Group on Dementia, 2013)

There is some evidence that nurses have deficits in their understanding of culturally competent compassionate care and that there is a need to develop learning tools for students', teachers and practitioners aimed at enhancing students' knowledge (Papadopoulos and Pezzella 2015). Papadopoulos (cited in Papadopoulos & Pezzella, 2015) has defined culturally competent compassion as:

> the human quality of understanding the suffering of others and wanting to do something about it using culturally appropriate and acceptable nursing/healthcare interventions which take into consideration both the patients' and the carers' cultural backgrounds as well as the context in which care is given (p.2).

Work by the RCN (Dhaliwal & McKay, 2008) has focused on the perspective of black nurses in the delivery of care to a predominantly white patient cohort. The majority of black nurses who were interviewed emphasised empathy as key in their motivation to care and considered this made a difference to the lives of sick and vulnerable patients. Despite the obstacles they faced from colleagues and managers, the acknowledgment of the value of their care through contact with patients affirmed the work that they did, helping to balance negative experiences.
There were many examples of racism directed at the black nurses by patients and their families, for example, patients refusing treatment from black nurses, but also, instances of direct verbal abuse. On one occasion this occurred in front of a matron who overlooked the incident and still urged the black nurse to treat the white patient who had complained

Dhaliwal and McKay (2008), propose that overlooking refusals to be treated by black nurses passively condones such action and invariably fosters a culture of racism within the workplace. Notably, only one nurse spoke about the existence of clear health policies against patient refusal to be treated by black staff. However, the black nurses frequently justified such racist behaviour from their perspective as compassionate caregivers, where their professionalism to some extent vindicated the patients' difficult behaviour as an acceptable dimension of ill-health.

4.8 Strategies to promote compassionate care.

To compensate for trends in alleged decreasing altruism, Straughair sees effective nurse recruitment, which identifies a motivation to care, as essential in the selection process of appropriate nurses. This approach is already implemented in some UK higher education establishments through strategies including one-to one interviews, group discussions, attitudinal surveys and emotional intelligence assessments (Saldanha 2006). In addition, Straughair proposes post-qualification education, that advances the patient perspective, whereby embedding compassion within the core of nursing.

Straughair (2012) has suggested that compassionate care begins at the recruitment process where nurse educators must strive to develop effective recruitment strategies which consider individual values and attitudes. Once recruited, policy and research (Bryant, 2010; Firth-Cozens & Cornwell, 2009; DH, 2010b; Straughair (2012) identifies that to enable nurses to demonstrate compassionate behaviours, appropriate support systems must be in place. Additionally, the Department of Health (2010b) recommend that senior nurses, ward sisters and corporate leaders must uphold the ethos of considerate care and be accountable for standards of patient care, whereby embedding compassion as a core value through leadership.

Through role modelling this way, Firth-Cozens and Cornwell (2009) assert that more senior staff demonstrate the delivery of high-quality compassionate nursing care to others. However, Alain (1989) urges caution, since trainee nurses may be unable to discriminate positive from negative role modelling, with the risk of perpetuating less worthy traits. Conversely, Illingworth (2006) has suggested that, through modelling, student nurses go through a process of professional socialisation, where values, attitudes and beliefs are transferred from more, to less experienced nurses.

The significance of transferring compassion this way, is in fostering a receptive working culture, an important consideration, as nurses are socialised in teams and therefore benefit from an appropriate care environment in which to fulfil their potential. In addition, although individuals may not always share the same opinions, if negative attitudes predominate, these can become the accepted culture (Thompson et al 2006). Compassion can also prove problematic in locations where to express emotion is considered a weakness. Therefore, training plays a central role in championing appropriate displays of emotion as beneficial to interpersonal relationships. Providing regular feedback to staff on their performance and recognising when they deliver compassionate care, also reinforces compassionate behaviours.

Moreover, constant exposure to trauma can invoke defensiveness, causing nurses to withdraw and distance themselves (Straughair, 2012). Stress and depression is evidenced by high self-criticism (Brewin and Firth-Cozens, 1997), and a lack of self-compassion may manifest as a lack of compassion towards patients (Gilbert, 2009). Bryant (2010) proposes that nurses are afforded a safe and recrimination-free environment to reflect on their practice, and Smyth (2011), that they discuss and reflect on challenging emotional and psychological situations, so as to maintain ongoing development in relation to compassion in nursing. In this, patient stories have proven a powerful resource, an approach evoking considerable enthusiasm in the recent study ‘Cultivating Compassion’ (Ramage et al 2015).

A person-centred approach to nursing is also extolled by Pope (2012) as nurturing compassion. She writes that by exploring the emotional aspects of care, nurses cultivate a better understanding of how patients and family members define themselves, including their likes, dislikes, values and beliefs. In relation to the unethical behaviours directed towards BME nurses, Buchan (2003) recommends sound and legitimate ethical employment policies to address these issues. To overcome such discrimination, Larsen (2007) urges workplaces to ensure proper treatment of their staff through stimulating respectful dialogue and the monitoring of proper and fair professional practices. Since cultural change begins at an organisational level, (Cornwell & Goodrich, 2009), implying that unanimous dissatisfaction with the workplace philosophy requires the cooperation of all staff (Moss & Chittenden, 2008). Withers and Snowball (2003) add that, in the face of discrimination, overseas recruits are supported in reporting their complaint so that the Trust's policy on discrimination can be operationalized. A recent RCN initiative called the 'cultural ambassador programme' (Embly 2016) has been set up in the West Midlands in response to concerns that BME staff are over-represented in disciplinary and investigation processes. The scheme involves training volunteers from BME backgrounds in the Equalities Act and in strategies to challenge cultural bias or discrimination. The volunteers offer support to those being investigated.
Cornwell and Goodrich (2009) make the point that in an NHS service predicated upon evidence-based healthcare and quantified targets, measuring compassion poses a challenge. Yet, how compassion is measured is central to understanding how effectively it is being delivered. If the voice of nurses, patients and their carers is to be heard, then measures of compassion must primarily derive from personal and subjective accounts, sought through interviews; questionnaires; frequent feedback mechanisms; and surveys (Cornwell & Goodrich, 2009). Again, we would emphasise that that an evaluation of the effectiveness of care – whether qualitative or quantitative - needs to go beyond compassion and consider other features of ethical or good care.

In a report by Willis (2012) the quality of compassion is considered in the context of nurse education. His account details the progress of nursing in terms of academic reform. Willis proposes that with the development of educational opportunities, nursing research and evidence-based practice began to blossom. The emphasis upon evidence-based practice advanced following the publication of a commissioned report; Fitness for Practice (UKCC, 1999), in response to government and NHS concerns about whether newly qualified nurses were 'fit for purpose' (Kenny, 2004, cited in Willis, 2012, p. 12). An important finding was that:

> There were no shortcomings found in nursing education that could be directly responsible for poor standards of care or a decline in care standards.

There is, however no room for complacency and innovations relating to the development of ethical values in professional education need to continue. Initiatives such as the production of an online compassion toolkit, as in the Cultivating Compassion project (Ramage et al 2015), and the use of immersive simulation in the Researching Interventions to Promote Ethics in social care project (Gallagher and Cox 2015) suggest creative and engaging approaches to ethics education. It is also important to note there have

critiques of the focus on compassion in healthcare. Gallagher (2013), for example, cautions against 'monoethics' and argues that compassion may be necessary for healthcare practice but it is not sufficient. Other virtues or values such as justice, courage, integrity and trustworthiness are also required to practice ethically. Philosopher, John Paley (2014), challenges the idea that recent care deficits were due to compassion failure in individuals. He draws on a substantial literature in social psychology and argues that care deficits were due rather to:

> an interlocking set of contextual factors that are known to affect social cognition. These factors cannot be corrected or compensated for by teaching ethics, empathy, and compassion to student nurses.

Mindful of this critique and of other research that highlights the importance of attention to micro (individual), meso (organisational) and macro (societal) factors (RCN 2009), a consideration of compassionate care in relation to BME and non-BME nurses needs to be considered more broadly.

4.9 Conclusion

This literature review has provided an overview of research from the 1990's and 2000s that detailed overseas' nurses experiences of marginalisation, discrimination and exploitation. There is some more recent evidence demonstrating that, in the London area, fewer BME staff attaining senior positions. In addition to an ethical and professional concern with the experience of BME nurses, there is now also an impetus for a serious consideration due to a global shortage of nurses and challenges with recruitment and retention. Self-compassion emerged as a precedent to compassion, with the concern that the detrimental experiences of some BME nurses may undermine their sense of self-kindness, and thus their ability to deliver compassionate care. It has been argued that not only was clarity as to the meaning of compassion required, but this needed to be set in a cultural framework and promoted in the context of contemporary nursing practice (Papadopoulos & Pazzella, 2015). Although the topic of language barriers featured prominently in both policy and research, a breakdown in communication, surfaced as a recurrent theme for both BME patients and the nurses providing their care. Nurses felt vulnerable in undertaking procedures requiring a verbal response, and patients, that the inability to communicate left them isolated and unable to articulate their needs, an issue of significance with specific clinical conditions such as cancer and dementia. Nurses may need to recognise the reality of cultural difference as legitimate, so that these differences can be negotiated through ongoing interaction with their patients.

For Straughair (2012), tackling deficiencies in the delivery of compassionate care began with the recruitment process, where through values-based recruitment, suitable candidates joined the profession. Developing a person-centred approach was thought to perpetuate such ideals where relational knowledge fostered connections and emotional engagement; insights that promoted an improved understanding of the 'other'. In addition, this participative stance empowered the patient. Making explicit what person-centred compassion comprises and how it can be realised is challenging due to its largely subjective nature, however, it is an essential feature of compassionate care and ethical care more generally.

5. FINDINGS FROM QUALITATIVE INTERVIEWS

5.1 Introduction

Semi-structured individual interviews were conducted with 16 nurses and healthcare assistants. Four self-identified as White British (one said she had Romany background), 11 as BME or White non-British and one self-identified as mixed-race Staff who identified as BME and White non-British were from Nepal, Poland, the Philippines, Bulgaria, Iran and Portugal. Their areas of practice were: care of the older person; paediatrics; endocrinology; rheumatology; midwifery; and orthopaedics.

Four key themes with sub-themes were identified from the analysis of the 12 qualitative interviews. To preserve the anonymity of participants, we refer only to their role (registered nurse [RN], registered midwife [RM] or health care assistant [HCA] and their country of origin. The themes are outlined in Table 2 below:

Table 2: Identified themes

Themes	**Sub-themes**
1.Elements of compassionate care	Treating people as individuals Provision of fundamental care Care of the family Empathy and sympathy
2.Enablers of compassionate care	Teamwork Staff development Organisational culture
3.Challenges regarding compassionate care	Staffing Patient challenges and expectations Bullying and discrimination Organisational culture
4.Perceptions of impact of nurses' culture on compassionate care	Influence of nurses' culture Impact on care

5.2 *Theme 1 – Elements of compassionate care*

Participants' had clear views that compassionate care related to respecting the individuality of patients, to providing fundamental care that responded to patients' holistic needs, to recognising that compassionate care was related to values such as sympathy and empathy.

Treating patients as individuals

Participants reported treating patients as individuals and recognising 'people as people' as an important element of compassionate care. They believed this encompassed awareness of patients' needs, cultural or otherwise, and avoiding assumptions based on patients' cultural backgrounds or economic situations. Thus it

is suggested that compassionate caregivers do not stereotype patients and families and compassionate care is not a one-size-fits-all approach. Participants suggested that in recognising the uniqueness of each patient and perceiving patients as people, it was possible to adapt their behaviour and provide bespoke care to show compassion that was responsive to need. Examples of their perspective are as below:

> I think compassion is to try and understand what is uniqueness. I think it's uniqueness of every people is different (RN, Portugal)

> I think compassionate care is being aware of individuals' backgrounds, needs and religious beliefs, how they portray life as well – everybody sees life in a different way (RN, UK).

Empowering patients was another dominate theme. Participants frequently described respecting patients' cultural needs when possible and appropriate (e.g. enabling patients to pray in a quiet space) which was facilitated by providing interpreters/interpreting themselves if necessary. Offering choice formed part of respecting and meeting patients' needs and expectations, although participants reflected that sometimes this was not possible. For example, a midwife described how women from some cultures preferred a caesarean-section but the reality sometimes meant it was impossible to fulfil their demands. To address the mismatch between patient expectations and what is considered clinically appropriate, some participants described how they explained to patients why they were unable to fulfil requests. Updating patients and families, clear explanations and checking understanding appeared vitally important in showing compassion. Participants also reported the importance of not doing things to patients without asking first and assessing how much help patients needed and helping rather than doing everything for those who were able, All of these aspects of empowering patients had effective communication in common but were sometimes difficult to achieve with a busy workload:

> Every patient is different with a different culture…of course you have to speak with the patient, you have to try and understand what is the real problem (RN, Portugal).

> Like if they want to be just comfortable, not get up in the chair, you know we advise them … but in the end they still have their own decision you know… just giving them some choices, what to eat. You don't just shove the plate in (RN, Philippines).

Participants explained that caring for patients' emotional needs and empowering them were crucial elements of compassionate care and made fundamental care more effective. Essentially, compassionate care appeared to influence patient outcomes. Thus, staff felt they were more likely to elicit information that might be relevant to the patient's condition; patients appeared more likely to tell staff their symptoms and concerns; and they were more likely to cooperate with staff:

> There is one patient, particular patient, she visited the ward quite often, you know she's one of our regular patients. In the beginning she was

> quite you know stressed and scared, and then you know when I talked to her I tried to make her understand that we are not going … we are doing scary things really, but if we explain to her what exactly we're doing you know, we can make her relax somehow, so she won't be so stressed and you know scared of what we are doing. And after that she let me … specially me … she let me do many things that she didn't let other people do to her. (RN, Iran).

It was also suggested that empowering patients and respecting their autonomy – helping them to do things for themselves when they could – eased staff workloads and allowed them to prioritise patients with the greatest clinical need. Responding to patients' individuality is then, according to project participants, an important element of compassionate care.

Provision of fundamental care

Other key elements of the provision of compassionate care included providing fundamental care; that is, attending to patients' physical and emotional needs. Compassionate care appeared to be expressed through actions as well as words:

> I always introduce myself, make sure they know my name, tell them day…you know that it's Monday 8th February. Just feel important you know. Like simple things, sometimes when the bowl, finish the wash, I put their feet in, you know? Older people haven't this ability now (HCA, Poland).

Compassionate care appeared to start with providing good fundamental care that could be demonstrated in practical ways (attending to physical needs) and connected to providing both dignity and respect. Washing a patient's feet is a very intimate and, most likely, a very welcome comfort to the patient. Participants frequently suggested providing fundamental care to patients was an element of compassionate care. Without competency in clinical care, participants suggested that empowering patients and caring for their physical and/or emotional needs were 'meaningless'. Delivering clinical care involved doing observations/monitoring patients, taking bloods and other tests (for example, blood pressure) as well as assessing pain.

Attending to patients' physical needs entailed providing personal hygiene care (for example, washing, oral care, and changing socks), taking patients to the toilet, making them comfortable (e.g. helping them to get out of bed), and feeding them/providing water when required.

Caring for patients' emotional needs was described by participants as 'doing the simple/little things' and kindness, such as being approachable and friendly. This includes greeting patients, introducing themselves, and smiling. A participant reported how she softened how patients were given information that might be upsetting, for example, telling parents of babies where the sex of their child was unclear that a 'simple' test would be able to tell them and that in the meantime they had a healthy baby. Ensuring privacy, for example, by closing curtains and respecting dignity were also perceived as compassionate and respectful behaviours.

For example, one participant described how she helped a patient who was unable to open his bowels on a busy ward:

> So he couldn't get out of the bed to go to the loo, and he didn't open bowels for a few days and he was on the bay with other patients, and it's very hard for him to open the bowels. I can give him just a bed pan and close the curtains, say 'take your time'. 30 minutes after – nothing happen. 'Okay you're going to try later'. I think this is not the point, you can understand what is the environment, you know because why he cannot open the bowels. This is the reason. Because he is on laxatives for a few days and the problem was he didn't want that other patients hear the sounds of open the bowels – that is the point so I move him to the side room so just to give him more privacy (RN, Portugal).

It might be suggested that the example above demonstrates physical care. However, the nurse could have attended to the patients' physical needs by providing a bed pan and closing the curtains. By taking the time to help the patient to somewhere more private and attending to his emotional needs - embarrassment and fear - the nurse demonstrated compassionate care.

Participants also highlighted the importance of clinical competence to meet holistic needs and of the importance of the 'simple things':

> Obviously before you can give compassionate care, care that's acceptable, you need to know what you're doing basically…taking observations…medical side of things. You have to have knowledge, a base too so that you can be giving are properly to provide … feed and to do personal things, washing and so on (RN, Philippines).

> So let's put it in a very simple language – don't brush it off, do it proper with care … and it's not about just physical care, include mental health care, include communication, see what's going on. So it's a little bit deeper than just physical care, compassionate care, that's my understanding (RN, Iran).

> Just simple things like washing face (RN, Nepal).

Providing compassionate care then also entailed adopting a holistic approach to caring for the patient which included providing competent clinical care and attending to physical and emotional needs as well as supporting their families.

Care of the family

Providing support to patients' families, for example, by updating and informing and by providing support was also cited as a component of compassionate care. This also appeared to facilitate fundamental care because families who were not kept informed and/or involved in the patient's care could become demanding of nurses and healthcare assistants' time and subsequently a challenge to providing compassionate care.

> We try to explain to them what's the situation of their mum, dad or anybody (RN, Nepal).
>
> Especially within my work it's the family as well. Making sure they're supported, they're well managed, they're informed of the care that we're giving them, that they're up to date. So today actually, I just went through with dad, just that he understood what they meant before and to make sure he got what the doctor was talking about (RN, British Romany).

The moral qualities or dispositions of the caregiver also featured as elements of compassionate care.

Empathy and sympathy

Showing empathy through 'putting themselves in the patient's position' and relating to patients was cited by all participants as an important element of compassionate care. Some of them drew on personal experiences as patients in the past which appeared to have a profound effect on how they delivered care and influenced their understanding of patients' individual needs, including the importance of being responsive to how they might be feeling:

> But still most of them, they are confused, so you have to understand that they can't help it (RN, Bulgaria).
>
> You can't look after a patient or a person without putting yourself into their shoe and what they're feeling…I believe it's one of the most important things (RN, Philippines).
>
> So you have the understanding of what they're going through, even if you're not experiencing it yourself … but you can actually feel what that other person must be going through (RN, British).
>
> Just try to put yourself in their shoes if I may say that, just to understand what they feel. And by understanding what they feel, you can help them (RN, Iran).

Participants reported that showing sympathy towards patients was a crucial part of compassionate care.

> For me it's being able to show sympathy and giving care to them…like an elderly patient with dementia we have to understand when they have bad days (RN, Nepal).
>
> It's about sympathy (RN, Bulgaria).

Another participant shared a vivid practice example that suggests the importance of empathy in compassionate care:

> I remember sitting by the side of him on the bed and just holding his hand and trying to comfort him, and getting quite upset myself. But it didn't matter really because I needed him to know that this was an

> awful situation that he was in, and I felt terribly sad for him. So that, what was that exchange of 'It's awful, it's totally awful what's happened to you'. To show that I was upset for him was a way of me expressing my total sadness for him. (RN, British mixed race).

So compassion, from the participants' perspective, encompasses empathy, sympathy, kindness and respect for both patient and caregiver. It involves also treating patients as individuals, recognising their uniqueness and treating patients as people.

5.3 *Theme 2 - Enablers of compassionate care*

Teamwork

Participants agreed that teamwork facilitated compassionate care and the majority reported they worked well within their team. They described examples including having clearly defined roles, helping each other with patients - for example, moving patients - sharing best practice through newsletters and booklets, and sharing information with each other about patients on an informal basis and during multidisciplinary meetings which involved all staff in decision-making. The following example suggests the importance of teamwork in meeting patient needs:

> If I notice that a patient looks different or the patient has got abnormal readings, or if something is bothering the patient, I have to go to my nurse and tell them 'look, this is happening. What shall we do?' So the nurse will say, 'Okay, this is what we will do.' Sometimes the nurse will come and help, sometimes she will say 'do this, help the patient, maybe she not comfortable. If it's like that, anyway it's a team (RN, Philippines).

Caregivers also need to have the appropriate preparation to deliver compassionate care.

Staff development

Participants reported training, and following guidelines, in clinical and compassionate care facilitated compassionate care. However, many had not received compassionate care training and reported funding cuts and lacking time as contributory factors. The benefits of training appeared unclear since many participants believed although compassionate care could be taught, putting it into practice was influenced by individuals' attitudes and behaviours, which they believed were difficult to change:

> I think compassionate care is something that no matter how much you train some people, a lot of it is dependent on the person and whether they're able to deliver it appropriately. But I definitely think you can educate people as to what compassionate care is, but how successfully they deliver it and build rapport with patients is separate to that (RN, British)

It was suggested that mentoring new staff in compassionate care would be beneficial because they could see and appreciate what is really meant by compassionate care in practice:

> It's being professional staff and what we have learned from our nursing and according to the guidelines and the policies of the trust as well from the NMC guidelines. We are encouraged to go to the Trust net; sometimes they have different newsletters and stuff (RN, Nepal).

Staff development is also influenced by organisational culture which is the next sub-theme.

Organisational culture

Participants in managerial roles reported providing feedback to staff who they perceived to have been uncompassionate with patients. They seemed to adopt a non-confrontational approach and involved the staff member in highlighting where they believed they had failed to provide compassionate care and why. This type of intervention appeared empowering because it provided staff with time to reflect and share ideas with managers without hostility. Further, many participants described the importance of feeling valued (i.e. having their opinions listened to) and having supportive managers who they felt would listen to concerns they might have, they could feed back to, and ask for advice about patients. Additionally, for participants who reported a Trust policy of providing patient centred care they appeared empowered because it demonstrated a shared commitment to deliver compassionate care:

> In the hospital's policy we need to put patients first. Which is quite a good idea … of my understanding of compassionate care…What they do is they give us a rough idea … so they want less paperwork, time for less paperwork, time more for patient. So at least now you can say 'Oh sorry I need to give time to my patients, I'll do this later'. The priority is patients (RN, Philippines).

> When you do talk to them [staff] afterwards I often ask open questions and see how they feel the situation was, so I'd say 'How do you feel that went in there? How do you feel you … you know when we needed to tell the parents that, how do you feel that went?' (RN, British).

Organisational culture appeared to be a key factor underpinning participants' ability to provide compassionate care to their patients in terms of the support they received from managers and members of their team, and whether they felt valued and empowered to be compassionate. Individual factors were also important. The view was also expressed that compassionate care was everybody's business and not just for those who delivered direct care.

> But now saying that, they have time for patients you know, time to care now which is a priority in our hospital in the hospital's policy, we need to put patients first. Which is quite a good idea, of my understanding of

> compassionate care. My manager supports that, so it's quite good. (RN, Philippines).
>
> The unit attitude is very important, so it starts from the top and it comes right down to the cleaners and everybody who works in the unit. Here you get people smiling at you, people coming for you, people are not pushed round the corners, and they don't get shouted at and everything else (HCA, Poland).

Most participants reported good relationships with other staff and believed they worked effectively as a team. Behaviours associated with effective teamwork included communicating in multidisciplinary meetings, sharing information, and helping each other. Challenges were also expressed in relation to compassionate care.

5.4 *Theme 3: Challenges regarding compassionate care*

Staffing

The retention of BME staff appeared to be a significant challenge experienced by participants, particularly those from overseas. Participants described how many of their BME colleagues had left nursing because they felt 'side-lined' and ostracised by their colleagues. There were also examples of nurses being promoted to more senior roles despite participants perceiving BME nurses who were more suited to those roles because they were more qualified, had greater experience, and demonstrated more compassion than the nurses who were promoted. Further, participants had experience of staff who were often less experienced, who demonstrated bullying, and who lacked compassion and who were then promoted. This appeared to negatively affect staff morale. So too when agency staff appeared less competent and BME staff were not permitted to carry out certain clinical activities:

> The staffing…they're sending agencies and when they come in they don't know the patients, they don't know the work, they don't know the routine, and sometimes for example it's a nurse coming in – 'I'm not allowed to give IVs, I'm not allowed to take bloods', at night time we only have two nurses and the agency will say 'I'm not allowed to do this, I'm not allowed to do that' (HCA, Philippines).

A demanding workload – comprising of low staffing levels combined with high numbers of patients including the expectation to do paperwork – was cited by all participants as the most common challenge of showing compassion. Some suggested they could be caring for up to 20 patients at a time, while others reported missing breaks to meet demand. As a result, participants explained they tended to prioritise patients according to clinical needs. Competing priorities and the ensuing stress appeared to make it more difficult for staff to feel and show compassion, creating a divide between their intentions and their abilities.

> I think the workload as well … when you're looking after 10, 11, 12 patients on a span of a couple of hours, I think it's quite hard … as

> much as possible you want to stay with the patient for longer than a couple of minutes (RN, Philippines).

Most participants described at least one example, and often several examples, of uncompassionate care they believed resulted from staff not spending enough time with patients. However, many of them felt it was possible to be compassionate (adopting the behaviours discussed previously and explaining why they were unable to spend more time with patients) in a limited timeframe. Further, providing compassionate care could be provided in parallel with clinical care:

> When I do something then I prompt the patient to talk at the same time and you get more information so later you don't need to go back to the patient and ask 'By the way, do you have this and this and this?' or 'Can you do this and this and this?' You can use the time when you are with the patient to get the information as well (RN, Bulgaria).

Such creativity may also be helpful as caregivers respond to challenges from patients and families.

Patient challenges and expectations

Patients and relatives were described as being challenging due to the disparity between their expectations and the reality of care but also in their attitude towards BME staff. This appeared particularly challenging since participants described the Trust as serving a predominately white British, middle class population. Some BME participants reported feeling patients treated them differently to their white British colleagues because they were from a different culture. These participants could not always describe particular behaviours but 'just a feeling' they had although a participant said relatives would often listen to her white British colleagues despite being more senior herself:

> As you can see I'm Asian background yeah … and sometimes I feel a bit, not intimidated, because I'm not from here. And if we're talking I mean with relatives of patients, and there's white nurses or whatever, sometimes they do more listen to them compared to us (RN, Philippines).

Patients with drug addiction were reportedly difficult to provide compassionate care to because they were more demanding than other patients and unwilling to wait to be helped:

> Sometimes it's difficult [to provide compassionate care] when we have very difficult patients. Sometimes they might be addicted with any drugs and they want certain things at certain times when we're looking after 10 or 12 patients on the same time and we need to prioritise according to the patients as well and their condition. I feel a little bit difficult to manage that kind of patient (RN, Nepal).

Some patients reportedly expected particular types of care despite their requests being unrealistic, for example, requesting forceps but not wanting an episiotomy). However, some participants expressed difficulties 'standing up' to patients because

as one participant stated ‘it takes courage’. Many of them provided numerous examples of vociferous patients - described by one participant as ‘those who shout the loudest’ - being given more time and attention than other patients, who might have greater medical, physical and/or emotional needs. Other participants reported prioritising care according to the seriousness of their patients’ condition irrespective of individual demands. It was unclear from the data whether participants explained to patients why they could not meet their expectations:

> Sometimes you have to balance that with the realities of care I find, certainly in midwifery and that type of thing. Their expectation and reality are actually quite far apart sometimes. So they’ll say I want this and this and this, but I don’t want an episiotomy and I don’t want this, But then they’ll say oh no I want a, you know an epidural (RM, British).

Participants also reported experiencing difficulties with relatives occasionally. For example, communicating with relatives who either did not speak English or spoke English as a second language was sometimes a barrier. However, participants appeared to overcome this by using interpreters or asking other members of staff who spoke the language to translate for them. Relatives from outside the UK could also be demanding of participants’ time because, sometimes, many of them expected staff to explain the patient’s condition and treatment. Participants addressed this by requesting a ‘spokesperson’. Thus, participants saved time which they were able to divert to other patients and their relatives. Participants who worked with elderly patients, particularly those with dementia, also reported difficult situations with relatives because relatives were often misinformed by patients about the care and treatment they were receiving. Thus effective communication with patients and families appeared crucial in reducing ambiguity surrounding care.

Bullying and discrimination

Participants described how staff attitudes and behaviours towards their colleagues were sometimes barriers to providing compassionate care. Some BME participants reported feeling discriminated against and side-lined by some of their colleagues. Their experiences included colleagues not including them in conversations, being questioned about whether they could understand English, and not being shown where to find equipment when they started in a new department:

> There is bullying here and people have- people left because of it. (RM, British).

> I feel discriminated, like put on the side…silly things…one girl… I ask her ‘where is the weighing hoist?’ I say ‘where is?’[She says] ‘Oh you can’t read the names? (HCA, Poland).

However, discriminatory treatment by colleagues was not reported by most BME participants:

> I don’t think you’ll find many people who are darker skinned or ethnic, have a different ethnicity, getting promoted – I almost never see it, and I’ve been here 15 years. I do think they are marginalised (RM, British).

> Some of them they was really lovely, you knew they have this compassion, they care and everything, and they left because they felt they treated badly, you know misunderstand you know (HCA, Poland).

Organisational culture featured both as an enabling and challenging feature of compassionate care.

Organisational culture

Staff attitudes and behaviours towards patients appeared problematic at times. Participants described instances of colleagues ignoring patients' requests, for example, for pain relief and being inappropriate. However, as previously mentioned perceptions of pain and pain management can be influenced by culture. Thus, some of the examples of BME staff not demonstrating compassion may have been influenced by cultural factors rather than staff being deliberately uncompassionate. Another cultural issue related to staff meetings:

> I'm here in the trust, 10 months – I never have staff meeting, I don't know if that's normal. We have staff meeting, we share information, like share like – that should be done…I just feel like if maybe you know colleague will be ask you know what we will do better, like nurses meet with … you know like ward meeting, things like that … maybe that will help you know (HCA, Poland).

Participants appeared more likely to report poor care it if they perceived their manager was supportive. Senior staff said they spoke to staff in lower bands compassionately to find out why they had behaved as they did and how they thought the patient might feel rather than trying to apportion blame. Senior staff in higher bands appeared to find it easier to challenge inappropriate behaviour than staff who occupied lower bands.

As for whether and how nurses' own cultural background impacted on compassionate clear, there were some interesting perspectives in the data.

5.5 *Theme 4: Perceptions of impact of nurses' culture on compassionate care*

Influence of nurses' culture

BME participants' values in particular appeared to be influenced by their own cultural background where caring for, and helping, their families and other people was the norm unlike in British culture where they perceived elderly people often had few relatives:

> I was brought up to help each other, you know, we were brought up to look after, you know an older person. When I see sometimes a granny at a shop or to the bus struggle, I just give them a hand. It's like something which I brought up with family, my mother, my parents teach me to do. My dad says 'Make sure you look after them, you wanted to be look after, and you wanted someone to look after us' (RN, Nepal).

Their cultural background appeared to positively influence compassion. However, some British participants believed the cultural background of nurses could negatively

influence compassionate care. For example, a ward manager reportedly observed German nurses being reluctant to offer pain relief to women in labour due a belief that pain during labour was 'natural' while African nurses were reportedly more likely to view patients in UK hospitals as 'spoilt' and therefore less likely to offer them choices about their care.

All participants had chosen to work in what they described as a 'caring' profession therefore they believed their values underpinning compassionate care were inextricably linked to wanting to 'provide the best care' they could and for some, this transcended cultural background.

Despite this, some participants believed nursing had shifted from being a vocation, where nurses were historically dedicated to nursing (described by one participant as 'being wedded to the role'), to a profession or job which had to be balanced with the demands of their personal life (i.e. the desire for a work-life balance). This shift was perceived as having a negative influence on compassionate care because nurses were reportedly more focused on their own needs than those of their patients and less likely to make sacrifices as a result.

Impact on care

There was little support for the view that the cultural background of the nurse impacted negatively or positively on compassionate care:

> I mean from my personal experience I don't think there is much of a difference with what I've seen. I mean I can't speak for everywhere. I think nursing staff … we all do things slightly differently, but I wouldn't necessarily say that it's necessarily you know culture based (RN, British Romany).
>
> I think it's not upon where you're from or what. It's upon your own value – who you are. It's individual (HCA, Poland).

5.6 *Conclusion*

Overall, then, the qualitative data reveals a complex picture of the elements of compassionate care and of the factors that contribute to and detract from cultures of compassionate care. The perspectives of BME and non-BME nurses reveal a good deal of insight and reflectivity, however, more data would need to be collected before claims could be made regarding the generalizability of the data to other Trusts and care contexts.

The third component of the project involved the analysis of Trust documents.

6. DOCUMENTARY ANALYSIS FINDINGS

6.1 Introduction

Documents that were analysed in this component of the research originated from a range of sources and were authored and/or created by diverse individuals/organisations and related to different units of care (see Table 3 below)

Table 3: Documents analysed by type, role and care context

Document Type	Author and/or Creator	Care context
Patient and family website feedback	Patients	Elderly (including dementia)
Patient and family feedback questionnaires	Carers/relatives	Paediatric
Trust's annual report	NHS Trust staff in one site	Maternity (pre- and postnatal)
Staff forum comments	NHS Trust	Orthopaedic
Quality Report	Care Quality Commission	Accident and emergency
Brochure of Patient Feedback Challenge	NHS Institute for Innovation and Improvement	-
Complaints statistics about acute Trusts	Parliamentary and Health Services Ombudsmen	-
Trust's equality and diversity report	-	-
Personal communication (email)	-	-

The emergent themes fit into one of two broad categories: patient/family and staff (Table 4). There is also overlap in relation to each theme. More specific detail of the documental analysis findings can be viewed in **Appendix 1**. An important feature of this data is that we cannot claim they represent the views of patients, families or staff on 'compassionate care' but rather their views regarding what matters to them in terms of good care or in relation to specific targets or standards according to the purpose of the data. There is also some overlap amongst data from patients, families and staff in some of the sections reported below.

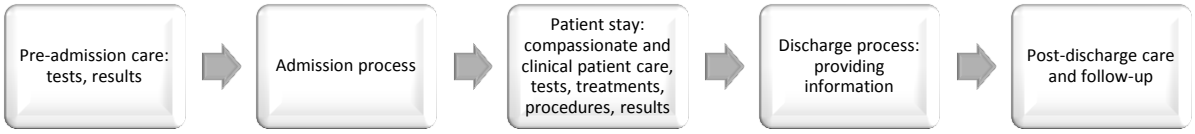
Table 4: Documentary analysis themes

Themes	Sub-themes
Patient and family perspectives	Staff attitudes and behaviour Communication Holistic care Responsibility for compassionate care
Staff perspectives	Importance of leadership Respecting diversity Recruitment Access to promotion Disciplinary action

There were five fundamental stages in patients' hospital journeys which emerged from patient and family feedback (See below). Patient and family feedback indicated that being cared for throughout their hospital journey was important to them. Evidence also suggested that good care was sometimes experienced throughout a journey (i.e. when positive feedback was received about the patient journey from 'start to finish' but without specific details) but could also be experienced during one stage yet not at another. For example, a patient reported:

> Even though the induction was painful at times, the staff were so kind and gentle. The level of medical care was second to none…After I gave birth however, I felt the care went downhill and I was rushed out of my delivery room very shortly without much chance of recovery by a patronising head of department midwife. (Patient feedback, maternity care, complaint on Trust website)

Figure 1: Patients' hospital journey



6.2 *Theme 1: Patient and family perspectives*

Four main sub-themes derived from the documentary analysis capture patient and family perspectives: staff attitudes and behaviour; communication; holistic care; and responsibility for compassionate care.

Staff attitudes and behaviour

Staff attitudes and behaviours such as being approachable and friendly, patience, attentiveness and responsive communication appeared to contribute to patients' and families emotional wellbeing. Further, privacy and dignity were also perceived as important.

Good care appeared to involve 'doing the little things'. Comments from staff, patients and families as well as observational data in reports described 'doing the little things' as an important facet of good care yet when these 'little things' were done badly, some patients and families complained. This suggests that while patients and families describe non-clinical elements of their care as 'little things', when these 'little things' are absent it is noticeable and impacts on their perceptions about their care.

Availability and accessibility of staff emerged from the data as important factors of good care. Complaints data suggested some patients and families experienced difficulties accessing consultants and doctors compared with nurses. Some complaints indicated consultants and doctors promised to follow-up but did not do so, thus patients appeared frustrated at not having their expectations met. Further, some patients perceived lengthy waiting times for tests, results and during the discharge process suggesting they may have experienced issues accessing staff. However, compliments data suggested accessing senior staff was not an issue for

others. There was no clear pattern indicating certain types of care (e.g. maternity versus care of the elderly) influenced patient and their families' access to staff. Access to nurses was rarely cited as an issue by patients and families who generally reported that staff members were attentive despite feedback suggesting they were often busy.

Staff attitudes and behaviours appeared essential in creating a compassionate working environment (internally) and in fostering relationships with patients, relatives and carers (externally). Teamwork (within and across departments), flexibility ('going above the call of duty'), communication (listening to patients and each other) and support were all described as important staff attributes in the provision of high quality care.

Communication

Communication was a key theme underlying compassionate care in the documents. Effective communication was important for reassuring patients and their families, expressing empathy and sympathy, and consistency of messages. Effective communication appeared important to patients and families because 35% of complaints made to the Parliamentary and Health Services Ombudsman about acute hospitals 2014/15 related to poor communication. Of those complaints involving communication, 71% referred to ineffective communication between hospital staff and the patient or their family. Further, staff attitude was linked to complaints about communication and was a factor in 21% of all complaints about acute hospitals in 2014/15.

Effective communication involved staff responsiveness to patients' and families' needs and reassuring them throughout their journey, although some feedback indicated specific points in the patient journey where communication was especially important. For example: during the admission process: before surgery; before a procedure; waiting for test results; during discharge; and post-discharge care. Reassurance entailed keeping patients and their families informed, providing clear information, and asking patients before giving them interventions. These factors also appeared to empower patients and families because they were able to be involved in decision-making about their care. Consistency of messages from different staff appeared to be a component of providing clear information and reassured patients and families. Some patients and families reported receiving inconsistent follow-up from hospital staff while others reportedly received no follow-up from more senior staff (e.g. consultants) which left them feeling confused and ignored.

Responsiveness to patients' and families' communication needs appeared important. For example, staff using age-appropriate language with young (e.g. talking to young patients and not just their parents) and elderly patients; understanding health conditions (e.g. being patient with dementia patients who might not understand) and communication impairments (e.g. speaking slowly and clearly); and sensitivity to culture and language (e.g. using interpreters when needed or using simple terminology) appeared to build trust, facilitate effective communication between staff, patients and their families and according to the Care Quality Commission (2015)

influenced the quality of care patients received. However, patients reported that unresponsive communication made them feel frightened, ignored or patronised.

Further, data from the Trust's Friends and Family Test suggested that while communication between accident and emergency and patients/families had improved (they met their target of ≥20%), their net promoter score of 48 was below their target score of 55 which they believed was partially owing to waiting time.

Responsive/effective communication appeared to be a facilitator of compassionate care among Trust staff and its success appeared to be influenced by the quality of leadership within the Trust. Ward-based staff were reportedly aware of initiatives at senior management level to address recruitment issues facing their Trust. Further, some data suggested difficulty changing staff attitudes and behaviours. However, from staff and Trust level feedback it appeared that, with effective communication, it was possible to influence attitudes and behaviours thus mobilising change:

> If you can show staff that what they can achieve [works] like an 'action, reaction', cause and effect, they can switch onto that. (Staff feedback, NHS Patient Feedback Challenge brochure)

Therefore, monitoring and reporting progress to staff appeared to be powerful motivators of compassionate care delivery. Knowledge sharing at staff forums or informally about staff perceptions and experiences as well as patient feedback, informing staff of changes and their impact, and access to training were examples of types of effective communication that appeared influential on staff attitudes and behaviours. In particular, 'peer to peer messages' were cited as 'powerful in engaging clinicians' in one report.

Holistic care

Caring for the whole patient, that is, their medical, physical, emotional and cultural needs are highlighted as very important in patient and family data. Compliments and complaints data were focused on non-medical rather than medical care which suggests other domains of care - physical and emotional - were viewed by patients and families as equally critical components of compassionate care. This is supported by data from the Parliamentary and Health Services Ombudsman which showed non-medical aspects of patient care featured in just under half of complaints about acute hospitals

Care provision was categorised as either responsive or unresponsive. Responsive care seemed to necessitate staff having exceptional knowledge and skills and involved 'doing the little things', treating patients as individuals, and attending to their physical and emotional needs. Patient and family feedback as well as observational data in reports on care was focused on meeting patients' physical needs and patients and families emotional wellbeing. Attending to patients' physical needs included creating a comfortable/appropriate environment, for example: provision of a play room for paediatric patients and ensuring patients were not too hot; helping patients, for example, taking patients to the toilet and helping new mothers with

breastfeeding; providing timely pain relief; and taking dietary requirements - providing gluten-free food for patients with allergies – into account.

There was very limited data on meeting cultural and religious needs of patients. The Care Quality Commission reported arrangements to provide diets and food meeting peoples' religious and ethnic needs. In contrast, one patient response to a patient satisfaction survey suggested their cultural needs were not met because their daughter was not given halal meat while she was in hospital. Without more evidence it is impossible to ascertain whether this experience was a 'one-off', an oversight, or reflective of a wider pattern of behaviour in the Trust.

The Trust reported patient and family feedback was organised according to clinical relevance rather than being grouped according to demographic information (e.g. ethnicity) thus nuances, and indeed patterns, in the data regarding the specific experiences of BME patients and family in comparison with patients from other backgrounds has not been captured.

Responsibility for compassionate care

Patient and staff feedback suggested that providing compassionate care was a collective responsibility of staff at all levels within the NHS. Porters, receptionists, consultants, food serving staff, junior doctors, nurses, healthcare assistants, physiotherapists, and hospital gym staff were mentioned in patient and family feedback (compliments and complaints) as well as staff feedback.

6.3 *Theme 2: Staff perspectives*

As can be seen above, there is common ground amongst patients, families and staff regarding the importance of staff attitudes and behaviour and communication. Other sub-themes that emerge from the documentary data analysis suggest: the importance of leadership; respecting diversity; recruitment; access to promotion; and disciplinary action

Importance of leadership

Participative leadership emerged as a key driver of compassionate care in the reports and staff feedback. Factors associated with effective and strong leadership included:

- Having a clear vision of compassionate care and the principles it embodies (i.e. focusing on quality and teamwork)
- Balancing flexibility and responsiveness with focussing on delivering against key objectives
- Using empirical evidence to influence practice (e.g. external review data, patient feedback)
- Setting standards for safety and quality (e.g. developing action plans and monitoring actions)
- Communication (e.g. listening and keeping staff informed)

- Empowering staff through participation (e.g. involving them in decision-making, allowing them to make decisions)
- Supporting staff (e.g. promoting teamwork, ensuring new staff are mentored and meeting cultural needs)
- Recognising achievements (e.g. creating forums for sharing achievements)
- Demonstrating awareness of issues (e.g. recruitment and retention of staff)

Perceptions about leadership were focussed on the factors described above. Report data suggested a considerable number of staff within the Trust had experienced 'inappropriate leadership' and the lack of 'formal leadership had been very difficult' for them. However, the data did not indicate what difficulties had arisen from 'inappropriate' or lack of 'formal' leadership.

Staff reported feeling 'listened to' and 'supported' under the new style of participative leadership. Midwives appeared empowered because they were able to make decisions regarding provision of a 'normalised childbirth experience'.

Respecting diversity

Data from the Trust's annual equality and diversity report for 2014/15 reported BME staff were more likely to perceive discrimination in the workplace compared with other groups (48% [n=98]) of respondents to a staff survey reported their ethnic origin as their perceived reason for discrimination) although how they experienced discrimination was not addressed by the data. Conversely, staff appeared enabled to observe their cultural identity (e.g. nurses were observed with covered heads) and one manager from a non-British background told the Care Quality Commission they had not encountered any discrimination in the workplace.

Recruitment

Data from the Trust's annual equality and diversity report for 2014/15 showed 32% of staff were from a BME group, which compares favourably to the average for local Acute Foundation Trusts (23%). According to the Care Quality Commission, management organised open recruitment evenings and overseas recruitment initiatives to meet increasing demands. However, actual recruitment data at the Trust showed a higher proportion of white candidates were appointed to posts (70.7%) within the Trust than were shortlisted (57.2%). Further, comments from a staff forum suggested that nurses from the Philippines were housed together and thus formed an alliance before entering wards. Consequently, the recruitment process of overseas nurses appeared to create an 'us and them' context. This appeared to be supported by negative feedback regarding BME staff talking in languages other than English in the workplace. For example, members of staff expressed difficulties engaging with staff who spoke languages other than English because it made them feel their interactions were unwanted.

Access to promotion

According to the Trust's annual equality and diversity report for 2014/15, BME staff were more likely to occupy lower band roles than white British staff and were under-represented at more senior bands. Additional data within the report indicated the proportion of BME staff in each band reduced with seniority irrespective of whether staff were qualified or not. They were also less likely to be promoted and, according to minutes from meetings about equality and diversity within the Trust, some staff believed this was owing to access issues. This may be for a number of reasons which include biased recruitment processes, accessibility to career development and skills training (staff reported experiencing difficulty accessing the training and development they required to undertake their roles), and the capability or credibility of some applicants. However, there was evidence of BME staff (including a manager) being encouraged, supported and supervised by their managers but it was unclear whether this was restricted to the probationary period for new staff or applied longer term thus enabling BME staff to achieve their full potential (Care Quality Commission report). Because BME staff tended to occupy lower band roles, staff communicated to us that nurses already in post at the Trust associated nurses from overseas with lower banding and less experience. According to one staff member their views may have been influenced by seeing nurses recruited from other countries into healthcare assistant roles until they assimilated to English nursing standards**.**

Disciplinary action

There was no evidence of a disproportionate level of employee relations action taken against BME staff.

6.4 *Conclusion*

Overall, findings from the documentary analysis illustrate the impact of positive patient and family experiences. In some cases, it appeared to positively influence patient outcomes:

> Friendly clean environment, nothing was too much of a chore, staff on hand constantly. Just so reassuring…I felt my recovery was more speedy too just with my pleasant surroundings! (Patient feedback, NHS Patient Survey)

Further, the effects of good care appeared far reaching with one comment on the Trust's website describing a staff member as 'gold dust to the community'. A shared desire of senior management and front-line staff to deliver good care also appeared to mobilise change through empowering staff in decision-making about care delivery. Staff morale, the work environment, staff relationships reportedly improved. Better communication and knowledge-sharing between different teams within the Trust resulted from these improved relationships suggesting that teamwork was positively influenced by the initiative. A reduction in patient complaints was also reported providing further support to the potential benefits of emphasising the importance of compassionate care for patients and families to NHS Trust staff and working with them to put the principles of good care into practice.

7. DISCUSSION

There is much in our findings that resonates with previous research as discussed in the literature review. The project aim was to explore the perceived relationship between the cultural diversity of nurses (to include midwives and healthcare assistants) and its impact on compassionate care. The objectives were: to investigate BME and non-BME nurses perspectives on compassionate care; what enables and inhibits compassionate care; and on what can be learnt from evidence of NHS documentation of patients, relatives' and staff' views as to what enables and undermines good care.

In discussing the themes that emerged from the qualitative interviews and documentary analysis, we are mindful that the data is from a small number of BME and non-BME nurses in one NHS Trust in the south of England. We cannot claim that our findings are generalizable. Nor indeed can we claim that we have definitive answers to the overall project research question regarding the relationship between nurses' cultural diversity and compassionate care. Whilst it is possible to report the perspectives of participants, it is not possible to claim that their views represent those of a wider sample. The documentary analysis data was collected for purposes other than for an evaluation of patient, family and staff perspectives on 'compassionate care' specifically. The most that can be claimed is that the documentary analysis findings represent perspectives on what matters to patients, family and staff in relation to good care and, perhaps, fair treatment in terms of promotion opportunities and respect for diversity.

Regarding the elements of compassionate care identified - treating people as individuals; provision of fundamental care; care of the family; and empathy and sympathy) – the sub-themes resonate strongly with what is already known about good or ethical care. Specifically, in relation to compassionate care, the findings confirm the features of compassionate care required by the NHS Constitution (DH 2015) and discussed by Firth-Cozens and Cornwell (2009) and Dewar and Nolan (2013). The participants in our study often spoke about the need to be flexible and responsive to patient need and readiness if care was to be compassionate. Compassionate care was care that is specific to the person receiving that care and needs to be considerate of the situation they are in at the time. They also recognised the importance of holistic care, that the 'small' things make a difference and of other values such as privacy, dignity and respect for patient autonomy.

In terms of the enablers of compassionate care, previous literature also recognised the value of teamwork, staff development and organisational culture (Firth-Cozens & Cornwell 2009). The important contribution of BME nursing staff in the NHS, identified in the literature review, is evident in the data. A study published in 2008 found that BME staff accounted for 28.4% of the Trust's total staff (Lyfar-Cissé 2008) whilst in a follow-up study published in 2010 the figure had risen to 29.5% (John 2010). An important finding from the Francis reports (2010, 2013) is the importance of organisational culture in supporting or undermining ethical care. Our study participants recognised that the leadership and values of their organisation with 'patients first' and 'time to care' made a significant contribution to compassionate care.

In many cases, nurses and midwives reported that supportive leaders and managers enabled them to deliver compassionate care within a busy and rule compliant setting. The argument is not that the boxes shouldn't get ticked, it is that the kind of leadership displayed by managers helped to ensure that staff were in the right frame of mind to notice, engage with and care compassionately, for patients and clients of the hospital. Good managers provided strong role models for the staff on their teams (Straughair, 2012, p.242).

Regarding the challenges that relate to compassionate care, study participants referred to staffing, patient challenges and expectations, bullying and discrimination and organisational culture. Staff shortages have been a feature in cases such as Mid Staffordshire (Francis, 2013: 1502) and there was some evidence that study participants experienced these also. There did appear to be occasions when workload might impact on staff ability to deliver compassionate care. Working with patient challenges and expectations was not a strong theme of the literature reviewed but was explicit in the data. As one participant said sometimes 'it takes courage' to respond to these challenges. References to experiences of bullying and discrimination is in keeping with earlier research reporting that some BME nurses employed in the UK were subject to negative experiences in terms of marginalisation, discrimination and exploitation (Allan & Larsen, 2003; Allan et al., 2003; Withers & Snowball, 2003; DiCicco-Bloom, 2004 Matti & Taylor, 2005; Alexis, 2015; Likupe, 2015). The majority of nurses in our sample, however, did not report significant, direct, experience of this type of problem. Nonetheless, the reports of examples of such experiences require attention. Reference to less positive aspects of the organisational culture of the Trust may indicate pockets of activity in the Trust where workloads and staffing levels create some heightened stress for staff (Straughair, 2012, p.242). The data is not sufficient to draw any strong conclusion at this stage.

The strong desire to deliver compassionate care, identified in the literature review was evidenced throughout all the interviews conducted in this Trust. The majority of stories told by respondents were positive. Whilst there was little evidence of managers modelling discriminatory behaviour (Pope 2012), it is clear that middle leadership behaviour and the creation of a particular sub-organisational culture have a strong impact on staff. Other middle leaders created a far more positive environment, which either attracted staff to the organisation or encouraged them to stay once they were there.

The fourth theme from the qualitative data related to participants' perceptions of the impact of nurses' culture on compassionate care. There was an acknowledgement that a nurses' cultural background, most particularly their early socialisation, might influence cultural care. There were positive and negative examples. For some, cultural background provided a strong rationale for care ('make sure you look after them') and, on the other hand, some cultural backgrounds might lend themselves to nurses withholding pain relief or considering UK patients to be 'spoilt'. An alternative view was that the cultural background of the nurse was of no consequence and it was 'who you are' that mattered.

Sub-themes of the staff perspectives in the documentary analysis included respect for diversity, recruitment, access to promotion and disciplinary action. In keeping with the qualitative data, some staff reported that BME staff were more likely to experience discrimination. Regarding recruitment, Trust data demonstrated that a

higher number of non-BME staff were appointed that were shortlisted for positions. In terms of promotion, the data showed that BME staff were less likely to be promoted and occupied lower band roles that white British. There was no evidence of a disproportionate number of BME staff represented in disciplinary hearings. This contradicts evidence found in the literature review that BME staff members were more likely to face disciplinary action than were their white, majority colleagues.

Patient and family complaints about communication resonate with some of the findings of the Francis report into the failings in care at Mid-Staffordshire Foundation Trust, however, found serious deficits in the level of compassion offered to patients in the hospitals that amongst the myriad of other issues raised the profile of the type of care offered by Mid Staffs in particular but also in other hospitals and resulted in a focus on compassionate care (Francis 2013). This may explain why patients sometimes complain about a lack of communication, humanity and real compassion when interacting with health care professionals and organisations. The routine and bureaucratic structures constructed around some health setting environments may be a cause of frustration as the structure gets in the way of compassion (Firth-Cozens & Cornwell 2009).

Firth-Cozens and Cornwall (2009) in discussing 'what stops compassion?' talk about the importance of the bio-medical model in professional training – the focus on "disease in scientific, pathological and physiological terms" (p.5). Whilst, this has led to great improvements in healthcare, it can, if practitioners are not careful, result in the neglect of compassionate care and failure to see the patient as a whole person (Firth-Cozens and Cornwell 2009). In such cases, physiological need may come so far before the individual needs of the person that these, and thus, compassionate care are ignored. Communication is also essential between professional colleagues as well as between care giver and patient/client. Where communication was open and timely compassionate care was more likely to be delivered. Where communication between either patient and staff member, or between two or more staff members, was hindered, whether by workload, culture or attitude, it was much more likely that there would be a breakdown in the delivery of compassionate care. There is, also, a need to consider the whole person, including their psychological needs alongside their physiological ones. Once the whole person is seen (made real) it is more likely that appropriate and compassionate care will be offered.

Overall, then, there is a good deal of resonance between findings from this pilot project and the literature review. Given the small number of participants and limited number of documents accessed, it is impossible to make claims about the relationship between staff diversity and compassionate care. What did seem clear is that the staff cared a great deal about compassionate and ethical practice.

8. CONCLUSIONS AND RECOMMENDATIONS

The project aimed to identify whether the cultural diversity of nurses impacts on perceptions of compassionate care and any differences in the delivery of such care between BME and non BME nurses. Given the small number of participants and

limited number of documents accessed, it is impossible to make claims about the relationship between staff diversity and compassionate care.

Bearing in mind the limited scope of this pilot study we have 3 areas of recommendations:

(1) **Healthcare practice** –We recommend that Trusts pay particular attention to staff induction and welcome/hospitality events to enable new staff to integrate more fully. We recommend also initiatives such as buddying to enable overseas staff to become familiar with the Trust and the local community. The cultural ambassador programme could also be considered to support BME staff members who are involved in the disciplinary process.

(2) **Staff education –** We recommend that staff utilise existing educational resources such as the Cultivating Compassion toolkit and that time and space is also made in everyday practice for discussion of ethical and professional practice more generally.

(3) **Future research –** This was a small scale study in one NHS Trust and findings are not generalizable. However, offering staff a safe forum to discuss issues of interest and concern appears to be important. We propose that future studies consider the complexity of the identities of BME and non-BME staff. Not all BME staff, for example, have come from overseas and many British nurses will self-identify as BME. What is the difference in their experience of care, if any? We propose a large scale study to investigate the significance of cultural identity and also to ask participants to speculate as to the causes and most effective responses to compassion challenges in the UK

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10. RESEARCH TEAM

Ann Gallagher is Professor of Ethics and Care and Director, International Care Ethics Observatory, University of Surrey. Ann has been working in the field of ethics for over two decades and is the Editor of *Nursing Ethics*. She has published widely and engaged in research relating to ethics in health and social care practice. Current and recent research topics include: compassion in the NHS, dignity in care homes, professionalism and paramedic practice and ethical aspects of professional regulation (email: a.gallagher@surrey.ac.uk). Ann was project Principal Investigator and collected and analysed data and led the writing of the final report.

Claire Jones is a freelance researcher with extensive experience in qualitative and quantitative research. She has worked as a Research Fellow, Senior Researcher and Medical Writer. Clair has conducted research in health care contexts and with the police. She has particular expertise in the areas of ethnic diversity and has conducted studies relating to police interviews with Afro-Caribbean and White British Suspects and with Black African and Black Caribbean women with breast cancer. Claire made a significant contribution to data analysis and report writing.

Chris Howorth, Royal Holloway University of London. Chris is a senior lecturer in Organisational Strategy in the school of management Chris's research interests are in Organisation Theory, Leadership, Change Management and Healthcare Organisation. He has carried out consultancy research in BME issues for a number of clients in sectors including the construction industry, military and local government. In addition to work on BME staff experience, current research includes re-evaluation of the use of Max Weber's work in organisation studies and optimal working hours. (e-mail: c.howorth@royalholloway.ac.uk). Chris collected project data and contributed to writing the discussion component of the final report.

Heather Caudle, Chief Nurse, Ashford and St Peter's Foundation Trust. With more than 20 years experience in Health and Social Care, Heather has worked as a nurse, systemic psychotherapist and strategic leaser in acute mental and supported housing sectors. Heather has a track record of developing and implementing transformational patient safety and quality improvement strategies. She was appointed as Chief Nurse in 2014 (email: Heather.Caudle@asph.nhs.uk). Heather initiated the project, contributed to the development of the project proposal and assisted with negotiating access to study participants.

Kit Tapson was Research Assistant for first 3 months of project. She has experience of qualitative research and administrative experience of co-ordinating research projects with a range of university and health organisation collaborators. Her PhD study related to the experience of young people who bully and their counsellors.

11. APPENDICES

APPENDIX 1 -: Examples of patient and family themes

Themes and subthemes	Example 1	Example 2	Example 3
Patient and family			
Providing compassionate care to patients throughout the hospital journey	Pre-admission and patient stay, needing directions: Directions to X ward in admission letter would have been useful. Saw the nurse check 02 and suction on arrival. The CQC would be very happy, [names removed] both awesome and amazingly attentive and very caring (Patient feedback, Friends and Family Test).	Patient stay, waiting for tests: The doctors and nurses are all very kind and helpful. I think it's good a person comes round to offer iPads and games to kids. On the other hand sometimes getting blood test results takes a long time. Apart from that everything is good (Patient feedback, Friends and Family Test)	Throughout the journey: X and her co-worker made my daughter feel very comfortable from the moment we arrived until we were discharged. Thank you. (Family feedback, Friends and Family Test)
Staff attitude and behaviours: (dis)empowering patients and families			
Communication	Understanding health conditions and communication impairments: One night of a bad experience with a bank HCA who was cold towards me, and not understanding my speech impairment. (patient feedback, Friends and Family Test, orthopaedics)	Using age-appropriate language: My child can be difficult to engage as she is very shy. All the staff on the ward worked really hard to find ways to engage with her. (patient feedback, Friends and Family Test, paediatrics)	Reassurance through keeping patients/family informed: I was getting quite worried and the nurse reassured me calling theatre to check my child was OK when he was down longer than expected
Availability and accessibility of staff	Difficulty accessing staff, waiting for results: Poor follow-up. Seems extremely disjointed and at times entirely inconsistent. Doctors and consultants do not follow-up or return when they say they will and implementation of follow-up actions are not done very thoroughly or results communicated. (Patient feedback, Friends and Family Test, orthopaedics)	Easy accessing staff: Great staff, super helpful, and very generous with their time (Patient feedback, Friends and Family Test)	Difficulty accessing senior staff: We have to speak to a special consultant which is like trying to get in touch with the queen (Feedback on Trust website)
Caring for the whole person			
Attending to physical and emotional needs	Not attending to physical needs: Leaving water out of reach and not helping her to see our baby in the night. Because she needed a wheel chair (website feedback).	Attending to emotional needs: Good care, feedback, courteous, caring, kind and supportive team (patient feedback, Friends and Family Test, care of the elderly).	Not attending to physical needs (pain relief): I was asking about epidural so many times but the midwife didn't care (website feedback)
Attending to cultural/religious needs	Meeting dietary requirements: Only the food is a problem, my daughter eats Halal food which was not available (Family feedback, Friends and Family Test, paediatrics)	There were arrangements to provide therapeutic diets and food that met people's religious and ethnic requirements (Care Quality Commission Report)	-
Differences between type of	A&E experience, waiting times and absence of pain	A&E net promoter score of 48 was below target score of 55	-

care	relief: Our A&E experience would have improved if my son had received pain relief sooner. It was 30 minutes before triage and nurses and an hour before he received some pain relief. Unfortunately he got lost in the system and waited over an hour for his second x-ray. (Parent, response on patient satisfaction questionnaire within the Trust).	(Trust's Friends and Family Test brochure)	
Responsibility for compassionate care	All staff: High quality of professionalism and displayed by all levels of hospital staffs (patient feedback, Friends and Family Test, care of the elderly)	All staff (including physiotherapists): All the staff were caring and supportive…would have appreciated better communication from physio re. no rehabilitation t community hospital (patient feedback, Friends and Family Test, care of the elderly)	All staff (including food serving staff): They were all so lovely…even the food serving staff (patient feedback, Friends and Family Test, orthopaedics)

APPENDIX 2: Examples from staff themes

Themes and subthemes	**Example 1**	**Example 2**
Staff theme: influence of organisational culture		
Importance of leadership: empowering staff	X always makes sure my efforts are known and appreciated on every shift (staff to staff feedback on website)	Putting principles into practice, working with staff, developing action plans, participative leadership style The new Associate Director of Midwifery had been in post for 14 months and a new engaging leadership style was evident. The current leadership team had developed a vision and were working on an action plan following the external review which focused on quality and team work (CQC Report)
Staff attitudes and behaviours	Going above the call of duty, being flexible, teamwork: These two members of staff go above the call of duty and do jobs outside of their working remit. X will come and help with clinical duties when we are short staffed and takes it upon herself to do gardening and is a very integral part of team (staff to staff feedback, website)	Making small changes to influence patient experience: Changes have been made within service areas, including discarding out of date publications left in waiting areas. The trust has identified that these small changes can have a big impact on patient experience.
Communication: influencing staff attitudes and behaviours	Improving effective communication, changing behaviours, improving teamwork: Staff anecdotally reported improved relationships – both internally with their colleagues and externally with patients, relatives and carers. The improved relationships led to knowledge-sharing across different teams within the Trust	It is very difficult to change attitudes and behaviours but if you can show staff that what they can achieve [works] like an 'action, reaction', cause and effect, they can switch onto that. (Staff feedback, NHS Patient Feedback Challenge brochure)

	(Working Together to Learn Patient Experience, NHS Institute for Innovation and Improvement)	
Issues facing a diverse work environment: creating a cohesive environment		
Respecting diversity	BME staff more likely to perceive discrimination in the workplace compared with other groups (48% [n=98]) of respondents to a staff survey reported their ethnic origin as their perceived reason for discrimination) (Equality and Diversity Annual Report, 2014/15)	The workforce was ethnically diverse. We saw that staff were enabled to observe their cultural identity, for instance, we saw nurses with covered heads. One manager from a non-British background told us they had not encountered any discrimination in the workplace and had been encouraged and supported by their managers to achieve their full potential.(Care Quality Commission at the Trust)
Recruitment	% shortlisted candidates: White 57.2; Asian 28.5; Black 13.3; Other 1 % appointed candidates: White 70.7; Asian 18.2; Black 6.3; Other 4.8 (Equality and Diversity Annual Report, 2014/15)	Recruitment process may create divisions: Nurses from overseas trained together meaning when they join the wards they have already formed alliances (summarised from staff email [at request of staff member])
Access to promotions	Discrimination grounds: 204/1466 (14%) reported discrimination Ethnic origin 29% Other 29%; Age 18%; Gender 16%; Disability 5%; religion 3%; sexual orientation 3% (Equality and Diversity Annual Report, 2014/15)	Meeting minutes access issues facing BME staff: BME staff not being promoted despite being qualified for the role
Disciplinary action	No evidence of a disproportionate level of employee relations action taken against BME staff which may reflect reluctance among managers to informally address performance/conduct issues of BME staff (Equality and Diversity Annual Report, 2014/15)	-